WELLPATH SELECT, INC.

CERTIFICATE OF COVERAGE
DIRECT ACCESS HMO

READ YOUR CERTIFICATE CAREFULLY

IMPORTANT CANCELLATION INFORMATION -- Please read the provision entitled "Termination of Coverage," which appears as Section 4 below.

THERE IS A PRE-EXISTING CONDITIONS EXCLUSION PERIOD INCLUDED WITH YOUR PLAN. Please see Section 7.3 below, "Exclusion of Coverage for Pre-existing Medical Conditions."

Welcome to WellPath!

We are extremely pleased to have You enrolling in Our Health Plan and look forward to serving You. We have built a strong network of area Physicians, Hospitals, and other Providers to offer a broad range of services for Your medical needs.

As a WellPath Member, it is important that You understand the way Your Health Plan operates. This Certificate of Coverage contains the information You need to know about Your Coverage with Us.

Please take a few minutes to read these materials and to make Your Covered family members aware of the provisions of Your Coverage. Our Member Services Department is available to answer any questions You may have about Your Coverage. You can reach them at (800) 935-7284 Monday through Friday, 8:00 a.m. to 5:00 p.m.

We look forward to serving You and Your family.

WellPath Select, Inc. ("WellPath")
Certificate of Coverage

The Agreement between WellPath Select, Inc. (hereafter called the "Health Plan", "WellPath", "We", "Us", or "Our") and You and between Health Plan and Your Dependents as Members of the Health Plan is made up of:

- This Certificate of Coverage, and amendments;
- The Schedule of Copayments
- The Enrollment Form
- Applicable Riders; and
- The Group Contract

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to this Agreement unless approved in writing by an officer of the Health Plan, and the resulting waiver, change, or amendment is attached to the Agreement. This Agreement begins on the date defined in the Group Contract. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the Health Plan. By paying premiums or having premiums paid on Your behalf, You accept the provisions of this Agreement.

THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY.

Many of the provisions of this Agreement are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement have special meanings. These words will appear capitalized and are defined for You. By using these definitions, You will have a clearer understanding of Your Coverage.

From time to time, the Agreement may be amended. When that occurs, We will provide an Amendment or new Certificate of Coverage to You for this Agreement. You should keep this document in a safe place for Your future reference.

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SECTION 1
USING YOUR BENEFITS

1.1 Membership Identification (ID) Card. Every Health Plan Member receives a membership ID card. Carry Your Health Plan ID card with You at all times, and present it whenever You receive health care services. If Your Health Plan ID card is missing, lost, or stolen, contact the Health Plan Member Service Department at 800-935-7284 to obtain a replacement.

- Referrals and Authorization. In the event You require Hospitalization, all care must be obtained from a Participating Provider unless specifically Authorized by Us. Prior Authorization is required if services are not available from a Participating Provider in the network. If Your Participating Provider feels that You need to see a Physician or other medical Provider who does not participate with the Health Plan, then Your Provider must call Us or might be required to submit medical information to Us in writing. The Health Plan's medical management staff will review the information and will notify Your Provider of the decision. The Participating Physician who admits You to an inpatient or outpatient facility is responsible for obtaining Authorization. For all other care, You may make an appointment directly with the designated Provider to obtain the Covered Services.

  Prior Authorization is required for the following services, medications and supplies:

  1. Ambulance Services (Non-Emergency)

  2. Outpatient Surgery

  3. Cosmetic and Reconstructive Services

  4. Durable Medical Equipment, Prosthetics, and Orthotics

  5. Elective Inpatient Admissions, including Acute, Skilled Nursing Facility, Hospice and Rehabilitation

  6. Services Considered Experimental or Investigational

  7. Home Health Services, including Hospice and Infusions

  8. Self-Administered Injectable Drugs, if Covered under a separate Prescription Drug Rider

  9. MRI, MRA, PET Scans, PET Fusion, Screening CT Scans and Nuclear Medicine Studies)

  10. Specific Oral Drugs as Indicated on Formulary, if Covered under a separate Prescription Drug Rider

  11. Transplant Services

Please Note: If We Authorize an admission, outpatient surgery or procedure based on a

material misrepresentation about the Member's health condition that was knowingly made by the Member or the Provider of the service, supply, or other item, and the Authorized services are a Covered Service but are not Medically Necessary, payment will be denied for charges incurred for those services.

NOTE REGARDING CONTINUITY OF CARE:
HMO Members with an Ongoing Special Condition have certain rights to continuity of care during the Transitional Period if a Provider agreement between Us and a Participating Provider terminates. In addition, newly Covered HMO Members who are undergoing treatment from a Provider for an Ongoing Special Condition and are newly Covered under the Plan because the Member's employer has changed health benefit plans have certain rights to transition Coverage by the Plan.

A. **Termination of Provider.** When an agreement between a Participating Provider and Us terminates, We will notify You of Your right to continuity of care if You are an existing HMO Member and We have reason to know that You are a patient of the terminated Provider and received care for an Ongoing Special Condition. You will then be able to elect to continue to receive Covered Services for treatment of the Ongoing Special Condition from the terminated Provider during the Transitional Period. **You must notify Us of Your desire to continue receiving treatment from the terminated Provider within 45 days.**

B. **Newly Covered Member.** If You are undergoing treatment from a Provider for an Ongoing Special Condition and You are a newly Covered HMO Member because Your employer has changed health benefit plans, then We will notify You of Your right to elect to continue treatment of the Ongoing Special Condition by the Provider during the Transitional Period. **You must notify Us of Your desire to continue receiving treatment from the Provider within 45 days.**

C. **"Ongoing Special Condition"** means:

(1) In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.

(2) In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.

(3) In the case of pregnancy, pregnancy from the start of the second trimester.

(4) In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

D. "Transition Period" means:

(1) For scheduled surgery, organ transplantation, or inpatient care: If surgery, organ transplantation or other inpatient care was scheduled for the Member prior to the date of notice or prior to the Enrollment Date as a newly Covered Member, or if the Member was on an established waiting list or otherwise scheduled to have the surgery, transplantation or other inpatient care, then the Transitional Period extends through the date of discharge after completion of the surgery, transplantation or other inpatient care, and through post-discharge follow-up care related to the surgery, transplantation of other inpatient care occurring within ninety (90) days after the date of discharge.

(2) For pregnancy: If the Member has entered the second trimester of pregnancy on the date of notice or prior to the Enrollment Date as a newly Covered Member, and the Provider was treating the pregnancy prior to the termination or prior to the Enrollment Date as a newly Covered Member, then the Transitional Period shall extend through the provision of 60 days of postpartum care.

(3) For terminal illness: If the Member was determined to be terminally ill at the time of the termination of the Provider agreement or at the time of the Enrollment Date as a newly Covered Member and the Provider was treating the terminal illness prior to the termination or the Enrollment Date, then the Transitional Period shall extend for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

E. Exclusions and Limitations of Continuity of Coverage.

(1) This section does not apply to You if Your Plan includes a Point-of-Service Amendment or option.

(2) WellPath is in no way obligated to provide payment or Coverage for services that are not Covered Services under the Plan. Nothing in this section shall be construed to provide Coverage for Non-Covered Services.

(3) The Provider providing transitional care must agree to adhere to WellPath's established policies and procedures and to accept reimbursement at the applicable rate, as provided by North Carolina law.

1.3 Payment to Providers.

A. Participating Providers. Payment of benefits for Covered Services will be arranged by Us to be made directly to the Participating Physician or Participating

Provider of the service. Payment for Medical Emergency and Urgent Care services will be made directly to the Provider or, at Our discretion, to the Member. Participating Physicians and Participating Providers may only seek payment from Our Members for approved Copayments and Coinsurance, calculated on the amount the Participating Physicians and Providers have agreed to in their contractual arrangements with Us. Members are also responsible for unauthorized or non-Covered Services.

Transplant services must be provided by a Coventry Transplant Network Facility to be Covered. In instances where Covered Services for transplants are provided by a Participating Provider that is not a Coventry Transplant Network Facility, the transplant services will **not** be Covered.

B. Non-Participating Providers.

(1) **Unreasonable Delay; Accessibility or Availability Concerns; Medical Emergency.** If a Medically Necessary service or supply cannot be obtained through a Participating Health Care Provider without unreasonable delay, or due to an accessibility or availability concern with Our Provider Network, You may obtain the service or supply from a Non-Participating Provider. You must obtain Pre-Approval from Us in order to have this service or supply Covered. If You obtain Pre-Approval, the Health Plan will cover the service or supply at the in-network benefit level, and You will be responsible only for any applicable Copayment, Coinsurance and Deductible. This also holds true in the case of a Medical Emergency in which the use of a Non-Participating Provider was because of circumstances beyond Your control.

(2) **Assignability of Benefits/Payment to Providers.** The benefits under this Plan are not assignable unless agreed to by Us. The Health Plan may, at its option, make payment to the Subscriber for any cost of any Covered Services and supplies received by the Subscriber or Subscriber's Covered Dependents from a Non-Participating Provider. In such instances, the Subscriber is responsible for reimbursing the Non-Participating Provider.

1.4 Submission of Bills and Claims. Participating Providers bill Us directly for all Covered Services (except Coinsurance). If You receive a bill or claim from a Provider, please send it to Us. You should submit a bill or a claim to Us within one hundred eighty (180) days of the date of service. Except in the absence of the Member's legal capacity, We will not accept claims or bills later than one year from the time submittal of the claim is otherwise required.

1.5 Copayments and Coinsurance. NOTICE: Your actual expenses for Covered Services may exceed the stated Coinsurance percentage because actual Provider

charges may not be used to determine Plan and Member payment obligations.

You are responsible for paying Copayments to Participating Providers at the time of service. Coinsurance amounts, based on the Health Plan's reimbursement to the Provider, will be billed to You by the Provider. Specific Copayments and Coinsurance amounts are listed in the Schedule of Copayments.

There may be situations under which You are required to pay a Deductible and/or Coinsurance amount for an In-Network Covered Service. In such a case, You would be responsible for paying the Deductible/Coinsurance based on the allowed amount. For example, assume Your Coinsurance is 20%, the doctor's billed charge is $120, and the allowed amount for that particular doctor is $100. You would pay $20, which is Your 20% Coinsurance of the $100 allowed amount. We would pay the remaining 80%, or $80, of the $100 allowed amount. You would not be responsible for paying the remaining $20 of the $120 billed charge.

- **Out-of-Pocket Maximum.** The individual Out-of-Pocket Maximum is a limit on the amount You must pay out of Your pocket for specified Covered Services in a Contract Year. The family Out-of-Pocket Maximum is the limit on the total amount Members of the same family Covered under this Agreement must pay for specified Covered Services in a Contract Year. The amount of the Out-of-Pocket Maximum is listed in Your Schedule of Copayments. Once the Out-of-Pocket Maximum is met, Covered Services are paid at 100% without any Copayments for the remainder of the Contract Year. However, certain services and expenses are not subject to the Out-of-Pocket Maximum. Any payments You make for those services and expenses will not be applied to satisfy Your Out-of-Pocket Maximum. Please see Your Schedule of Copayments for the list of services and expenses that do not apply to Your Out-of-Pocket Maximum.

- **Maximum Lifetime Benefit.** The maximum lifetime benefit payable per Member, if applicable, is listed in the Schedule of Copayments.

1.8 How to Contact the Health Plan. Throughout this Agreement You will find that We encourage You to contact Us for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact Us at the telephone number on the back of Your identification card.

Telephone numbers and addresses to request review of denied claims, register complaints, place requests for prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this Agreement.

1.9 Final Determinations Regarding Certificate of Coverage. We have sole and absolute discretion to construe and interpret the provisions of this Certificate of Coverage, including, but not limited to, eligibility to become or remain a Member, entitlement to Covered Services, all claims and/or benefit determinations, and grievance procedures.

- **Health and Wellness Programs.** From time to time, We may arrange for third party vendors to provide goods or services to some Members for a fee, a discount or at no charge to the Member. Those goods and services may include, but are not limited to, the following:

- Discount programs for alternative medicine
- Disease management programs which emphasize preventive care, early diagnosis and prompt treatment for diseases and conditions such as asthma, breast cancer, complex chronic disease, congestive heart failure and diabetes.
- Maternity management programs
- Programs which emphasize preventive care such as immunization and mammogram reminders

While the Health Plan may arrange for the provision of such goods and services through third party vendors, the third party vendor (and not the Health Plan) is responsible to provide, and is liable for, such goods and services to Members. For more information on the above health and wellness programs, please call the Member Services Department.

1.11 Important Telephone Numbers and Addresses.

Member Services:
(800)-935-7284
WellPath Select, Inc.
c/o Coventry Health Care
PO Box 7102
London, KY 40742
Attn: Member Services

To Request a Review of Denied Claims:
(800)-935-7284
WellPath Select, Inc.
2801 Slater Road, Suite 200
Morrisville, NC 27560
Attn: Appeals/Grievance Coordinator

To Appeal a Noncertification of Services:
(866)-935-7284
WellPath Select, Inc.
2801 Slater Road, Suite 200
Morrisville, NC 27560
Attn: Appeals/Grievance Coordinator

To Register a Complaint:
(800)-935-7284
WellPath Select, Inc.
2801 Slater Road, Suite 200
Morrisville, NC 27560
Attn: Appeals/Grievance Coordinator

To Request Prior Authorization:

(800)-708-9355
WellPath Select, Inc.
2801 Slater Road, Suite 200
Morrisville, NC 27560
Attn: Precertification Department

To Submit Claims:

WellPath Select, Inc.
c/o Coventry Health Care
PO Box 7102
London, KY 40742
Attn: Claims Department

SECTION 2
ENROLLMENT AND ELIGIBILITY

2.1 Eligibility.

A. Subscriber Eligibility. To be eligible to be enrolled You must:

- Live or work in the Service Area; and
- Be an employee or Retiree of the Group; and
- Be eligible to participate equally in any alternate health benefits plan offered by the Group by virtue of his/her own status with the Group, and not by virtue of dependency; and
- Meet any eligibility criteria specified by the Group and approved by WellPath, including, without limitation, the criteria set forth in Section 2.2 below (Retiree); and
- Complete and submit to WellPath such applications or forms that WellPath may reasonably request.

B. Dependent Eligibility. To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Be the lawful spouse of the Subscriber or be an unmarried child of the Subscriber or of the Subscriber's spouse including:

- Children under age nineteen (19) who are either the birth children of the Subscriber, the birth children of the Subscriber's spouse or legally adopted by or placed for adoption or

foster care with the Subscriber or the Subscriber's spouse;

- Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is required to provide health care coverage pursuant to medical child support order,

- Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian;

- Children nineteen (19) or older who are either the birth, adopted or foster children of the Subscriber or of the Subscriber's spouse, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19), proof of such incapacity is furnished to Us by the Subscriber upon enrollment of the person as a Dependent child or within thirty-one (31) days of the Dependent child's reaching age nineteen (19) and annually thereafter;

- Children under the age of twenty-five (25) or the age set forth in the Group Contract who are either the birth or adopted children of the Member and are attending on a full-time basis an accredited educational institution, defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program on a full-time basis, provided that the Subscriber provides documentation of such attendance to WellPath upon request, and at least twice annually. Coverage ends the last day of the month in which the Dependent attains the age of twenty-five (25) or is no longer enrolled in school on a full-time basis. **Please Note:** The Subscriber must advise WellPath within thirty-one (31) days of the student's loss of full-time attendance status.

C. Newborn, Foster, and Adopted Children. To enroll a newborn, foster, or adoptive child, You must submit a Group Enrollment Form through Your employer within thirty-one (31) days of acquiring the new Dependent, regardless of whether You have received a Social Security Number for Your Dependent by the thirty-first (31st) day. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home if additional monthly premiums will be required when the child is added to Your Plan. If no additional monthly premium will be required when You add a Dependent child to Your Plan, You should complete a Group Enrollment Form so that We may send an identification card to facilitate the child's access to Covered Services. A newborn child will be Covered from the moment of birth. A foster care or adopted child will be Covered from the date of placement in the home.

A newborn or foster child of an unmarried family Dependent is ineligible for benefits unless the newborn child is enrolled as a family Dependent of a Subscriber. This eligibility requires proof of legal guardianship or adoption of the newborn or foster child by the Subscriber.

2.2 Retirees. A Retiree or Retiree spouse who is eligible to be covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and

B coverage on the later of the date he/she is first eligible for Medicare or the Effective Date of this Agreement in order to be eligible or continue Coverage under this Agreement. If a Retiree or a Retiree spouse does not enroll within thirty-one (31) days of the later of the date he/she is first eligible for Medicare or the Effective Date of this Agreement, his/her Coverage under this Agreement shall terminate.

2.3 Change of Group's Eligibility Rules. In order to be eligible for Coverage under this health benefit plan, individuals must meet specific Group eligibility requirements. So long as this Agreement is in effect, any change in the Group's eligibility requirements must be approved in advance by WellPath.

2.4 Persons Not Eligible to Enroll.

A. A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with WellPath for Coverage under this Agreement.

B. A person whose Coverage under this Agreement was terminated due to a violation of a material provision of this Agreement shall not be eligible to enroll with WellPath for Coverage under this Agreement.

C. Late Enrollees are not eligible to enroll except during the next Group Enrollment Period.

2.5 Enrollment.

A. Group Enrollment Period. All eligible employees or Retirees of a Group and their eligible Dependents may enroll with WellPath for Coverage under this Agreement during the Group Enrollment Period or a Special Enrollment Period.

B. Any new employee or employee who transfers into the WellPath Service Area may enroll with WellPath for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit a WellPath Enrollment Application for purposes of enrolling with WellPath for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he/she is not eligible to enroll until the next Group Enrollment Period unless there is a special enrollment under Section 2.6.

C. A special enrollee may enroll with WellPath for Coverage under this Agreement as provided below.

D. Eligible employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Agreement are not eligible to enroll until the next open enrollment period, unless they are eligible to enroll as a special enrollee, as described in Section 2.6 below.

2.6 Special Enrollment.

A. Special Enrollment Due to Loss of Other Coverage. Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Health Plan if the employee waived initial Coverage under this Health Plan at the time Coverage was first offered because the employee or Dependent had other coverage at the time Coverage under this Health Plan was offered and the employee's or Dependent's other coverage was:

- COBRA continuation coverage that has since been exhausted; or,

- If not COBRA continuation coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term "loss of eligibility for such coverage" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. This term does not include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation).

Required Length of Special Enrollment Notification. An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date that the other coverage was lost.

Effective Date of Coverage. If the employee or Dependent enrolls within the thirty-one (31) day period, Coverage under the Health Plan will become effective no later than the first (1^{st}) day of the 1st calendar month after the date the completed request for special enrollment is received.

B. Enrollment Due to New Dependent Eligibility. Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Health Plan if the employee has acquired a Dependent through marriage, birth, adoption or placement for adoption or foster care.

(1) **Non-participating Employee.** An employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption, placement for adoption of his or her child or placement of a foster child (even if the child does not enroll).

(2) **Non-participating Spouse.** Your spouse may enroll at the time of marriage to You, or upon the birth, adoption or placement for adoption of his or her child or placement of a foster child (even if the new child does not enroll).

(3) **New Dependents of Covered Employee.** A child who becomes a

Dependent of a Covered employee as a result of marriage, birth, adoption or placement for adoption or foster care may enroll at that time.

(4) **New Dependents of Non-enrolled Employee.** A child who becomes a Dependent of a non-enrolled employee as a result of marriage, birth, adoption or placement for adoption or foster care may enroll at that time but only if the non-enrolled employee is eligible for enrollment and enrolls at the same time.

Required Length of Special Enrollment Notification. An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date of marriage, birth, adoption or placement for adoption or foster care.

Effective Date of Coverage. Coverage shall become effective:

- In the case of marriage, no later than the first (1^{st}) day of the first (1^{st}) calendar month beginning after the date a completed enrollment request is received by the Health Plan; and

- In the case of a Dependent's birth, the date of such birth; and

- In the case of a Dependent's adoption or placement for adoption or foster care, the date of such adoption or placement for adoption or foster care.

  - **Notification of Change in Status.** A Covered employee must notify the Health Plan of any changes in Your status within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Change of Status Form to the Health Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, Medicare eligibility or coverage by another payer. If additional monthly premiums will be required to enroll a new spouse or a new Dependent child, You must submit an enrollment application and Change of Status Form through Your Group within thirty-one (31) days of acquiring the new Dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home. If no additional monthly premium will be required when You add a Dependent child to Your Plan, You should complete a Status Change Form so that We may send an identification card to facilitate the child's access to Covered Services. A newborn child will be Covered from the moment of birth. A foster care child or adopted care child will be Covered from the date of placement in the home provided Coverage for that child is put into effect within thirty-one (31) days. The Health Plan should be notified within thirty-one (31) days of the death of any Member.

SECTION 3
EFFECTIVE DATES

3.1 Effective Date.

A. During Group Enrollment Period. An employee or Retiree who is eligible for Coverage under this Agreement and enrolls during a Group Enrollment Period shall be Covered under this Agreement as of the Member Effective Date, a date mutually agreed to by WellPath and the Group.

B. Newly Hired Employees. A newly hired employee who is eligible for Coverage shall be Covered under this Agreement as of the date that he/she first becomes eligible for Coverage so long as WellPath receives the employee's completed Enrollment Application within thirty-one (31) days of the date that the employee first became eligible for Coverage.

C. Newly Eligible Employees. An employee of the Group who transfers into the Service Area, and had been otherwise eligible for Coverage under this Agreement shall be Covered no later than the first (1st) day of the month following the date that he/she first transfers into the Service Area so long as WellPath receives the employee's Enrollment Application within thirty-one (31) days of the date that the employee first become eligible for Coverage.

D. Special Enrollees. Special enrollees shall be Covered under this Agreement as provided in Section 2.6 above.

Member Effective Date for Dependents. Dependents may be enrolled during a Group Enrollment Period, upon the valid enrollment of a newly hired or newly eligible employees (as provided in Section 3.1 above). In the case of Dependents who are enrolled during the Group Enrollment Period or upon the valid enrollment of a newly hired or eligible employee, the Dependent Effective Date shall be the same as the Member Effective Date.

Dependents who are special enrollees shall be Covered under this Agreement when stated in Section 2.6 above. The Member Effective Date of:

(1) a newborn biological Child shall be the date of birth;

(2) a Child newly acquired through adoption shall be the date of the adoption; and

(3) a Child Placed for Adoption or foster care, or a Dependent placed under legal guardianship, shall be the date of the placement.

Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order shall be Covered as of the date specified in the order. If no date is specified in the order,

Coverage shall be effective as of the date the order is issued by the court.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Coverage For Members. Your Coverage shall terminate upon the occurrence of any one of the following events:

A. No Longer Meet Eligibility Requirements. At least thirty (30) days notice of termination of Your Coverage if You no longer meet the eligibility requirements set forth in this Agreement, including, without limitation, living outside the Service Area for a period longer than permitted under this Agreement.

B. Member is Eligible for Medicare Coverage and Fails to Enroll. At least thirty (30) days notice of termination of Coverage if You are eligible to enroll in Medicare Parts A and B (Title XVIII of the Social Security Act as amended), and You fail to enroll in Medicare Parts A and B coverage within thirty (30) days of the later of the date that You first become eligible to enroll or the Member Effective Date.

C. Reasons Other Than Nonpayment of Premium or Supplemental Charges (e.g., Copayments). At least fifteen (15) days notice of the termination of Your Coverage due to a reason other than nonpayment of premium.

D. Nonpayment of Premium or Supplemental Charges (e.g., Copayments). In accordance with the thirty-one (31) day grace period for premium payment noted in the Group Contract, if the premium payment has not been received on or before the thirty-first (31st) day of the month that the premium was due, Your Coverage shall terminate retroactively to the first (1st) day of that month. If supplemental charges (e.g., Copayments) required for Hospital or medical services are not paid, We will provide You at least thirty (30) days notice of the termination of Your Coverage due to the nonpayment of supplemental charges;

E. Group Contract Terminates or is Not Renewed. Upon the termination or non-renewal of the Group Contract by the Group. Renewal is at the option of the Group, however, We shall have the right to terminate this Agreement as specified in the Group Contract. Refer to Section 4.2 below for more information;

F. Failure to Establish Satisfactory Patient-Physician Relationship. At least thirty (30) days notice of termination to You if You and Your Participating Provider fail to establish a satisfactory patient-Physician relationship and:

(1) WellPath has, in good faith, provided You with the opportunity to select an alternative Participating Provider;

(2) You have been notified by WellPath in writing at least thirty (30) days in advance that the patient-Physician relationship is unsatisfactory and specific changes are necessary in order to avoid termination; and

(3) You have failed to make a good faith effort to make the specific changes outlined in WellPath's notice detailed in sub-section immediately above.

If a Dependent fails to establish a satisfactory patient-Physician relationship, only the Coverage of the Dependent shall be terminated. If the Subscriber fails to establish a satisfactory patient-Physician relationship, the Coverage of the Subscriber and his/her Dependents will be terminated.

G. Fraud, Material Misrepresentation and/or Criminal Behavior. Immediately upon written notice if You participate in fraudulent or criminal behavior in relation to Health Plan or Provider, including but not limited to:

(1) Performing an act or practice that constitutes fraud or material misrepresentation, including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

(2) Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

(3) Threatening or perpetrating violent acts against the Health Plan, a Provider, or an employee of the Health Plan or a Provider. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

(4) Misrepresenting or giving false information and/or failure to fully disclose health information on any enrollment application form and related health statement. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

4.2 Termination of Group Contract. As required by law, We will renew or continue in force the Coverage at the option of the employer Group. However, We will nonrenew or discontinue health insurance Coverage for a Group if one or more of the following occurs:

A. Nonpayment of premium

B. Fraud

C. Violation of participation or contribution rules

D. ***** Termination of Coverage in the market

E. Group moves out of Service Area

F. Association membership ceases (applicable to bona fide association plans only)

* Should WellPath cease to offer a certain product within the Service Area, WellPath will adhere to the following:

- 90 days notice to each policyholder and each covered person prior to termination of Coverage
- offer the policyholder the option to purchase insurance coverage currently being offered by the Plan in the market, uniformly, to current or new participants and their beneficiaries who are or may become eligible for participation

* Should WellPath cease to offer any Coverage within the Service Area, WellPath will adhere to the following:

- Notice to the North Carolina Insurance Commissioner , each policyholder and each covered person within 180 days prior to the date of discontinuation.

4.3 Effect of Termination.

A. If Your Coverage under this Agreement is terminated under Section 4.1, all rights to receive Covered Services shall cease as of the date of termination; except that if Your Coverage under this Agreement is terminated due to material misrepresentation, giving false information and/or failure to fully disclose health information on any enrollment application form and related health statement, We have the right to terminate Your Coverage effective the date of Your initial enrollment. If We terminate Your Coverage effective the date of Your initial enrollment, We will return all premium payments which have been paid to date.

B. Identification cards are the property of WellPath and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

C. Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under WellPath's Grievance and Complaint procedures. WellPath may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

D. Please note that if WellPath pays for benefits, claims, administration costs and other expenses (collectively "expenses") incurred by the Group and/or Member after the termination date of the Group and/or Member, then WellPath has the right to recoup from the Provider, or collect from the Group and/or Member, all monies paid after the termination date for such expenses.

4.4 Certificates of Coverage. At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended. (Please see Section 7.4 for more information.) You also are entitled to notification of the termination of the Group Contract at the time of termination.

SECTION 5
CONTINUATION OF COVERAGE

5.1 Continuation of Coverage for Certain Subscribers and Dependents.

A. You are eligible to retain Coverage under this Group Contract during any continuation of coverage period or federal or state election period, provided the premiums for such Members continue to be paid by the Group pursuant to the terms of the Group Contract and COBRA or other applicable state or federal law or regulation, and You are eligible for continuation coverage under applicable state or federal law or regulation.

B. Coverage shall automatically terminate at the end of the minimum period of time required by COBRA or other applicable federal or state law or regulation.

C. You should contact the Group for the answers to any questions You have with respect to continuation of coverage. WellPath does not administer COBRA coverage.

D. You should also refer to Section 9 for any conversion privilege You may have at the end of any period of continuation coverage.

E. Continuation of Group Coverage Under North Carolina Law. Subscribers whose Coverage would otherwise terminate because of termination of their employment by Group, and any Covered Dependents (including spouse or child) whose Coverage would otherwise terminate because they no longer meet the Dependent eligibility requirements described in Section 2.1.B above due to death of the Subscriber, divorce, or the attainment of a limiting age, may continue coverage for themselves and their Covered Dependents, for up to eighteen (18) months. The Group may charge continuation Members up to a 2% administrative fee each month to administer such Coverage. The Member should contact the Group for more information concerning this administrative fee. State continuation coverage is subject to the terms of this Health Plan Agreement and

the following conditions.

(1) The Subscriber must have been continuously Covered under this Agreement (and any Group health benefit contract it replaced) during the three (3) month period ending with the termination of employment.

(2) Continuation of coverage is not available for any Member who: (a) is or could be covered by any other plan of group health benefits whether insured or uninsured within thirty-one (31) days of the date of termination; (b) is eligible for COBRA continuation coverage; or (c) has Coverage terminated because of fraud or failure to pay a required contribution.

(3) The Subscriber must make a written request to the Group for continuation of coverage within sixty (60) days following termination of employment, or other loss of eligibility for Coverage under the Plan.

(4) The Subscriber must pay the monthly premium required by WellPath for continuation coverage to the Group on or before the first day of each month.

(5) Continuation of coverage of a continuation Member shall terminate on the date of the first of the following events:

(a) Termination of the continuation Member's coverage for any reason specified in Section 4 (other than the Subscriber's termination of employment).

(b) The continuation Member becomes covered by any other plan of group health benefits.

(c) The expiration of the eighteen (18) month period following the date on which coverage otherwise would have terminated due to the Subscriber’s termination of employment. If any continuation of coverage under this Section 5 terminates because the end of the maximum period of continuation has been reached, individual conversion coverage under Section 9 below may be available at the end of such period.

(d) If the continuation Member fails to make timely payment of a required premium, the end of the last month for which the premium was paid in full.

(e) Termination of this Agreement for any reason.

SECTION 6
COVERED SERVICES

The Health Plan covers only those health services and supplies that are (1) Medically Necessary, (2) provided by a Participating Provider, and (3) not excluded under the exclusions and limitations set forth in Sections 6 and 7 of this Certificate of Coverage and Your Schedule of Copayments. **All transplants must be provided by a Coventry Transplant Network Facility.**

The following section **Schedule of Covered Services** provides the health care services and supplies Covered under this Agreement. The schedule is provided to assist You with determining the level of Coverage and Authorization procedures, limitations, and exclusions that apply for Covered Services that are Medically Necessary, subject to the exclusions and limitations set forth in Section 6 and 7. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by Us. **If a service is Medically Necessary but not specifically listed and not otherwise excluded, then it is not a Covered Service.**

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

If You elect breast reconstruction in connection with a mastectomy, You are entitled to Coverage under this Agreement for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas; and
- Post-Mastectomy bras which will be limited to 2 per year.

Such services will be performed in a manner determined in consultation with the attending Physician and the patient. See Section 6 for further detail regarding this Coverage.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *****See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Primary Care Physician/Provider (PCP) Office Visits (Diagnostic and Treatment Services) **Please Note:** *All other services not listed are subject to the applicable Copayment, Coinsurance and/or Deductible noted in Your Schedule of Copayments, in addition to Your regular PCP office visit Copayment, Coinsurance and/or Deductible.*	Office visits to Participating Primary Care Physicians / Providers (PCP's) for Covered Services, including: • Diagnosis and treatment of illness or injury • Laboratory services provided in the PCP's office • X-rays, such as chest x-rays and standard plain film x-rays, provided in the PCP's office • Covered immunizations
Specialist Office Visits (Diagnostic and Treatment Services) **Please Note:** *All other services not listed are subject to the applicable Copayment, Coinsurance and/or Deductible noted in Your Schedule of Copayments, in addition to Your regular Specialist office visit Copayment, Coinsurance and/or Deductible.*	Office visits to Participating Specialists for Covered Services, including: • Diagnosis and treatment of illness or injury • Laboratory services provided in the Specialist's office • X-rays, such as chest x-rays and standard plain film x-rays, provided in the Specialist's office • Allergy testing • Covered immunizations
Ambulance	• Covered Service for ground ambulance to Hospital when ambulance travel is Medically Necessary • Covered Service for air ambulance when Medically Necessary
Blood and Blood Product Administration	Covered Service for administration, storage and processing of blood and blood products in connection with services Covered under the Certificate of Coverage

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Bone Mass Measurement	Covered Service
Breast Reconstruction (Post-Mastectomy)	Covered Service. Consistent with the Women's Health and Cancer Rights Act, if You have a mastectomy and elect reconstructive surgery in connection with the mastectomy, Coverage will be provided for: • Reconstruction of the breast on which the mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Prostheses and physical complications of mastectomy, including lymphedemas; • Post-Mastectomy bras which are limited to 2 per year. Coverage will be provided in a manner determined in consultation between You and Your attending Physician
Cardiac and Pulmonary Rehabilitation Therapy	Covered Service, but limited to treatment for therapy conditions that in the judgement of a Participating Physician and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy
Cervical and Ovarian Cancer Screening	For female Members, the Health Plan covers: • This exam includes a pelvic exam and examinations and laboratory tests for screening for the early detection of cervical cancer in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage includes the examination, the laboratory fee and the laboratory results. However, laboratory fees will be Covered only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission. • Surveillance tests for women age 25 and older who are at risk for ovarian cancer. "At risk for ovarian cancer" means: (a) having a family history with at least one 1st degree relative with ovarian cancer and a second relative, either 1st degree or 2nd degree, with breast, ovarian, or nonpolyposis colorectal cancer; or (b) testing positive for a hereditary ovarian cancer syndrome. "Surveillance tests" mean annual screenings using: (a) transvaginal ultrasound; and (b) rectovaginal pelvic examination.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Chemotherapy and Radiation Therapy	Covered Service
Colon Cancer Screening	Covered Service
Dental & Oral Surgical Services **(For diagnosis and treatment of the temporomandibular joint (jaw or cranio-mandibular joint), please refer to the section "TMJ" in this Schedule of Covered Services.)**	Covered Service for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate. Coverage benefit limited to the functional restoration of structures and treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue, or gums when You seek treatment within 72 hours of the accidental injury. Limited benefit. Not a Covered Service for the care, treatment, filling, removal, replacement, repair, or artificial restoration of the teeth (either natural or artificial), root canal, surgery for impacted teeth, surgery involving structures directly supporting the teeth, or orthodontia.
Dialysis	Covered Service for hemodialysis and peritoneal services provided by participating outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.
Durable Medical Equipment (DME) and Associated DME Supplies	Covered Service when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, and when all of the following circumstances apply: • it can withstand repeated use; • it is primarily and customarily used to serve a medical purpose; • it is generally not useful to a person in the absence of illness or injury; and • it is appropriate for use in the home. Glucometers will be obtained from WellPath's National Vendor, when available. Upgrades to equipment which are not Medically Necessary are the responsibility of the Member.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *****See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Education and Counseling	Covered Service, including but not limited to: Diabetes education and management classes Prenatal classes
Elective Sterilization	Covered Service
Emergency Services	Covered Service as set forth in Section 6.1 below. The WellPath definition of "Emergency Services," "Medical Emergency," and "Emergency Out of Area" are found in the Definition section. Services for Medical Emergencies, including Medical Emergency services in a Hospital, a Physician's office, or other ambulatory setting are Covered to the extent necessary to screen and to stabilize the person Covered under the Plan if the prudent layperson acting reasonably would have believed that a Medical Emergency existed. Payment of claims for Emergency Services shall be based on the retrospective review of Your presenting history and symptoms. If Medical Emergency services are provided by an out-of-area emergency department or Physician, follow-up services must be performed by a Participating Provider.
Eyeglasses and Corrective Lenses Following Cataract Removal Surgery	Not a Covered Service, except when necessary for the first pair of cataract lenses or glasses following cataract removal surgery, when an intraocular lens is not implanted at the time of surgery. However, lenses or glasses must be obtained with a referral from a Participating Provider. Please note that the cataract removal surgery must be performed while You are enrolled with Us. **Please Note:** For Members who prefer eyeglasses or for when contact lenses are not appropriate following cataract removal surgery, the Plan will cover the cost of the 1st pair of eyeglass frames with the 1st pair of eyeglass lenses, as noted above.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *****See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Family Health Planning	Covered Service includes counseling, treatment and follow-up, information on birth control, insertion and removal of intra-uterine devices and contraceptive implants, and measurement for contraceptive diaphragms Injectable contraceptives are excluded, unless Covered under a Prescription Drug Rider.
Genetic Testing and Counseling	Covered Service for genetic counseling and testing that is needed for diagnosis or treatment of genetic defects
Growth Hormone	Covered Service when used to treat a congenital anomaly such as Turner's Syndrome, but only if the growth hormone is approved by the FDA for treatment of the congenital anomaly
High Technology Diagnostic Services	All high technology diagnostic services, tests, and procedures, including but not limited to: • MRI • MRA • CAT Scans • Thallium Scans / Nuclear Stress Tests • PET Scans • Echocardiograms • Ultrasounds • Supplies • Professional, anesthesia and ancillary services

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *****See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Home Health Care and Home Infusion Services	Covered Service when all of the following requirements are met: the service is ordered by a Participating Physician; services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, or occupational therapist; • the services may be a substitute or alternative to hospitalization; • part-time intermittent services are required; • a treatment plan has been established and periodically reviewed by the ordering Physician; • services are Authorized by Us; • the agency rendering services is Medicare certified and licensed by the State of location; and • the Member is homebound. **Please Note:** Private duty nursing and Custodial Care are not Covered.
Hospice	Covered Service. If You are terminally ill, the Health Plan covers hospice services, and related bereavement counseling for Your family members (whether provided before or after Your death), if *all* of these conditions are met: • You elect to receive care in or by a hospice; • Your Provider certifies that You have a life expectancy of six months or less; and • before the services are provided, Your Provider prepares a written treatment plan authorizing the services Your Provider must provide Us with the life expectancy certification and written treatment plan. Hospice care may be received at home or in a hospice or other inpatient facility.
Injectable Drugs administered in the Provider's office *except that* Covered immunizations are Covered as noted under "Primary Care Physician/Provider (PCP) Office Visits" and "Specialist Office Visits" in Section 6 and Your Schedule of Copayments	Includes administration and drugs such as, but not limited to: • Chemotherapy • Remicade • IV antibiotics • Analgesics • Allergy serum and shots

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *****See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Inpatient Hospital Care, including observation stays **(does not include Maternity Services, discussed separately below)**	Covered Service as follows: • All professional services during inpatient stay • General nursing care • Use of operating room • Surgical services and supplies • Anesthesia services • Ordinary casts, splints and dressings • All drugs, oxygen and internal prosthetic devices used in Hospital • Laboratory and X-ray examinations • Electrocardiograms • Semi-private accommodations • Intensive Care Unit • Coronary Care Unit Except where We have given specific Authorization, You must be admitted to a Participating Hospital and be under the care of a Participating Physician to be eligible to receive payment for non-emergency Covered Services. Consistent with Our utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay. Coverage will continue until We notify You that Coverage will cease. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or portion thereof is not Medically Necessary, You and Your Provider will be notified that Coverage will cease.
Inpatient Rehabilitation Facility	Covered Service
Inpatient Skilled Nursing Facility	Covered Service
Laboratory and Reference Pathology Services	Covered Service when ordered by a Participating Provider and provided by a Participating Provider or Participating laboratory.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *****See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Mammography	The Plan covers low dose mammography screening for breast cancer performed in Your Provider's office or in a radiology facility based on the following schedule: A. One or more mammograms per Contract Year, as recommended by the Provider, including the Provider's interpretation of the mammogram, for any woman who is determined to be at risk for breast cancer. A woman is considered at risk for breast cancer if the woman: • has a personal history of breast cancer; • has a personal history of biopsy-proven benign breast disease; • the woman's mother, sister or daughter has or has had breast cancer; or • has not given birth prior to the age of 30. B. One baseline mammogram for any woman age 35 through age 39. • One mammogram every other Contract Year for any woman age 40 through age 49, or more frequently on recommendation of the Provider. • One mammogram a Contract Year for any woman age 50 years or older.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Maternity Services	Covered Service for Hospital and professional services before and during confinement, and during the postpartum period. • Inpatient Care for a mother and her newborn child is Covered for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by cesarean section. • **Prior Authorization is not required for the minimum stays**; however, We do advise that the Plan be contacted for case management purposes. • Any stay beyond the minimum must be Authorized by Us. • Any decision to discharge a mother and her newborn child before the forty-eight (48) or ninety-six (96) hour minimum is made by the Physician in consultation with the mother. When the mother and newborn child are discharged early, We will provide Coverage for post-delivery follow-up care within seventy-two (72) hours after discharge upon request to the Plan's Health Services Department. **Global Fee Information:** If the Member's maternity care begins prior to the 24th week of gestation, the Plan pays the Provider with a global fee. A global fee is an inclusive fee that covers services rendered throughout the pregnancy. The global fee includes but is not limited to: • the initial office visit • routine office visits with the obstetrician • prenatal care, delivery and postpartum care • laboratory services • one (1) ultrasound **Please Note:** Additional ultrasounds performed at the Member's request that are not Medically Necessary are **not Covered** by the Plan. Routine maternity care, including term, premature labor and delivery, elective cesarean sections, elective abortions, and routine prenatal and postnatal services are not Covered for Dependent children. Complications of Pregnancy and elective abortions when the mother's life is endangered are Covered for all female Members, including Dependent children.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Newborn Hearing Screening	For a newborn, physiological screening in each ear for the presence of permanent hearing loss is a Covered Service when ordered by the attending physician.
Occupational Therapy	Covered Service when Medically Necessary to restore a previously existing normal physical function which is lost due to trauma, stroke, a surgical procedure, or other acute condition, or to correct an impairment which is caused by trauma, stroke, a surgical procedure, or other acute condition, and significant improvement will be achieved through relatively short-term therapy.
Outpatient Hospital and Outpatient Facility Services	Covered Service when provided and billed in the Outpatient Hospital / Facility setting, including but not limited to: • Professional fees • Anesthesia and related charges • Ancillary services • Diagnostic tests • Injectable drugs
Outpatient Surgery	Covered Services include associated services such as professional, ancillary, laboratory and radiology services. Coverage includes but is not limited to: • General nursing care • Use of operating room • Surgical services and supplies • Anesthesia services • Ordinary casts, splints and dressings • Internal implantable devices • All drugs, oxygen and internal prosthetic devices used in Hospital • Laboratory and X-ray examinations
Physical Therapy	Covered Service when Medically Necessary to restore a previously existing normal physical function which is lost due to trauma, stroke, a surgical procedure, or other acute condition, or to correct an impairment which is caused by trauma, stroke, a surgical procedure, or other acute condition, and significant improvement will be achieved through relatively short-term therapy.
Podiatry	Covered Service when Medically Necessary
Prostate-Specific Antigen (PSA) Tests	Coverage includes prostate-specific antigen (PSA) tests for the presence of prostate cancer performed in a Provider's office or at a laboratory upon the recommendation of the Provider.
Prosthetic, Orthotic and Corrective Devices (External)	Covered Service when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member.

SCHEDULE OF COVERED SERVICES

COVERAGE FOR SERVICES OR SUPPLIES THAT ARE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

SERVICE OR SUPPLY	CRITERIA AND COVERAGE PROVIDED *See Section 1.2 for a list of services that require Prior Authorization *** See the Schedule of Copayments for Benefit Limitations and Member Copayments**
Pulmonary and Cardiac Rehabilitation Therapy	Covered Service, but limited to treatment for conditions that in the judgment of a Participating Physician and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.
Radiology Services, such as X-rays	Covered Service when provided in a freestanding radiology facility or office. **Please Note:** This does not include the Covered Services noted under "High Technology Diagnostic Services."
Speech Therapy	Covered Service when expected to restore speech to a person who has lost a previously existing speech function due to injury or disease when significant improvement is expected to be achieved through relatively short-term therapy. Coverage is also provided to restore speech to individuals born with cleft lip or cleft palate.
Temporomandibular Joint (TMJ)	Diagnosis and treatment of the temporomandibular joint (jaw or craniomandibular joint) by splinting, the use of intraoral prosthetic appliances to reposition the bones, or surgery including arthroscopy, if: • such treatment is Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint involved; and • there is clearly demonstrable radiographic evidence that the joint abnormality is caused by disease, traumatic injury, or a congenital deformity
Termination of Pregnancy	Covered Service for termination of pregnancy during the first trimester.
Transplants, including evaluations	See Section 6.4
Urgent Care Services	See Section 6.2
Wigs for Hair Loss Resulting From Cancer Treatment	See Section 6.5.F

6.1 Emergency Benefits. In the event You experience a Medical Emergency, seek help immediately at the nearest Participating Hospital, Participating Physician's office or other Participating emergency facility. If time permits, contact Your Participating Provider. If You are unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital would create a danger to Your health, You should obtain medical attention from the nearest Hospital or through 911 Emergency Services (where available). Screening and stabilization services provided in a Hospital emergency department for a Medical Emergency may be received from either Participating or non-participating Providers and are not required to be Prior Authorized.

You are urged to notify Us as soon as possible following the rendering of emergency health care. The determination of Covered Services for services rendered in an emergency facility is based on Our review of Your emergency department medical records, along with those relevant symptoms and circumstances that preceded the provision of care. Services rendered by non-Participating Providers or in non-Participating facilities are Covered Services until Your condition has stabilized. However, after Your condition has stabilized, services rendered by non-Participating Providers or in non-Participating facilities are not a Covered Service if You remain in a non-Participating facility after We have made the appropriate arrangements for transfer to a Participating facility. Emergency Services performed outside the country are Covered provided that You are responsible for submitting an itemized bill and supporting medical records that have been translated into English, if necessary.

A. What is a Medical Emergency? A Medical Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

Emergency medical services are Covered to the extent necessary to screen and to stabilize the person covered under the Plan and does not require Prior Authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for Emergency Services shall be based on the retrospective review of Your presenting history and symptoms. Some examples of a Medical Emergency include but are not limited to:

C. Broken bone;
D. Chest pain;
E. Seizures or convulsions;
F. Severe or Unusual Bleeding;
G. Severe burns;
H. Suspected poisoning;

I. Trouble breathing;
J. Vaginal bleeding during pregnancy.

6.2 Urgent Care Benefits. Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as a Medical Emergency but requires prompt medical attention. Your Participating Provider can help You determine whether or not You need to receive care at an Urgent Care Center.

Some examples of Urgent Care cases include but are not limited to:
(a) High fever;
(b) Non-severe bleeding;
(c) Sprains.

The above examples may be expanded by WellPath when You are out of the Service Area and the services are Authorized by WellPath.

When traveling out of the Service Area, call the out of Service Area network at 1-866-676-7427.

6.3 Chemical Dependency Treatment - Medical Detoxification. Medical detoxification services require Prior Authorization from the Health Plan.

6.4 Transplant Services (Including Evaluations). Services related to Medically Necessary organ transplants are Covered when Authorized by Us and rendered at a Coventry Transplant Network Facility.

Donor screening tests are Covered and are subject to a lifetime benefit maximum. The lifetime benefit maximum is listed in the Schedule of Copayments.

If not Covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a Member will be Covered for the duration of the Group Contract as long as the recipient is a Member and when Authorized by Us.

Please Note: We do not cover the cost of any care, including complications, arising from an organ donation by a Member when the recipient is non-covered individual.

Travel expenses for Members and living donors are Covered according to Our transplant travel benefit policy, which is available to Members upon request. Travel expenses are only available when We are the primary carrier and a Coventry Transplant Network Facility is used.

Transplant Covered Services which are not rendered by a Coventry Transplant Network Facility are **not** Covered. Specifically, even if the transplant Covered Services are rendered by a Participating Provider, unless such Participating Provider is also a Coventry Transplant Network Facility, the services **will not be Covered**.

6.5 Other Benefits.

A. Reconstructive Breast Surgery.

(1) Coverage shall be provided for reconstructive surgery of the breast on which the mastectomy has been performed, and for all stages of reconstructive surgery performed on the nondiseased breast to produce a symmetrical appearance (if reconstructive surgery on the diseased breast is performed).

(2) Also Covered are prostheses and the treatment of physical complications of all stages of the mastectomy, including lymphedemas.

(3) For purposes of the administration of these benefits, "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer; and "reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Reconstructive breast surgery following a mastectomy will be Covered regardless of the lapse of time since the mastectomy.

B. Post-Mastectomy Care.

(1) Following a Medically Necessary mastectomy, the decision whether to discharge the Member is made by the attending Physician in consultation with the Member.

(2) The length of a post-mastectomy inpatient stay is based on the unique characteristics of each Member, including health and medical history.

C. Dental-Related Anesthesia and Hospital or Ambulatory Facility Charges. Anesthesia and Hospital or facility charges for dental services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems, where the Provider treating the patient certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the dental procedure(s) will be Covered. Prior Authorization of the facility will be required in accordance to the Health Plan's utilization review process. The professional component of the anesthesia services are Covered; however any other professional component (such as dentistry) is not Covered.

D. Clinical Trials. "Covered Clinical Trials" means Phase II, Phase III, and Phase

IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: (i) involve the treatment of life-threatening conditions; (ii) are medically indicated and preferable for that Member compared to available noninvestigational treatment alternatives; and (iii) have clinical and preclinical data that shows the trial will likely be more effective for that Member than available noninvestigational alternatives. Covered Clinical Trials must also meet the following requirements:

(1) Must involve determinations by participating treating Physicians, relevant scientific data, and opinions of experts in relevant medical specialties.

(2) Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The Health Plan may also Cover Clinical Trials sponsored by other entities.

(3) Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

The Health Plan shall provide Coverage for participation in Phase II, Phase III, and Phase IV Covered Clinical Trials by its Members who meet protocol requirements of the trials and provide informed consent.

Only Medically Necessary costs of Covered Services associated with participation in a Covered Clinical Trial, including those related to Covered Services typically provided absent a clinical trial, the diagnosis and treatment of complications, and Medically Necessary monitoring, are Covered by the Health Plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials. The Health Plan will not cover or reimburse the Member or Provider for non-FDA approved drugs provided or made available to a Member who received the drug during a Covered Clinical Trial after the Clinical Trial has been discontinued.

The following clinical trial services are *not* Covered by the Health Plan:

- Services that are not Covered Services;
- Those services provided solely to satisfy data collection and analysis needs;
- Those services related to investigational drugs and devices; and
- Those services that are not provided for the direct clinical management of the Member.

In the event a claim contains charges related to Covered Services Covered under this section, and those charges have not been or cannot be separated from costs related to services which are not Covered under this section, the Health Plan may deny the claim.

E. Smoking Cessation. The Health Plan offers direct reimbursement to You if You successfully stop smoking while Covered by this Health Plan, as follows:

(1) We will reimburse the maximum allowable amount Covered by the Plan for the actual costs for Prescription Drugs, over-the-counter drugs ("OTC") or non-pharmaceutical smoking cessation programs.

(2) To receive reimbursement, You must provide WellPath:

- receipts for the Prescription Drugs, over-the-counter drugs ("OTC") or non-pharmaceutical smoking cessation program; and
- a written statement signed by You affirming that You have stopped using tobacco products, including cigarettes, cigars, pipes and smokeless tobacco.

F. Coverage of Wigs For Hair Loss Resulting From Cancer Treatment. The Plan will provide the Coverage outlined in the Schedule of Copayments for wig(s) needed for hair loss resulting from cancer treatment.

SECTION 7
EXCLUSIONS AND LIMITATIONS

The Health Plan does not cover the following items, except as may be otherwise provided in the Schedule of Covered Services or in a Rider to the Health Plan:

1. Any services and/or supplies, or supply that are not provided by Participating Providers in accordance with Our utilization management policies and procedures. This exclusion shall not apply to Medical Emergencies in or outside the Service Area and Urgent Care services outside the Service Area. We reserve the right to evaluate and determine Coverage for care not directly provided by a Participating Provider.

2. Any services rendered while the individual is not Covered.

3. Any services rendered by persons not specified elsewhere as licensed Providers of health care.

4. Any services or supplies provided which are not within scope or licensure or certificate of the Provider.

5. Any services provided by a licensed Provider of health care which are not medical services or which may be performed by non-medical personnel.

6. Care rendered by Yourself or by a business entity that You control; and care rendered to You by a relative.

7. Any service or supply that is not Medically Necessary.

8. Any service or supply that is not a Covered Service *or* that is directly or indirectly a result of receiving a non-Covered Service, such as medical complications, *except that* complications which constitute a Medical Emergency until the emergency condition is stabilized, and Complications of Pregnancy, will be Covered.

9. Any service or supply for which You have no financial liability or that was provided at no charge.

10. Services and supplies furnished under or as part of a study, grant, or research program, except for the Covered Clinical Trials noted under Section 6.5.D above.

11. Costs for medical records for claims payment or appeals requests.

12. If You have a Point-of-Service Plan, any costs in excess of the Out-of-Network Rate (ONR) for charges incurred at a Non-Participating Provider.

13. Court-ordered services or services that are a condition of probation or parole.

14. Non-Emergency Services provided outside the Service Area, including elective care, care for non-Emergency conditions occurring in a Member or Dependent residing permanently or temporarily outside of the Service Area, follow-up care of an illness or injury, or care required as a result of circumstances that could have been reasonably foreseen by You before leaving the Service Area.

15. Procedures and treatments that We determine to be Experimental or Investigational.

16. Non-Emergency Services provided in an emergency facility.

17. Artificial insemination with donor semen or storage of frozen semen for possible use. All services related to the diagnosis and treatment of Infertility including but not limited to office visits for the evaluation of Infertility, diagnostic testing, diagnostic laparoscopy or hysteroscopy, ultrasound and x-ray procedures for the evaluation of Infertility, surgical or medical procedures to correct Infertility, drug therapy to correct Infertility and its causes, all techniques of assisted reproductive technology.

18. Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan.

19. Cosmetic Services and Surgery and the complications incurred as a result of those services and surgeries, except for services to correct a congenital defect for newborn, foster and adoptive children. Cosmetic surgery means surgery to change the texture or appearance of the skin; or the relative size or position of any part of the body; when such surgery is not needed to correct or substantially improve a bodily function. Removal of skin lesions is considered cosmetic unless the lesions interfere with normal body functions or malignancy is suspected.

20. Custodial and domiciliary care, residential care, protective and supportive care including, but not limited to, educational services, rest cures, and convalescent care. Care for senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any other persistent illness, disorder or condition that the Plan determines cannot be significantly relieved or improved by medical treatment.

21. Dental care, appliances, implants, or x-rays, including cysts related to the teeth and any Physician Services or X-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. Services, including emergency department visits, for the treatment of pain of dental origin including pain from decayed teeth or bruxism. However, Emergency services related to acute trauma to the teeth are Covered.

22. Take home disposable or consumable outpatient supplies, such as sheaths, bags, elastic garments and bandages, syringes, needles, blood or urine testing supplies, home testing kits, vitamins, dietary supplements and replacements, food, food supplements, and food replacements, and special food items, unless they are specified as Covered.

23. Durable Medical Equipment, such as comfort or convenience items; bed boards; patient, bath, and toilet lifts; chairs and rails; over-bed tables; wheelchair trays and flotation devices; air purifiers; exercise equipment; stethoscopes; blood pressure gauges; breast pumps; orthotics; orthopedic shoes; shoe inserts and arch supports; heel lifts, cups and pads; and batteries for all devices including wheelchairs.

24. External prosthetic items and devices, except for those items specified as Covered. Examples of prosthetic items and devices which We do not cover include, but are not limited to: cosmetic prostheses (except for breast prostheses prescribed following a mastectomy for breast cancer or breast disease); cranial molding helmets, banding, and anything that changes the shape of the head, mechanical organ replacement devices (such as mechanical hearts or left ventricular assist devices); repair or replacement required due to Your inappropriate use or maintenance of the device; Experimental or Investigational

devices; orthopedic shoes and other supportive devices for the feet; dentures or eyeglasses; splints and braces (unless they are used instead of casts); replacement required because the device is lost, misplaced or stolen; hearing aids or devices; or prosthetics specifically intended for sports or occupational purposes. We do not cover the replacement, repair or maintenance of any prosthetic item or device that is not Covered.

25. Routine maternity care, including term, premature labor and delivery, elective cesarean sections, elective abortions, and routine prenatal and postnatal services for Dependent children. However, elective abortions when the mother's life is endangered and Complications of Pregnancy are Covered for all female Members, including Dependent children.

26. War or acts of war; war related sickness, injury, services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran's Administration services and for which facilities are reasonably accessible to You.

27. Services or supplies for the treatment of an occupational injury or illness which are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

28. Any administrative or overhead fees, clinic charges, or charges associated with ownership and/or operation of the facility of any Provider practice.

29. If the Health Plan Authorizes an admission, outpatient surgery or procedure based on a material misrepresentation about the Member's health condition that was knowingly made by the Member or the Provider of the services, supply, or other item, and the Authorized services are a Covered Service but are *not* Medically Necessary, payment will be denied for charges incurred for those services.

30. Provider claims that contain billing for services or procedures that, based on nationally accepted claim billing rules, are considered inappropriate for reimbursement, such as but not limited to:

- Services and/or procedures that are incidental or mutually exclusive with other services rendered;
- Professional fees attached to a service that has no professional component indicated;
- Services that are considered part of the global reimbursement; and
- Fees for after hours care billed by 24-hour facilities.

7.2 Specifically excluded services include but are not limited to (this is not an exhaustive list):

1. Acupuncture.

2. Audiometric testing and expenses for the purpose of the provision of hearing aids and tinnitus maskers. Hearing aids and hearing related implants.

3. Storage of umbilical cord blood or long-term storage of autologous blood for future use except for currently scheduled surgery.

4. Braces and supports prescribed for athletic participation or employment.

5. Charges resulting from Your failure to cancel a scheduled appointment.

6. Chemical Dependency Treatment, unless Covered by a separate Rider. Medical detoxification is Covered as noted under Section 6.3 of the Schedule of Covered Services.

7. Chiropractic manipulation of the spine or other body parts unless Covered by a separate Rider.

8. C Leg System / hydraulic knee.

9. Cochlear Implants, including testing, programming, therapy related to the provision of cochlear implants.

10. Cognitive Rehabilitation.

11. Treatment, destruction, or removal of skin tags or keloids.

12. Cranial molding helmets, banding, and anything that changes the shape of the head.

13. Equipment or services for use in altering air quality or temperature

14. Educational testing or neuro-psychological testing related to issues of school performance, learning disability or school behavior. Neuro-psychiatric testing and other evaluation to aid in the determination of disputed child custody.

15. Exams for employment, school, camp, sports, licensing, insurance, adoption, marriage or those ordered by a third party.

16. Exercise equipment.

17. Foot care that is routine, such as removal or reduction of corns and calluses, clipping of the nails, treatment of flat feet, fallen arches, and chronic foot strain.

18. Genetic counseling and genetic studies that are not needed for diagnosis or treatment of genetic abnormalities.

19. Growth hormones, except that they are a Covered Service when used to treat a congenital anomaly such as Turner's Syndrome, but only if the growth hormone is approved by the FDA for treatment of the congenital anomaly.

20. Hair analysis.

21. Hair transplant or wig(s), except for the limited Coverage of wigs under Section 6.5.F.

22. Home services to help meet personal/family/domestic needs.

23. Hypnotherapy.

24. Immunizations for travel or employment.

25. Injectable drugs that are commonly and customarily administered by the Member ("Self-Administered Injectable Drugs"). However, if You do not have a Prescription Drug Rider under this Plan, medically appropriate and necessary equipment, supplies, and medications such as insulin used to treat diabetes are Covered, in addition to the benefits described under the Schedule of Covered Services in Section 6 above.

26. Injectable contraceptives such as Depo-Provera, unless Covered under a Prescription Drug Rider to this Plan. If You do not have Prescription Drug Coverage under this Plan, the Plan will only cover outpatient contraceptive services, such as insertion and removal of IUD and fitting of diaphragm.

27. Interferential stimulators.

28. Marriage or relationship counseling; family counseling; vocational or employment counseling.

29. Medical evacuation.

30. Mental health services, unless Covered by a Rider.

31. Naturopathy.

32. Nutritional counseling related to weight gain or weight loss.

33. Foot orthotics, except orthotics for the treatment of patients with diabetes and/or ischemic foot disease.

34. Over-the-counter supplies such as but not limited to ACE wraps, elastic supports, braces, neoprene sleeves, finger splints, shoe inserts, and heel cups.

35. Relief bands for motion sickness.

36. Oral Surgery (including orthognathic or prognathic procedures) for correction of an occlusal defect, or for removal of symptomatic impacted third molars.

37. Orthognathic surgery and related services are excluded, except for treatment of temporomandibular joint disease (TMJ) and treatment in the instance where the Member is a minor child and the services are intended to treat a congenital abnormality (such as cleft lip or cleft palate) that is associated with a functional deficit.

38. Orthodontia and related services.

39. Penile prostheses.

40. Prescription drugs and pharmacy services unless Covered by a Rider.

41. Non-prescription (over-the-counter) medications except when given during an inpatient admission or when Covered by a separate Rider.

42. Prescription drugs administered in a Physician's office or emergency department are Covered, but "take home" drugs for later use are excluded from Coverage.
    i. Prescription drugs used for an indication not approved by the FDA or in amounts in excess of FDA approval are excluded even when provided in a Physician's office or emergency department. However, the requirement for FDA approval of the specific indication or dosage will be waived under the following circumstances:
        1. The drug is used for the treatment of cancer and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
        2. The American Medical Association Drug Evaluations; or
        3. The American Hospital Formulary Service Drug Information; or
        4. The United States Pharmacopeia Drug Information. or;
        5. The drug has been approved by the FDA for the treatment of some disease and the proposed indication for the drug is listed as an accepted "off-label" use by one of the

following standard drug compendia:

6. The American Hospital Formulary Service Drug Information; or
7. The United States Pharmacopeia Drug Information; or
8. Facts and Comparisons

43. Phone consultations.

44. Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school.

45. Private duty nursing in any location.

46. Personal comfort and convenience items.

47. Refractive surgery to the eye, including but not limited to, Radial keratotomy and refractive laser eye surgery.

48. Services and supplies for students which schools are required to provide by law.

49. Sex transformation procedures and related tests, treatments and mental health services.

50. Treatment of sexual dysfunction, including sex therapy, and drugs, tests, and evaluations related to sexual dysfunction.

51. Reversal of voluntary sterilization.

52. Speech therapy for fluency disorders, such as but not limited to stuttering.

53. Surgery performed to address psychological or emotional factors.

54. Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother.

55. Transplant services, including: transplant services and screening tests not Authorized by Us, Experimental or Investigational procedures, travel and lodging expenses incurred by a Member that are not Covered under the transplant travel benefit policy noted in Section 6.4, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-covered individual.

56. Travel and transportation, other than Medically Necessary transportation Authorized by Us and ambulance service in a Medical Emergency.

57. Treatment of mental retardation, developmental delay, learning disability or pervasive developmental conditions such as, but not limited to, autism or Asperger's syndrome.

58. Services for diagnosis and treatment for disorders relating to learning, motor skills, or communication.

59. Vision care; eye exams and measurement related to refractive correction; eye exercises and vision therapy; and eyeglasses, contact and corrective lenses, unless Covered by a Rider to the Health Plan. An exception is made for the first pair of cataract lenses or glasses following cataract removal surgery when an intraocular lens is not implanted at the time of surgery, and when the lenses or glasses are obtained with a referral from a Participating Provider.

60. Vocational therapy.

61. Work hardening programs.

62. Weight reduction therapy including treatment of obesity, morbid obesity, and other categories of obesity, supplies and services, including but not limited to diet programs, tests, examinations or services and medical or surgical treatments such as intestinal bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature. Gastric bypass surgeries (both laparascopic or open) including but not limited to: Rous en Y procedures, jeunoileal bypass, gastric banding, biliopancreatic bypass, gastroplasty, and gastric balloon.

63. AirWatch Asthma Monitoring System and similar devices to automate collection and reporting of pulmonary function tests.

64. Devices or services to automate glucose testing, including but not limited to Continuous Glucose Monitoring System, Freestyle Blood Glucose Monitoring System and GlucoWatch Biographer Monitoring System.

65. Light box therapy for Seasonal Affective Disorder and related conditions.

66. OrthoTrac Pneumatic Vest, Corflex Disc Unloader, and similar braces designed to decrease pressure on the lumbar spine.

67. Hometrac, Homestretch, Spina, Lordex and similar home traction devices for lumbar back pain.

68. Acupressure devices for nausea and vomiting including but not limited to Relief Band.

69. Ankle replacement surgery.

70. Intradiscal Electrothermal Therapy for back pain.

71. Intrauterine fetal surgery for meningomyelocele or diaphragmatic hernia.

72. Lung Volume Reduction Surgery for emphysema.

73. Meniscal Allograft for knee injuries or conditions.

74. Occipital Decompression Surgery for fibromyalgia.

75. Pallidotomy for Cerebral Palsy.

76. Therapy for snoring, such as but not limited to Somnoplasty.

77. Antineoplaston therapy for cancer of the ovary or other sites.

78. Brain Stimulation for dystonia and/or multiple sclerosis.

79. Chelation therapy for coronary artery disease.

80. Extracorporeal Magnetic Therapy for stress urinary incontinence.

81. Therapeutic Electrical Stimulation for spinal cord injury or cerebral palsy.

82. Gene Therapy.

83. Lymphocyte Immunization for recurrent spontaneous abortions.

84. Procuren therapy for acute and chronic skin wounds.

85. Topical hyperbaric oxygen therapy for open wounds.

86. Antigen Leukocyte Antibody test for food allergy.

87. Extreme Drug Resistance Assay for cancer of the ovary or other sites.

88. ChemoFx Assay for treatment of various forms of cancer.

89. In Vitro Chemotherapy Sensitivity and Resistance Assays for directing cancer therapy.

90. Computed Tomography for screening for lung cancer in smokers or asymptomatic individuals.

91. Total Body Computed Tomography, Magnetic Resonance Imaging or Positron

Emission Tomography for screening of asymptomatic individuals.

92. Ultrafast CT for screening of asymptomatic patients for coronary artery disease.

93. Nuclear Magnetic Resonance Spectroscopy of blood evaluation of risk of coronary artery disease.

94. SurfaceElectromyography for back pain and other diagnoses.

95. Thoracic Electrical Bioimpedence measurement for hypertension, congestive heart failure, dyspnea, and other diagnoses.

96. Virtual Bronchoscopy.

97. Aerosolized Colistin for tracheobronchitis.

98. Botulinum toxin for hyperhidrosis, headaches including migraines, Legg-Calve-Perthe's disease, or any cosmetic indication.

99. Gonadotropin releasing hormone agonist therapy for paraphilia or other disorder of sexual conduct.

100. Sensory Integration Therapy, reintegration therapy, and kinetic therapy.

101. Vision Therapy.

102. Equestrian Therapy (hippotherapy), llama therapy, pet therapy or similar services.

7.3 Exclusion of Coverage for Pre-existing Medical Conditions. We may exclude Coverage for Pre-existing Medical Conditions if provided for in the Certificate of Coverage, Schedule of Copayments, and/or Group Contract. Any exclusion applies only to a condition for which medical advice, diagnosis, care, or treatment was recommended by, or received from, an individual licensed or similarly authorized to provide such services under applicable state law within the six (6) month period prior to the Enrollment Date.

For purposes of this section only, the "Enrollment Date" is the earlier of: (1) the first (1^{st}) day of Coverage under this Agreement; or (2) if the Group Contract imposes a waiting period, the first (1^{st}) day of the waiting period. If there is a waiting period, the Pre-existing Medical Condition exclusion period is offset by the period of time beginning with the first (1^{st}) day of the waiting period and ending on the first (1^{st}) day of Coverage under this Agreement.

Except in the case of a Late Enrollee, the exclusion period for Pre-existing Medical

Conditions ends no later than twelve (12) months after the Enrollment Date. In the case of a Late Enrollee, the exclusion period will end no later than eighteen (18) months after the Enrollment Date. **Note:** If there is a waiting period for a Late Enrollee, then the exclusion period will be offset by the period of time beginning with the first (1st) day of the waiting period and ending on the first (1st) day of Coverage under this Agreement. The exclusion period also will be reduced by Your prior period of Creditable Coverage. A prior period of Creditable Coverage is the number of days credited to a Member that operates to reduce or eliminate the Health Plan's Pre-existing Medical Condition exclusion period.

Note: The Health Plan will not impose a Pre-existing Medical Condition exclusion period for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the Member held prior Creditable Coverage and the condition was covered under that prior Creditable Coverage; provided that there is no Significant Break in Creditable Coverage of more than 63 consecutive days.

The Health Plan will not impose a Pre-existing Medical Condition exclusion period for pregnancy or on a newborn, a child under eighteen (18) years of age who is adopted, placed for adoption, or placed for foster care, provided the child is Covered under this Agreement within thirty-one (31) days of birth, adoption, placement for adoption, or placement for foster care. However, if the child has a Significant Break In Creditable Coverage of at least sixty-three (63) consecutive days, the Health Plan may impose a Pre-existing Medical Condition exclusion period on the child.

7.4 Member's Certificate of Creditable Coverage. At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

A certificate of Creditable Coverage under this Plan will be issued:

- when the Subscriber or Dependent ceases to be Covered under this Group health benefits Plan for any reason;
- when the Subscriber or Dependent loses coverage at the end of a COBRA or other continuation period under this Plan; and
- when requested by the Subscriber or Dependent within twenty-four (24) months of the termination of Coverage.

This certificate will list the period of Coverage under this Plan and will identify any waiting period under this Plan. Any waiting period under this Plan shall not be counted by any future health plan as a lapse in Creditable Coverage or as period of Creditable Coverage under this Plan.

The terminated Member can request a copy of this certificate up to twenty-four (24) months after the date their Group Coverage or continuation period ended, whichever is

later.

SECTION 8
COORDINATION WITH OTHER COVERAGE

8.1 Coordination With Other Plans [NAIC Model]. This coordination of benefits ("COB") provision applies when a Member has health care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

8.2 Definitions.

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

(1) "**Plan**" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law and subject to the rules on COB with Medicare set forth below.

(2) "**Plan**" does not include: individual insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage, blanket, franchise individual, automobile or homeowner coverage, benefits for nonmedical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

(3) Each contract for coverage under Section 8.2.A.1 or 8.2.A.2 is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. The order of benefit determination rules determine whether We are a "**Primary**" Plan or "**Secondary**" Plan when compared to another Plan covering You or Your Covered Dependent. When We are Primary, Our benefits are determined before those of any other Plan and without considering any other Plan's benefits. When We are Secondary, Our benefits are determined after those of another Plan and

may be reduced because of the Primary Plan's benefits.

C. "**Allowable Expense**" means a health care service or expense including Deductibles and Copayments, that is covered, at least in part by any of the Plans covering You or Your Covered Dependent. When a Plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

(1) If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private hospital room is otherwise a covered benefit) is not an Allowable Expense.

(2) If a Member is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(3) If a Member is covered by one Plan that calculates its benefits or services on the basis of Usual and Customary Rates and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.

(4) The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred Provider arrangements.

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

E. "**Closed Panel Plan**" is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

F. "**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

8.3 Order of Benefit Determination Rules. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always Primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

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

(2) **Child Covered Under More Than One Plan**. The order of benefits when a child is covered by more than one Plan is:

(a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is Primary.

(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

(c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The Plan of the Custodial Parent;
- The Plan of the spouse of the Custodial Parent;
- The Plan of the noncustodial parent; and then
- The Plan of the spouse of the noncustodial parent.

(3) **Active or Inactive Employee.** The Plan that covers a Member as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Member is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(4) **Continuation Coverage**. If a Member whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the Member as an employee, member, subscriber or retiree (or as that Member's dependent) is Primary, and the continuation coverage is Secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(5) **Longer or Shorter Length of Coverage**. The Plan that covered the Member as an employee, member, subscriber or retiree longer is Primary.

(6) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, We will not pay more than We would have paid had We been Primary.

8.4 Effect On the Benefits of this Health Plan. When We are Secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.

If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

This Section 8.4 is also applicable to coordination of benefits with Medicare (as described in Section 8.5)

8.5 Coordination of Benefits With Medicare.

A. Active Employees and Spouses Age 65 and Older.

Groups With Fewer Than 20 Employees. If an employee is eligible for Medicare and works for a Group with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, then Medicare will be the primary payer for the employee. Medicare will pay its benefits first. This Health Plan will pay benefits on a secondary basis. If, in this instance, the employee's Covered spouse is eligible for Medicare, then Medicare is the primary payer for the employee's Covered spouse and the Health Plan will pay benefits on a secondary basis for the Covered spouse.

Groups With At Least 20 Employees. If an employee is eligible for Medicare and works for a Group with at least 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, the Health Plan will be primary for the employee. If, in this instance, the employee's Covered spouse is eligible for Medicare, then the Health Plan will be primary for the Covered spouse. However, an employee and/or the employee's Covered spouse, as applicable, may decline Coverage under this Health Plan and elect Medicare as Primary. In this instance, this Health Plan, by law, cannot pay benefits Secondary to Medicare for Medicare Covered Services. You will continue to be Covered by this Health Plan as Primary unless You (a) notify Us, in writing, that You do not want benefits under this Health Plan or (b) otherwise cease to be eligible for benefits under this Health Plan.

B. Disability - Active Employees and Spouses Under Age 65. If You are under age 65 and actively work for the Group, and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below), then Medicare is the primary payer. This Health Plan will pay benefits on a secondary basis. If Your Covered spouse becomes entitled to benefits under Medicare due to disability (other than ESRD as discussed below), then Medicare is the primary payer for Your Covered spouse and the Health Plan will pay benefits on a secondary basis.

C. Disability - Active Employees and Spouses Age 65 or Older.

Groups With Fewer Than 100 Employees. If You are age 65 or older and actively work for a Group with fewer than 100 employees, and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below), then Medicare is the primary payer. The Health Plan will pay benefits on a secondary basis. If Your Covered spouse becomes entitled to

benefits under Medicare due to disability (other than ESRD as discussed below), then Medicare is the primary payer for Your Covered spouse and the Health Plan will pay benefits on a secondary basis.

Groups With At Least 100 Employees. If You are age 65 or older and actively work for a Group with at least 100 employees, and You or Your Covered spouse becomes entitled to benefits under Medicare due to disability (other than ESRD as discussed below), this Health Plan will be primary for You and Your eligible Dependents. Medicare will pay benefits on a secondary basis.

D. End Stage Renal Disease (ESRD). If You are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be primary for the first 30 months. Medicare will pay benefits on a Secondary basis during the first 30 months. After the first 30 months, Medicare will be Primary and this Health Plan will be Secondary. If this Health Plan is currently paying Your benefits as secondary at the time You become entitled to Medicare due to ESRD, this Health Plan will continue to pay benefits on a secondary basis. If Your Covered spouse becomes entitled to Medicare due to ESRD, the same rules apply.

E. Coordination of Benefits for All Medicare Eligibles. If You or one of Your Dependents is covered by Medicare Part A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:

- Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
- Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been covered by Medicare; or
- Amounts paid under all other plans in which You participate.

8.6 Right to Receive and Release Needed Information. By accepting Coverage under this Agreement You agree to:

- Provide Us with Information about other coverage and promptly notify Us of any coverage changes;
- Give Us the right to obtain information as needed from others to coordinate benefits; and
- Return any excess amounts to Us if We make a payment and later find that the other coverage should have been primary.

SECTION 9
CONVERSION

If the Coverage of any Member terminates due to termination of this Agreement, or as the result of a termination without cause under Section 4.1 above, then such Member may convert Health Plan membership to individual conversion membership, except that the Member shall not be

entitled to conversion coverage if termination of the Member's Coverage under the Plan occurred because:

A. of termination of employment or membership in the Group and either the Member was not entitled to continuation of Group coverage or failed to elect such continuation;

B. the Member failed to make timely payment of any required contribution for the cost of continuation of coverage;

C. the Member had not been continuously Covered under this Health Plan or for similar benefits under any other group policy that it replaced during the period of three (3) consecutive months immediately prior to termination of active employment ending with such termination;

D. this Health Plan terminated or the Group's participation in this Health Plan terminated, and the Coverage under this Health Plan was replaced by similar coverage under another group plan or policy within thirty-one (31) days of date of termination; or

E. the Member failed to continue Group coverage for the entire maximum period of eighteen (18) consecutive months following termination of active employment, unless that failure to continue was caused by a change of insurer by the Group from WellPath to a new health plan, and said change of insurer was consummated during the eighteen (18) month continuation period. If the Member is unable to continue coverage during the entire eighteen (18) month period because of a change of insurer by the Group from WellPath to a new health plan, which change was consummated during the eighteen (18) month continuation period, the Member shall at that time be entitled to conversion coverage from WellPath.

Additionally, WellPath shall not be required to issue conversion coverage to any person if such person:

A. is or can be covered by Medicare;

B. is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy; is or could be covered for similar benefits under any coverage for individuals in a Group, whether insured or uninsured; is or could be covered for similar benefits by reason of any state or federal law; and those benefits together with the benefits of the conversion coverage would result in overinsurance according to WellPath's standards for overinsurance.

In order to obtain individual conversion coverage, any Member eligible to convert Plan membership must submit an enrollment application for conversion to WellPath within thirty-one (31) days after the date of termination and submit premium payments required under such conversion coverage. The effective date of such individual conversion coverage shall be the day next following the effective date of termination of the Member's Coverage under this Agreement.

Notwithstanding the other provisions of this Section 9, a Member who is covered for similar health care benefits under any other insured or uninsured group arrangement that does not cover a pre-existing condition of the Member may convert to individual conversion coverage and continue such coverage until the Member's pre-existing condition is covered under the other group arrangement.

SECTION 10
UTULIZATION REVIEW AND RESOLVING COMPLAINTS AND GRIEVANCES

10.1 Upon the request of a Member (or a bona fide perspective insured), WellPath will provide the following:

- A copy of the Certificate of Coverage, Schedule of Copayments, provider directory, and any applicable Riders and amendments.
- An explanation of the Utilization Review criteria and treatment protocols for a specific condition used by WellPath in making a preauthorization decision (in writing if requested).
- WellPath procedures and medically-based criteria for determining whether a specified procedure, test or treatment is Experimental.
- WellPath drug Formularies and Prior Authorization requirements for prescription drugs.

Information regarding drugs or classes of drugs excluded from Coverage.

A. Utilization Review Procedures. The information necessary to make a decision includes the results of any patient examination, clinical evaluation, or second opinion. WellPath will obtain all information required to make the utilization review decision, including pertinent clinical information. Only information necessary to certify the health care service in question will be requested. If the necessary information is not provided by the Provider or Member, a decision will be rendered within the time frames specified below and based on the information received.

Members and their Providers may call the Health Services staff toll free at 866-935-7284. WellPath will provide the reasons for denying a specific requested treatment, including an explanation of utilization review criteria and treatment protocols on which the denial is based. If WellPath determines that a service or supply is Authorized, WellPath will not retract the determination or reduce payments after the service or supply is provided. However, WellPath reserves the right to retract a determination and reduce payments if the original determination was based upon a material misrepresentation that was knowingly made, including eligibility at the time of service, made by the Member or Provider.

(1) **Prior Authorization and Concurrent Review.**

(a) Prior Authorization and concurrent utilization determinations will

be communicated to the Member's Provider within **three (3) business days** after WellPath receives all necessary information. In the event additional information is needed for a Prior Authorization request, WellPath will request the additional information within 15 days of receipt of the request. The Provider will be given forty-five (45) days from the receipt of WellPath's request to submit additional documentation. The Member and Provider will be notified of the request for additional information in writing. WellPath will issue a determination within three (3) business days of receipt of the additional information. If the additional information is not submitted, then WellPath will issue a determination within fifteen (15) days of the expiration of the time allowed to submit the additional information.

Urgent requests for Prior Authorization will be responded to within seventy-two (72) hours.

(b) For concurrent reviews, WellPath will remain responsible for health care services until the Member has been notified of the noncertification. This notice will generally be provided to the Provider or facility who will then notify their patient. If this is not appropriate, then the Member will be called or notified by mail. Urgent Requests for concurrent care will be responded to within twenty-four (24) hours.

(2) Urgent Requests

An Urgent Request is a claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent care determinations

- could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or
- In the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a request is an Urgent Request is determined by WellPath applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any request that a physician with knowledge of the Member's medical condition determines is an Urgent Request will be treated as an Urgent Request.

Urgent requests for Prior Authorization will be responded to within seventy-two (72) hours. In the event additional information is needed for

a Prior Authorization request, WellPath will request the additional information within twenty-four (24) hours of receipt of the request. The Provider will be given forty-eight (48) hours from the receipt of WellPath's request to submit additional documentation. WellPath will issue a determination within forty-eight (48) hours of receipt of the additional information or within forty-eight (48) hours of the expiration of the time allowed to submit the additional information, whichever is sooner.

Urgent Requests for concurrent care will be responded to within twenty-four (24) hours. In the event additional information is needed for a concurrent review request, WellPath will request the additional information within twenty-four (24) hours of receipt of the request. The Provider will be given forty-eight (48) hours from the receipt of WellPath's request to submit additional documentation. WellPath will issue a determination within forty-eight (48) hours of receipt of the additional information or within forty-eight (48) hours of the expiration of the time allowed to submit the additional information, whichever is sooner.

(3) **Retrospective Review.** For retrospective review determinations, WellPath will make a determination within **thirty (30) days** after receiving all necessary information. If additional information is required, WellPath will request the additional information within 30 days following receipt of the claim. The Member must provide the requested additional information within ninety (90) days of receipt of WellPath's request. WellPath will make a determination within thirty (30) days of receiving the additional information or within **thirty (30) days** of the expiration of the time allowed to submit the additional information, whichever is sooner. For a certification (Prior Authorization), WellPath will provide written notification to the Member's Provider. For a noncertification (Coverage was denied, reduced or terminated), WellPath will provide written notice to the Member and the Provider within **five (5) business days** after making the determination.

Retrospective review includes the review of claims for Emergency Services to determine whether those claims meet the definition of Medical Emergency. Medical Emergency is defined in Section 12.

10.2 The Health Plan takes Member concerns, complaints and grievances seriously and has established consistent procedures for responding to them. WellPath has developed complaint resolution, appeal and grievance policies and procedures to provide Members with a mechanism to voluntarily voice their concerns, misunderstandings and/or dissatisfaction with any aspect of Health Plan policies and procedures or care rendered by a contracted Provider.

A. Definitions.

Days: All references to days are considered calendar days unless otherwise specified.

Expedited First Level Appeal of Noncertification: An oral or written request by a Member, Member's representative or Provider acting on behalf of a Member to change a Noncertification decision. An Expedited Appeal is appropriate under two different types of circumstances. The first circumstance is when an individual acts on behalf of the Health Plan applying the judgment of a "prudent layperson." A "prudent layperson " means an individual who possesses an average knowledge of health and medicine believes that the timeframe of a non-expedited appeal would reasonably appear to seriously jeopardize the Member's life or health or their ability to regain maximum function. The second circumstance is that an appeal shall be treated as an Expedited Appeal when a Physician with knowledge of the Member's medical condition believes that the Member will be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Second Level Appeal of Noncertification: An oral or written request by a Member, Member's representative or Provider acting on behalf of a Member to change a Noncertification decision made at the First Level Appeal of Noncertification and/or the Expedited First Level Appeal of Noncertification. An Expedited Appeal is appropriate under two different types of circumstances. The first circumstance is when an individual acts on behalf of the Health Plan applying the judgment of a "prudent layperson." A "prudent layperson " means an individual who possesses an average knowledge of health and medicine believes that the timeframe of a non-expedited appeal would reasonably appear to seriously jeopardize the Member's life or health or their ability to regain maximum function. The second circumstance is that an appeal shall be treated as an Expedited Appeal when a Physician with knowledge of the Member's medical condition believes that the Member will be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

External Review: An independent review of an appeal decision in which a Noncertification rendered by WellPath or its designee is upheld, and for which the Member or the Member's authorized representative has requested an External Review. An External Review is conducted by an Independent Review Organization, or "IRO," on behalf of the North Carolina Department of Insurance.

First Level Appeal of Noncertification (Standard): An oral or written request by a Member, Member's representative or Provider acting on behalf of a

Member to change a Noncertification decision. A standard or non-expedited First Level Appeal of Noncertification is appropriate when an Expedited First Level Appeal of Noncertification is not necessary.

First Level Grievance: An oral or written complaint submitted by a Member, a Member's representative, or a Provider acting on behalf of the Member expressing dissatisfaction with a response to a Verbal Complaint or inquiry, or any aspect of the delivery of services (except Noncertification determinations) including, but not limited to: the Health Plan administration, payment of claims, access to care, or the quality of clinical care for which follow-up action is requested by the Member, the Member's representative or the Provider acting on behalf of a Member.

Grievance: An oral or written complaint submitted by a Member about any of the following:

- The Health Plan's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a Member about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the Certificate of Coverage.
- Claims payment or handling; reimbursement for services.
- The contractual relationship between the Member and the Health Plan.
- The outcome of an Appeal of Noncertification.

Noncertification:** A determination made by the Health Plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet Health Plan requirements for Medical Necessity, appropriateness, health care setting, or does not meet the prudent layperson standard for Coverage of Emergency Services. The requested service is therefore denied, reduced, or terminated.

**** Please note:** If the Health Plan makes a Noncertification decision based on a specific exclusion of a health service under the Plan benefit documents (also called a "Benefits Exclusion"), then appeals related to this type of Noncertification are not subject to or entitled to an External Review administered by the North Carolina Department of Insurance. However, such a Noncertification shall be reviewed by the Health Plan in accordance with this policy. ******

Plan Representative: Any employee of the Health Plan authorized to receive and/or resolve complaints and concerns from Members, the Member's representative and Providers.

Quality of Care Complaint: A complaint by a Member, or on behalf of a Member, regarding the quality of care rendered, or professional conduct of a Provider. This category includes the Provider's medical knowledge and ability to perform routine or specialized procedures and to interpret results. These complaints are investigated and handled in accordance with the Health Plan's Quality Review Policy.

Second Level Appeal of Noncertification (Standard): An oral or written request by a Member, Member's representative or Provider acting on behalf of a Member to change a Noncertification decision made at the First Level Appeal of Noncertification and/or the Expedited First Level Appeal of Noncertification. A standard or non-expedited Second Level Appeal is appropriate when an Expedited Second Level Appeal of Noncertification is not necessary.

Second Level Grievance: An oral or written request by a Member, Member's representative or Provider acting on behalf of a Member to change a First Level Grievance determination.

Verbal Complaint: A verbal expression of Member dissatisfaction with any aspect of the delivery of services including, but not limited to, the administration of the Health Plan, payment of claims, access to care, or the quality of clinical care that the Member: (1) has not been able to resolve by speaking directly with the Participating Provider or other involved person; and (2) for which no formal follow-up action is required.

B. Overview of Process and Time Limits for Response to Requests. Any Member, Member's representative or Provider may express, either orally or in writing, a complaint, grievance, appeal, and/or request a review of a decision, policy, or action of the Health Plan. The grievance/appeal process also includes grievances/appeals based on Benefit Exclusions.

Appeals of Noncertifications. Members, the Member's representative or Provider may appeal a Noncertification decision. The appeal of a Noncertification may be expedited or non-expedited.

Grievances. Members, a Member's representative and a Provider have the right to file a grievance.

Grievances and Noncertification appeals must be submitted verbally or in writing, accompanied by medical records, operative reports, and any other documentation supporting the grievance or appeal, within one hundred eighty (180) days of the date of the Explanation of Benefits or notice to the Provider and/or Member. Requests for grievances or appeals received after such one hundred eighty (180) day period will not be eligible for review under the Health Plan's internal grievance/appeal process. The Health Plan will provide upon request and free of charge, reasonable access to and copies of all documents,

records, and other information relevant to the Member's claim for benefits.

Records of each complaint, grievance or appeal received will be maintained by the Health Plan for a period of seven (7) years.

C. Types of Review Committees.

Grievance Coordinator: The Appeals/Grievance Coordinator is responsible for tracking all grievances and for responding in writing to all written complaints and grievances. The Appeals/Grievance Coordinator is authorized to independently resolve non-clinical complaints, inquiries or First Level Grievances that meet any of the following criteria:

- The Health Plan clearly made an error in claims processing; and/or
- The Member provides additional information that clearly affects the Health Plan's initial processing of a claim.

All non-clinical First Level Grievances that the Appeals/Grievance Coordinator is not authorized to independently resolve are resolved by the First Level Grievance Committee.

First Level Grievance Committee: The First Level Grievance Committee is responsible for reviewing First Level Grievances related to claims payment, benefit determinations, access and service. The committee meets as frequently as necessary to comply with the time frames outlined in this document. The Medical Director participates on the committee on an ad hoc basis when grievances are clinical in nature. The First Level Grievance Committee is chaired by the Appeals/Grievance Coordinator (a non-voting member), shall not be comprised of the same person or persons who initially handled the matter that is the subject of the grievance, and shall include at least one Health Plan Senior Manager.

Second Level Grievance Panel: The Second Level Grievance Panel is responsible for reviewing a grievance regarding a First Level Grievance decision. The panel is composed of persons who were not involved in any matter giving rise to the Second Level Grievance, including at least two non-employees of the Health Plan who have no financial interest in the outcome of the case and who are not subordinate to the person(s) who were involved in any prior level of determination or decision related to the Grievance. All of the persons reviewing a Second Level Grievance involving a clinical issue shall be Providers who have appropriate expertise, including at least one clinical peer. The Vice President for Medical Affairs or his designee (provided s/he has not been involved in any prior level of determination or decision related to the Grievance), the Manager of Quality Improvement (provided s/he has not been involved in any prior level of determination or decision related to the Grievance), and the Appeals/Grievance Coordinator who chairs the panel shall attend the meeting to present information and answer questions. The Second Level Grievance Panel

meets as frequently as necessary to comply with the time frames outlined in this document.

Appeals Coordinator: The Appeals/Grievance Coordinator is responsible for coordinating and tracking all appeals of Noncertifications and providing a written response for all levels of appeals. The Appeals/Grievance Coordinator, in conjunction with the Manager of Quality Improvement, will be responsible for coordinating External Review requests and for tracking External Review requests to the North Carolina Department of Insurance.

First Level Noncertification Appeals Committee: The First Level Noncertification Appeals Committee is responsible for reviewing requests for appeals of Noncertifications. The committee is comprised of at least three Providers from various primary and medical specialties who: (1) are licensed to practice medicine in the State of North Carolina (at least one of whom is a Participating Provider, and at least one of whom is a clinical peer); (2) were not involved in any matter giving rise to the First Level Noncertification Appeal and who are not subordinate to the person(s) who were involved in any prior level of determination or decision related to the appeal; (3) do not have a financial interest in the case; (4) are not employees of the Health Plan; and (5) have the appropriate clinical expertise. The First Level Noncertification Appeals Committee meets as frequently as needed and is chaired by the Vice President for Medical Affairs or his designee.

Second Level Noncertification Appeals Panel: The Second Level Noncertification Appeals Panel is responsible for reviewing appeals of First Level Appeals of Noncertification decisions. The panel consists of Providers who: (1) are licensed to practice medicine in the State of North Carolina (at least one of whom is a Participating Provider, and at least one of whom is a clinical peer); (2) were not involved any matter giving rise to the Second Level Noncertification Appeal and who are not subordinate to the person(s) who were involved in any prior level of determination or decision related to the appeal; (3) are not employees of the Health Plan; (4) do not have a financial interest in the case; and (5) have the appropriate clinical expertise. The Second Level Noncertification Appeals Panel convenes as frequently as necessary to comply with the time frames described in this document, and is chaired by the Vice President for Medical Affairs or his designee (provided s/he has not been involved in any prior level of determination or decision related to the appeal). If the Second Level Noncertification Appeals Panel is comprised of at least three persons, a Health Plan Medical Director who was not involved in the initial decision may serve on the Second Level Noncertification Appeals Panel.

D. Written or Verbal Complaints. The following process resolves a written or Verbal Complaint.

(i) A Verbal Complaint may be received by any Plan Representative and will be documented in the Health Plan's tracking system. If a Member

requests written follow-up regarding their concerns, a Verbal Complaint Form documenting the substance of the concern will be filled out and forwarded to the Appeals/Grievance Coordinator. All documentation will include the following information:

(a) Member's or Provider's name and identification number;
(b) Name of person expressing the concern;
(c) Nature of the concern and date received;
(d) Provider or department associated with the concern, if applicable; and
(e) A description of the action that the Member, Member's representative or Provider requests the Health Plan to take in response to his/her concern.

(ii) In many cases, the Plan Representative receiving the Verbal Complaint will be able to resolve the Member's or Provider's issue during the call or walk-in interaction. The action taken to address the complaint is documented in the Health Plan's tracking system. If the person expressing the complaint requests written documentation of the resolution, this request will be documented on the Verbal Complaint Form and in the Health Plan's tracking system. The request will then be forwarded to the Appeals/Grievance Coordinator, who will send out the written letter to the Member, Member's representative or Provider within ten (10) days of receipt of the Verbal Complaint.

(iii) Verbal Complaints regarding any aspect of clinical care, including urgency, are forwarded to the Health Services Department for investigation.

(iv) If the Member or Provider is not satisfied with the verbal response to his/her complaint, the Member, Member's representative, or Provider is informed that he/she may request a First Level Grievance Review and is given the opportunity to submit his/her grievance and any supporting material in writing. The Complaint/Grievance Form will be made available to the Member for completion.

(v) If the Member, Member's representative or Provider indicates that he/she would like to submit a First Level Grievance in writing but is unable to because of a physical or mental disability, the Plan Representative will document the grievance on the Complaint/Grievance Form and submit the form to the Appeals/Grievance Coordinator for follow-up and resolution.

E. <u>First Level Grievances</u>.

(i) A Member, Member's representative or Provider on behalf of the Member may submit a written request for a First Level Grievance,

accompanied by medical records, operative reports, and any other documentation supporting the grievance, within one hundred eighty (180) days of the date of the Explanation of Benefits or notice to the Provider and/or Member. The person(s) reviewing the Grievance shall not be the same person(s), and shall not be subordinates of those same person(s), who initially handled the matter that is the subject of the grievance.

Upon receipt of a Member Grievance Form or other written correspondence, the Appeals/Grievance Coordinator will document the grievance in the Health Plan's tracking system. If the grievance appears to be clinical in nature, the information is forwarded to the Medical Director for review. If the issue is benefit related, it is processed by the Appeals/Grievance Coordinator. If the issue relates to a Noncertification, it is processed as an appeal through the Appeals/Grievance Coordinator.

The Appeals/Grievance Coordinator will send written acknowledgment of receipt of the grievance to the Member, the Member's representative, or the Provider within three (3) business days of receipt. The Member, Member's representative, or Provider will not be allowed to be present during the First Level Grievance Review. The acknowledgement will include:

- the name, address, and telephone number of the Appeals/Grievance Coordinator;
- a statement of the Member's right to submit written material; and
- information on how to submit written material.

(ii) The Appeals/Grievance Coordinator will then work with the appropriate department(s) for investigation and resolution. At the completion of the investigation, the Appeals/Grievance Coordinator will render a decision regarding those grievances for which he/she is authorized to independently resolve, and other grievances will be referred to the Grievance Committee for review. Decisions of the Grievance Committee are made by majority vote.

(iii) A written decision of the First Level Grievance Review will be provided to the Member, the Member's representative, or Provider within fifteen (15) days of receipt of the request. The Health Plan may not unilaterally extend time periods required by law. However, the Health Plan may extend time periods, based upon the Member's request, in the interest of assisting the Member.

Except for investigations into complaints about quality of care, the results of which are subject to confidentiality and nondisclosure restrictions, the written decision of the First Level Grievance Review will be in clear terms and will include:

(a) The professional qualifications and licensure (if applicable) of the

person(s) reviewing the grievance;

(b) A statement of the committee's understanding of the reason for the grievance;

(c) The specific reason(s) for the determination (i.e., "not a Covered benefit");

(d) Reference to the specific Health Plan provisions on which the determination was based (i.e., reference to the specific section of the Member's Certificate of Coverage, Evidence of Coverage, or Schedule of Copayments);

(e) If an internal rule, guideline, or protocol was relied upon in making the determination, then either: (1) the specific rule, guideline, or protocol; or (2) a statement that it was relied on, that a copy will be provided free of charge and upon request, and instructions for obtaining a copy of the rule, guideline or protocol;

(f) A statement advising the Member of the right to request a Second Level Grievance and a description of the procedures to request a Second Level Grievance Review (if the determination is not in favor of the Member);

(g) A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the grievance;

(h) A statement of the Member's rights to bring civil action under ERISA Section 502(a) after the internal review process has been exhausted; and

(i) Notice of the availability of the Insurance Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

F. **Second Level Grievances.** If a Member is not satisfied with the decision rendered at the First Level Grievance Review, the Member, Provider, or Member's representative, may request a Second Level Grievance Review by submitting a written request to the Appeals/Grievance Coordinator within thirty (30) days of receipt of the First Level Grievance determination. The Member, Member's representative or Provider may request and receive all information relevant to the Second Level Grievance.

(i) Second Level Grievances are resolved within fifteen (15) days of receipt of the request for the Second Level Grievance Review, and are reviewed by the Second Level Grievance Panel. The Appeals/Grievance Coordinator will send the Member or his/her representative a written acknowledgment of receipt of the request within three (3) business days after it is received. The acknowledgment will include:

- The name, address and telephone number of the Appeals/Grievance Coordinator;
- A statement of the Member's rights, including the right to request and

receive all information relevant to the case;

- A statement of the Member's or Member's representative's right to appear before the review panel to present his/her case or, if unable to appear in person, the right to communicate with the committee by conference call or other appropriate technology;
- The right to submit supporting materials prior to and at the review meeting, and to ask questions of any member of the review panel;
- The right to be assisted or represented by a person of his/her choice, including a family member, employer representative or attorney; and
- Notification that the Member's right to a full review is not dependent upon on his/her attendance at the meeting.

- The Member and his/her representative, and the Provider (if appropriate), will receive written notification of the Committee's decision within five (5) days after the decision has been made but not greater than fifteen (15) days from receipt of the request. The Health Plan may not unilaterally extend time periods required by law. However, the Health Plan may extend time periods, based upon the Member's request, in the interest of assisting the Member.

The written decision of the Second Level Grievance Review will be in clear terms and will include:

- The professional qualifications and licensure (if applicable) of the person(s) reviewing the grievance;
- A statement of the committee's understanding of the reason for the grievance;
- The specific reason(s) for the determination (i.e., "not a Covered benefit");
- Reference to the specific Health Plan provisions on which the determination was based (i.e., reference to the specific section of the Member's Certificate of Coverage, Evidence of Coverage, or Schedule of Copayments);
- If an internal rule, guideline, or protocol was relied upon in making the determination, then either: (1) the specific rule, guideline, or protocol; or (2) a statement that it was relied on, that a copy will be provided free of charge and upon request, and instructions for obtaining a copy of the rule, guideline or protocol;
- A statement advising the Member or Provider that the committee's decision is final;
- A statement that the Member is entitled to receive, upon request and free of charge, reasonable access

to and copies of all documents, records and other information relevant to the grievance;

- A statement of the Member's rights to bring civil action under ERISA Section 502(a) after the internal review process has been exhausted; and
- Notice of the availability of the Insurance Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

G. **Issuance of Noncertifications.** The Health Services Department is responsible for conducting utilization review of services provided to Health Plan Members. If a determination is made that health services furnished or proposed to be furnished are not Medically Necessary, are Experimental and Investigational, or are not being provided in the appropriate setting, a notice of Noncertification is issued, which denies, reduces or terminates Coverage of the health services in question. The Member and/or Provider are notified in writing of the denial. The notification includes:

1. The specific reasons for the Noncertification;
2. Reference to the specific Health Plan provisions on which the Noncertification is based;
3. A description of any additional materials or information the Member should provide WellPath in order for Us to reconsider payment of the claim, and an explanation of why such materials are needed;
4. A description of WellPath's review procedures and the time limits applicable to such procedures;
5. A statement of the Member's right to request an External Review after the internal review process has been exhausted;
6. A statement of the Member's right to bring civil action under ERISA Section 502 following review of an adverse benefit action after the internal review process has been exhausted;
7. If an internal rule, guideline, or protocol was relied upon in making the determination, then either: (1) the specific rule, guideline, or protocol; or (2) a statement that it was relied on, that a copy will be provided free of charge and upon request, and instructions for obtaining a copy of the rule, guideline or protocol; and
8. If the determination was based on Medical Necessity, Experimental nature of the treatment, or a similar exclusion, then either: (1) an explanation of the scientific or clinical reasons for the determination, applying terms of the Health Plan to the Member's circumstances; or (2) a statement that such explanation will be provided upon request, free of charge.

H. **First Level Appeal of Noncertification (Standard; Non-Expedited).**

(i) A Member, Member's representative or Provider may submit a written request for a First Level Appeal of Noncertification within one hundred eighty (180) days of receipt of a Noncertification decision. The Appeals/Grievance Coordinator will acknowledge receipt of requests for non-expedited appeals of Noncertifications within three (3) business days to the Member (or the Member's representative). The Member (or the Member's representative) will be provided with: (a) the name, address, fax number and telephone number of the Appeals/Grievance Coordinator; (b) a statement of his/her right to submit written material; and (c) information on how to submit written material.

(ii) The First Level Noncertification Appeals Committee reviews appeals of Noncertification. The committee will convene, review the appeal and render a decision within fifteen (15) days of receipt of the appeal request. As it considers its decision, the First Level Noncertification Appeals Committee will give due consideration to the availability or non-availability of optional health care services proposed by the Health Plan. The Health Plan may not unilaterally extend time periods required by law. However, the Health Plan may extend time periods, based upon the Member's request, in the interest of assisting the Member.

(iii) A written notice of the First Level Appeal of Noncertification decision will be provided to the Member (or Member's representative) and Provider within fifteen (15) days of receipt of the appeal request. The written notice will be in clear terms and will contain the following:

1. The professional qualifications and licensure of the committee members reviewing the appeal;
   (a) A statement of the committee's understanding of the reason for the appeal;
   (b) The specific reasons for the Noncertification;
   (c) Reference to the specific Health Plan provisions on which the determination is based (i.e., reference to the specific section of the Member's Certificate of Coverage, Evidence of Coverage, or Schedule of Copayments);
   (d) A reference to the evidence or documentation that is the basis for the decision, reference to the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria;
   (e) If the Health Plan's Noncertification is upheld, a statement advising the Member or Member's representative of the right to request a Second Level Appeal of Noncertification and a description of the procedures to request a Second Level Appeal of Noncertification Review;
   (f) A description of any additional materials or information needed the Member should provide WellPath in order for Us to

reconsider payment of the claim, and an explanation of why such materials are needed;

(g) A statement of the Member's right to request an External Review after the internal review process has been exhausted;

(h) A statement of the Member's right to bring civil action under ERISA Section 502 following review of an adverse benefit action after the internal review process has been exhausted;

(i) If an internal rule, guideline, or protocol was relied upon in making the determination, then either: (1) the specific rule, guideline, or protocol; or (2) a statement that it was relied on, that a copy will be provided free of charge and upon request, and instructions for obtaining a copy of the rule, guideline or protocol;

(j) If the determination was based on Medical Necessity, Experimental nature of the treatment, or a similar exclusion, then either: (1) an explanation of the scientific or clinical reasons for the determination, applying terms of the Health Plan to the Member's circumstances; or (2) a statement that such explanation will be provided upon request, free of charge; and

(k) Notice of the availability of the Insurance Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

(iv) In some instances, appeals of Noncertification will be forwarded to an organization to which the Health Plan has delegated responsibility for utilization management review. The delegate must adhere to the time frames for notification and resolution noted in this document. If a Member, Member's representative or Provider remains dissatisfied with the delegate's First Level Appeal of Noncertification determination, he/she may request a Second Level Appeal of Noncertification Review by submitting such request and any supporting documentation to the Health Plan Appeals/Grievance Coordinator. The Appeals/Grievance Coordinator will process the appeal in accordance with the Second Level Appeal of Noncertification process outlined in this document.

I. <u>Expedited First Level Appeal of Noncertification</u>.

The Member, Member's representative or Provider may request an expedited appeal when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of the Member, or jeopardize the Member's ability to regain maximum function. Additionally, an appeal shall be treated as an expedited appeal when a Physician with knowledge of the Member's medical condition believes that the Member will be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. This request may be made verbally or in writing. The Health Plan will accept additional information from the requesting Provider either by telephone, fax or other acceptable means for an expedited appeal and confer with a clinical

peer reviewer within twenty-four (24) hours.

(i) The clinical peer reviewer will be a Provider licensed in North Carolina who was not involved in the original Noncertification. The requesting Provider will be notified of the expedited appeal outcome by telephone. If the original determination is upheld, the Provider will be notified of the decision.

(ii) Written notice of this decision will be provided to the Member (or the Member's representative) and the Provider as soon as possible but no later than thirty-six (36) hours after receiving the request for an expedited review, or within thirty-six (36) hours of receipt of additional information from the requesting Provider, whichever is sooner. The written notice will be in clear terms and will contain the following:

1. The professional qualifications and licensure of the Provider(s) reviewing the appeal;
2. A statement of the committee's understanding of the reason for the appeal;
3. The specific reasons for the Noncertification;
4. Reference to the specific Health Plan provisions on which the determination is based (i.e., reference to the specific section of the Member's Certificate of Coverage, Evidence of Coverage, or Schedule of Copayments);
5. A reference to the evidence or documentation that is the basis for the decision, reference to the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria;
6. If the Health Plan's Noncertification is upheld, a statement advising the Member (or the Member's representative) of the right to request a Second Level Appeal of Noncertification and a description of the procedures to request a Second Level Appeal of Noncertification Review;
   (a) A description of any additional materials or information the Member should provide WellPath in order for Us to reconsider payment of the claim, and an explanation of why such materials are needed;
   (b) A statement of the Member's right to request an External Review after the internal review process has been exhausted;
   (c) A statement of the Member's right to bring civil action under ERISA Section 502 following review of an adverse benefit action after the internal review process has been exhausted;
   (d) If an internal rule, guideline, or protocol was relied upon in making the determination, then either: (1) the specific rule, guideline, or protocol; or (2) a statement that it was relied on, that a copy will be provided free of charge and upon request, and instructions for obtaining a copy of the rule, guideline or

protocol;

(e) If the determination was based on Medical Necessity, Experimental nature of the treatment, or a similar exclusion, then either: (1) an explanation of the scientific or clinical reasons for the determination, applying terms of the Health Plan to the Member's circumstances; or (2) a statement that such explanation will be provided upon request, free of charge; and

(f) Notice of the availability of the Insurance Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

J. <u>Second Level Appeal of Noncertification (Standard; Non-Expedited)</u>.

(i) If a Member is not satisfied with the decision rendered at the First Level Appeal of Noncertification Review, the Member, Provider, or the Member's representative, may request a Second Level Appeal of Noncertification Review by submitting a written request to the Appeals/Grievance Coordinator within thirty (30) days after receipt of the First Level Appeal of Noncertification determination. The Member, Member's representative or Provider may request and receive all information relevant to the Second Level Appeal of Noncertification free of charge.

(ii) The Appeals/Grievance Coordinator will send the Member (or his/her representative), and the Provider a written acknowledgment of receipt of the request for a Second Level Appeal of Noncertification Review within three (3) business days after it is received. The written acknowledgment will include:

(a) The name, address, facsimile number and telephone number of the Appeals/Grievance Coordinator;

(b) A statement of the Member's rights, including the right to request and receive all information (free of charge) relevant to the case;

(c) The right to appear before the panel to present his/her case or, if unable to appear in person, the right to communicate with the panel by conference call or other appropriate technology;

(d) The right to submit supporting materials before and at the panel meeting, and ask questions of any member of the panel;

(e) The right to be assisted or represented by a person of his/her choice, including a family member, employer representative or attorney; and

(f) Notification that the Member's or Provider's right to a full review is not dependent upon on his/her attendance at the panel meeting.

(iii) The Appeals/Grievance Coordinator will convene a Second Level Noncertification Appeals Panel to review the appeal of Noncertification. The Second Level Noncertification Appeals Panel will convene and review the appeal and recommend a decision no later than fifteen (15) days after receiving the request for the Second Level Noncertification Appeals Panel Review.

(iv) Written notification of the panel's decision will be issued to the Member and his/her representative, and the Provider within three (3) business days after completing the review but no later than fifteen (15) days after receipt of the request. The Health Plan may not unilaterally extend time periods required by law. However, the Health Plan may extend time periods, based upon the Member's request, in the interest of assisting the Member.

The written decision for the Second Level Appeal of Noncertification will be in clear terms and will include:

- The professional qualifications and licensure of the Provider(s) reviewing the appeal;
- A statement of the panel's understanding of the appeal and all pertinent facts;
- The specific reasons for the Noncertification;
- Reference to the specific Health Plan provisions on which the determination is based (i.e., reference to the specific section of the Member's Certificate of Coverage, Evidence of Coverage, or Schedule of Copayments);
- The panel's recommendation and the rationale behind the recommendation;
- A statement advising the Member or Provider that the panel's decision is final;
- A description of any additional materials or information the Member should provide WellPath in order for Us to reconsider payment of the claim, and an explanation of why such materials are needed;
- A statement of the Member's right to request an External Review after the internal review process has been exhausted;
- A statement of the Member's right to bring civil action under ERISA Section 502 following review of an adverse benefit action after the internal review process has been exhausted;
- If an internal rule, guideline, or protocol was relied upon in making the determination, then either: (1) the specific rule, guideline, or protocol; or (2) a statement that it was relied on, that a copy will be provided free of charge and upon request, and instructions for obtaining a copy of the rule, guideline or protocol;
- If the determination was based on Medical Necessity, Experimental nature of the treatment, or a similar exclusion, then either: (1) an explanation of the scientific or clinical reasons for the determination, applying terms of the Health Plan to the Member's circumstances; or (2) a statement that such explanation will be provided upon request, free of charge; and
- Notice of the availability of the Insurance Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

K. <u>Expedited Second Level Appeal of Noncertification</u>.

- The Member, Member's representative or Provider may request an Expedited Second Level Appeal of Noncertification when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of the Member, or jeopardize the Member's ability to regain maximum function. Additionally, an appeal of Noncertification shall be treated as an expedited appeal when a Physician with knowledge of the Member's medical condition believes that the Member will be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. This request may be made verbally or in writing. The Health Plan will accept additional information from the requesting Provider either by telephone, fax or other acceptable means for an Expedited Second Level Appeal of Noncertification.

- The Appeals/Grievance Coordinator will immediately notify the Medical Director and Manager of Quality Improvement of the receipt of an Expedited Second Level Appeals of Noncertification Review request resulting from an appeal of Noncertification decision.

- The Appeals/Grievance Coordinator will send the Member or his/her representative a written acknowledgment of receipt of the request for an Expedited Second Level Appeal of Noncertification Review within twenty-four (24) hours of receipt of the request. The written acknowledgment will include:
- The name, the address, fax number and telephone number of the Appeals/Grievance Coordinator;
- A statement of the Member's rights, including the right to request and receive all information relevant to the case;
- The right to appear before the panel to present his/her case or, if unable to appear in person, the right to communicate with the panel by conference call or other appropriate technology;
- The right to submit supporting materials before and at the panel meeting, ask questions of any member of the panel;
- The right to be assisted or represented by a person of his/her choice, including a family member, employer representative or attorney; and
- Notification that the Member's or Provider's right to a full review is not dependent upon on his/her attendance at the panel meeting.

(i) The Appeals/Grievance Coordinator will coordinate and convene an Expedited Second Level Noncertification Appeals Panel as soon as possible after receipt of the expedited request. The panel will convene a review meeting and communicate its decision within thirty-six (36) hours of receipt of the request for an Expedited Second Level Appeal of Noncertification, or within thirty-six (36) hours of receipt of

any additional materials the Provider may wish to submit, whichever is sooner.

(ii) The Appeals/Grievance Coordinator will provide verbal notification to the Member, his/her representative, or the Provider of the panel's decision on the same day that the decision is made in order to comply with the thirty-six (36) hour resolution time frame requirement. The Appeals/Grievance Coordinator will also send a written notification of the panel's decision to the Member, his/her representative, and the Provider within thirty-six (36) hours. The written notification will be in clear terms and will include:

- The professional qualifications and licensure (if applicable) of the members of the panel;
- A statement of the panel's understanding of the nature of the appeal and all pertinent facts;
- The panel's recommendation and the rationale behind that recommendation;
- The specific reasons for the Noncertification;
- A description of or reference to the evidence or documentation considered by the panel in making the recommendation;
- Reference to the specific Health Plan provision on which the determination is based (i.e., reference to the specific section of the Member's Certificate of Coverage, Evidence of Coverage, or Schedule of Copayments);
- A statement advising the Member or Provider that the panel's decision is final;
- A description of any additional materials or information the Member should provide WellPath in order for Us to reconsider payment of the claim, and an explanation of why such materials are needed;
- A statement of the Member’s right to request an External Review after the internal review process has been exhausted;
- A statement of the Member’s right to bring civil action under ERISA Section 502 following review of an adverse benefit action after the internal review process has been exhausted;
- If an internal rule, guideline, or protocol was relied upon in making the determination, then either: (1) the specific rule, guideline, or protocol; or (2) a statement that it was relied on, that a copy will be provided free of charge and upon request, and instructions for obtaining a copy of the rule, guideline or protocol;
- If the determination was based on Medical Necessity, Experimental nature of the treatment, or a similar exclusion, then either: (1) an explanation of the scientific or clinical reasons for the determination, applying terms of the Health Plan to the Member’s circumstances; or (2) a statement that such explanation will be provided upon request, free of charge; and
- Notice of the availability of the Insurance Commissioner's office for assistance,

including the telephone number and address of the Insurance Commissioner's office.

L. **Quality of Care Complaints.** Quality of Care Complaints are referred to the Health Services Department. The Medical Director will review each complaint. If the Medical Director finds a substantiated quality of care issue, the issue will be brought to the Quality Improvement Committee and the Plan Quality Oversight Committee for review. Quality of Care Complaints are resolved as stated below.

(i) The Appeals/Grievance Coordinator logs in the complaint letter, including the Member name, date of receipt, and a brief summary of the issue.

- Within ten (10) business days of receipt of the Quality of Care Complaint letter, the Appeals/Grievance Coordinator sends out a written consolidated acknowledgment letter and First Level Grievance decision letter to the Member. The letter shall include the following information:
- identify the Health Plan contact person;
- indicate that substantiated quality of care issues will be referred to the Quality Improvement Committee for review and consideration of any appropriate action against the Provider;
- state that the results will not be available to the Member due to peer review protections; and
- indicate that North Carolina law does not allow for a Second Level review for grievances concerning quality of care.

(iii) The Appeals/Grievance Coordinator forwards the copy of the Quality of Care Complaint letter and the consolidated acknowledgement / decision letter to the Quality Management division of the Health Services Department for resolution.

(iv) The Quality Management division reviews the complaint and takes appropriate action, including submission to the Quality Improvement Committee and Quality Oversight Committee for review, as indicated.

Because the investigation of a quality of care issue is a confidential and privileged peer review activity, the written response sent to the Member by the Appeals/Grievance Coordinator is prepared based on guidelines received from the Health Services Department, and will not include any details about the investigative results or what corrective steps, if any, were taken.

10.2 **Notice of the Availability of the Managed Care Patient Assistance Program.** You may obtain assistance from the Managed Care Patient Assistance Program ("MCPA") if You have any questions or problems concerning Your health care Coverage. The MCPA is located at the North Carolina Department of Justice. You may contact the MCPA at the following address and telephone numbers:

Managed Care Patient Assistance Program
Attorney General's Office
P.O. Box 629
Raleigh, North Carolina 27602
(919) 733-6272 - Direct Number
(866) 867-6272 - Toll Free Number (for in-state residents only)
(919) 733-6276 - Fax Number
E-mail Address: MCPA@ncdoj.com

10.3 **External Review by Independent Review Organizations.** North Carolina law provides for review of Noncertification decisions by an external, independent review organization ("IRO"). Except for cases when You request an Expedited Appeal from WellPath, External Review is available to You only after You have exhausted WellPath's internal review process. You or an authorized representative must make a request to the North Carolina Department of Insurance ("NC DOI") for an External Review within sixty (60) days of receiving WellPath's written notice of final determination that the services in question are not approved (after You have exhausted WellPath's internal review process). The NC DOI administers this service at no charge to You, and will arrange for the review of Your case by an IRO once the NC DOI establishes that Your request is complete and eligible for review.

WellPath will notify You in writing of Your right to request an External Review each time You:

- Receive a Noncertification decision; or
- Receive a First or Second Level Appeal of Noncertification decision upholding a Noncertification decision; or
- Receive a Second Level Review decision upholding the original Noncertification.

In order for Your request to be eligible for External Review, the NC DOI must determine the following:

- That Your request is about a Medical Necessity determination that resulted in a Noncertification;
- That You had Coverage with WellPath in effect when the Noncertification decision was issued;
- That the service for which the Noncertification was issued appears to be a Covered Service under Your Health Plan; and
- That You have exhausted WellPath's internal review process as described in this document.

External Review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

- **<u>Standard External Review</u>.** For a **standard** External Review, You will be considered to have exhausted the internal review process if You have:
    - Completed WellPath's appeal and Second Level Review process and received a written Second Level determination from WellPath; or
    - Filed for a Second Level Review and except to the extent that You have requested or agreed to a delay, have not received WellPath's written decision within sixty (60) days of the date You submitted the request; or
    - Received notification that WellPath has agreed to waive the requirement to exhaust the internal review process.

  If Your request for a standard External Review is related to a retrospective Noncertification (a Noncertification which occurs after You have received the services in question), You will not be eligible to request a standard External Review until You have completed WellPath's internal review process and received a final written determination from WellPath.

  If You wish to request a standard External Review, You (or Your representative) must make this request to the NC DOI within sixty (60) days of receiving WellPath's written notice of final determination that the services in question are not approved. When processing Your request for External Review, the NC DOI will require You to provide the NC DOI with a written, signed authorization for the release of any of Your medical records that may need to be reviewed for the purpose of reaching a decision on the External Review.

  Within ten (10) business days of receipt of Your request for a standard External Review, the NC DOI will notify You and Your Provider of whether Your request is complete and whether it is accepted. If the NC DOI notifies You that Your request is incomplete, You must provide all requested additional information to the NC DOI within ninety (90) days of the date of WellPath's written notice of final determination. If the NC DOI accepts Your request, the acceptance notice will include:

  (a) The name and contact information for the Independent Review Organization ("IRO") assigned to Your case;

  (b) A copy of the information about Your case that WellPath has provided to the NC DOI; and

  (c) Notification that You may submit additional written information and supporting documentation relevant to the initial Noncertification to the assigned IRO within seven (7) days of Your receipt of the acceptance notice.

  If You choose to provide any additional information to the IRO, You must also provide that same information to WellPath at the same time using the same means of communication (e.g., You must fax the information to WellPath if You faxed it to the IRO). When faxing information to WellPath, please send it to 1-919-337-1873. If You choose to mail Your information, send it to:

WellPath Select, Inc.
2801 Slater Road, Suite 200
Morrisville, NC 27560
Attention: Appeals/Grievance Coordinator

Please note that You may also provide this additional information to the NC DOI within the seven (7) day deadline noted in paragraph (c) above, rather than sending it directly to the IRO and WellPath. The NC DOI will then forward this information to the IRO and WellPath within two (2) business days of receiving Your additional information.

The IRO will send You written notice of its determination within forty-five (45) days of the date the NC DOI received Your standard External Review request. If the IRO's decision is to reverse the Noncertification, WellPath will reverse its Noncertification decision within three (3) business days of receiving notice of the IRO's decision, and provide Coverage for the requested service or supply that was the subject of the Noncertification decision. If You are no longer Covered by WellPath at the time WellPath receives notice of the IRO's decision to reverse the Noncertification, WellPath will only provide Coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

- **Expedited External Review.** An **expedited** External Review of a Noncertification decision may be available if You have a medical condition where the time required to complete an expedited internal appeal, a Second Level Review, or a standard External Review would reasonably be expected to seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function. If You meet this requirement, You may make a written or verbal request to the NC DOI for an expedited review after You:
    - Receive a Noncertification decision from WellPath AND file a request with WellPath for an expedited appeal; or
    - Receive an appeal decision upholding a Noncertification decision AND file a request with WellPath for an expedited Second Level Review; or
    - Receive a Second Level Review decision upholding the original Noncertification.

  You may also make a request for an expedited External Review if You receive an adverse Second Level Review decision concerning a Noncertification of an admission, availability of care, continued stay or Emergency Care, but have not been discharged from the inpatient facility.

  In consultation with a medical professional, the NC DOI will review Your request and determine whether it qualifies for expedited review. You and Your Provider will be notified within three (3) days if Your request is accepted for expedited External Review. If Your request is not accepted for expedited

review, the NC DOI may: (1) accept the case for standard External Review if WellPath's internal review process was already completed; or (2) require the completion of WellPath's internal review process before You may make another request for an External Review with the NC DOI. An expedited External Review is not available for retrospective Noncertifications.

The IRO will communicate its decision to You within four (4) days of the date the NC DOI received Your request for an expedited review. If the IRO's decision is to reverse the Noncertification, WellPath will, within one (1) day of receiving notice of the IRO's decision, reverse the Noncertification decision for the requested service or supply that is the subject to the Noncertification decision. If You are no longer Covered by WellPath at the time WellPath receives notice of the IRO's decision to reverse the Noncertification, WellPath will only provide Coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's External Review decision is binding on WellPath and You, except to the extent You may have other remedies available under applicable federal or state laws. You may not file a subsequent request for an External Review involving the same Noncertification decision for which You have already received an External Review decision.

C. **Requesting an External Review.** For further information about External Review or to request an External Review, please contact the NC DOI at:

By Mail:
NC Department of Insurance
Healthcare Review Program
P.O. Box 26387
Raleigh, NC 27611-6387
(877) 885-0231 (toll free in state)
(919) 715-1163 (out of state)
(919) 715-1175 (fax)
www.ncdoi.com (visit Consumer section)

In Person:
Dobbs Building
430 N. Salisbury Street
4th Floor, Suite 4105
Raleigh, NC 27603
(Toll-free in NC) 1-877-885-0231
(Out of NC) 1-919-715-1163
www.ncdoi.com **for External Review information and Request Form**

The Healthcare Review Program is available to provide Consumer Counseling

on utilization review and internal appeals and grievance issues.

SECTION 11
CONFIDENTIALITY OF YOUR HEALTH INFORMATION

As part of this Agreement, You agree to provide Us access to any records and medical information held by any Provider of Covered Services under this Agreement. You also give Us, Our representatives, and authorized regulators or accrediting bodies access to Your general medical record for:

- claims processing, including claims We make on Your behalf for reimbursement;
- quality assessment and improvement;
- underwriting (for reinstating or adding a Dependent); and
- evaluation of potential or actual claims against Us.

SECTION 12
DEFINITIONS

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement.

12.1 **"Agreement" -** The Certificate of Coverage and amendments, the Enrollment Form, Applicable Riders, and the Group Contract together form the Agreement.

12.2 **"Authorization/Authorize/Prior Authorization" -** WellPath has given approval for payment for certain services to be performed and an Authorization Number has been assigned. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by WellPath. If You need specialty services from a Non-Participating Provider, an Authorization means the Member's PCP or obstetrician/gynecologist Physician has recommended a Non-Participating Provider for treatment of a specific condition, and WellPath has assigned an Authorization for a certain number of visits or days.

12.3 **"Coinsurance" -** The percentage amount You must pay above the specified benefit payable as a condition of the receipt of certain services as provided in this Certificate of Coverage.

12.4 **"Complications of Pregnancy" -** Medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, which result in the mother's life being in jeopardy or making the birth of a viable infant impossible, and which requires the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic

pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within 10 days of delivery: urinary tract infection; mastitis, thrombophlebitis; and endometritis. Emergency cesarean section will be considered eligible for Coverage only when provided in the course of treatment for those conditions listed above as a Complication of Pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered Complications of Pregnancy.

12.5 "Contract Year" - The period during which the total amount of yearly benefits under Your Coverage is calculated. The Contract Year is the period of twelve (12) consecutive months commencing on the Group Effective Date and each subsequent anniversary.

12.6 "Copayment" - A specified dollar amount You must pay as a condition of the receipt of certain services as provided in this Certificate of Coverage.

12.7 "Cosmetic Services and Surgery" - Plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

12.8 "Coventry Transplant Network Facility" - A Provider or Facility designated by Us to provide transplant services and treatment to Members at the In-Network rate.

12.9 "Coverage" or "Covered" - The entitlement by a Member to Covered Services under the Certificate of Coverage, subject to the terms, conditions, limitations and exclusions of the Certificate of Coverage, including the following conditions: (a) health services must be provided when the Certificate of Coverage is in effect; and (b) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Certificate of Coverage occur; and (c) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Certificate of Coverage; and (d) health services must be Medically Necessary.

12.10 "Covered Services" - The services or supplies provided to You for which WellPath will make payment, as described in the Agreement.

12.11 "Creditable Coverage" - With respect to an individual, coverage of the individual under any of the following:

- A self-funded employer group health plan under the Employee Retirement Income Security Act of 1974;
- Group or Individual health insurance coverage;
- Part A or part B of title XVIII of the Social Security Act;

- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- Chapter 55 of title 10, United States Code;
- A medical care program of the Indian Health Service or of a tribal organization;
- A State health benefits risk pool;
- A health plan offered under chapter 89 of title 5, United States Code;
- A public health plan (as defined in federal regulations);
- A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C 2504 (e)); or
- The Health Insurance Program for Children established in Part 8 of Chapter 108A of the General Statutes, or any successor program

Creditable Coverage does not include coverage consisting solely of coverage for excepted benefits.

12.12 "Deductible" - The dollar amount of medical expenses for Covered Services that You are responsible for paying before benefits subject to the Deductible are payable under this Agreement.

12.13 "Dependent" - Any member of a Subscriber's family who meets the eligibility requirements as outlined in this Certificate of Coverage.

12.14 "Directory of Health Care Providers" - A listing of Participating Providers. Please be aware the information in the directory is subject to change.

12.15 "Effective Date" - The date of Coverage as determined by the Group and agreed to by Us, as set forth in the Group Contract.

12.16 "Emergency Out of Area" - Covered Services provided when an enrollee is temporarily absent from the Service Area, that are immediately required as a result of:

- an unforeseen illness, injury, or condition; and
- it is not reasonable given the circumstances to obtain services through WellPath.

12.17 "Emergency Services" - Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

12.18 "Enrollment Form" - The application for enrollment in the Health Plan.

12.19 "Experimental or Investigational" - A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-Authorization that is proposed for off-label prescribing;
- Any health product or service that is subject to Investigational Review Board (IRB)

review or approval;

- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except for limited services required by law. Please refer to "Covered Clinical Trials" in Section 6.5.D for a description of these limited services;
- Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

12.20 "Formulary" - A listing of prescription drugs approved by WellPath for Coverage under this Agreement. These are dispensed through a pharmacy to Members. This list is subject to periodic review and change by WellPath. The Formulary is available for review in Participating Provider offices or by contacting the Member Services Department.

12.21 "Group" - The organization or firm contracting with WellPath to arrange health care services for Subscribers and their Dependents through which eligible Subscribers and Dependents become entitled to the Covered Services described herein.

12.22 "**Group Contract" -** The Agreement including between the Group and Us that states the agreed upon contractual rights and obligations of WellPath, the Group, and Members, and that describes the costs, procedures, Covered Services, conditions, limitations, exclusions, and other obligations afforded to Members.

12.23 "**Group Effective Date" -** The date that is specified in the Group Contract as the Effective Date of this Agreement.

12.24 "Group Enrollment Period" - Shall mean a period of time occurring at least once annually during which time any eligible employee may enroll with WellPath for Coverage under this Certificate of Coverage.

12.25 "Health Plan" - WellPath Select, Inc.

12.26 "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 one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

12.27 "Infertility" - Infertility means the inability of a woman to conceive a pregnancy after six months of unprotected intercourse or the inability of a woman to carry a pregnancy

to live birth.

12.28 **"Late Enrollees" -** Shall mean individuals who fail to enroll with WellPath for Coverage under the Agreement during the required thirty-one (31) day period when they first become eligible for Coverage. This term does not include special enrollees.

12.29 **"Medical Director" -** The Physician specified by Us as the Medical Director or other Health Plan staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

12.30 **"Medical Emergency" -** A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

12.31 "Medically Necessary" or "Medical Necessity" - Covered services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease and, except for Covered Clinical Trials, not for Experimental, Investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not solely for the convenience of the Member, the Member's family, or the Provider.

12.32 "**Member" -** Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions.

12.33 **"Member Effective Date" -** The date entered on Our records as the date when Coverage for a Member under this Agreement begins in accordance with the terms of this Agreement, which Coverage shall begin at 12:01 a.m. on such date.

12.34 **"Non-Participating Provider" -** A Provider who has no direct or indirect written Agreement with the Us to provide health services to Members.

12.35 **"Participating Provider" -** A Provider who has entered into a direct or indirect written agreement with Us to provide health services to Members. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers delivered to You in connection the Agreement. The participation status of Providers may change from time to time.

12.36 "Peer-Reviewed Medical Literature" - A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

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

12.38 "Pre-Existing Medical Condition" - Any medical condition for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed Provider within the six (6) months immediately preceding the Member's Enrollment Date under the Agreement. Certain health services related to a Pre-existing Medical Condition may be subject to a Copayment or not Covered at all. Members may contact the Health Plan to find out to which procedures a Copayment applies.

12.39 "Provider/Provider Network" - A Physician, Hospital, Skilled Nursing Facility, Home Health Agency, Hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

12.40 "Retiree" - Shall mean a former employee of the Group who meets the Group's definition of retired employees to whom the Group offers Coverage under this Certificate of Coverage.

12.41 "Schedule of Covered Services" - Description of Covered Services contained in the chart in Section 6.

12.42 "Service Area" - The geographic area served by WellPath as approved by the North Carolina Department of Insurance. WellPath's Service Area is subject to change.

12.43 "Significant Break in Coverage" - A continuous period of at least sixty-three (63) days occurring after the termination of a Member's coverage under a prior plan and ending before the Member's Enrollment Date under this Plan. A period of time is a "Significant Break in Coverage," only if the Member is not covered under any prior plan during such period. Time enrolled in a short term limited duration health insurance policy is not considered a Significant Break in Coverage, so long as duration of the enrollment on the short term limited duration health insurance policy or policies does not exceed 12 months. Any waiting period under this Health Plan shall not be counted in determining whether any break in coverage is a Significant Break in Coverage.

12.44 "Special Enrollment Period" - The period set forth in Section 2.6 of this Certificate of Coverage.

12.45 "Specialty Care Physician/Specialist" - A Physician who provides medical services to Members within the range of a medical specialty.

12.46 "Subscriber" - The eligible employee or Retiree who has elected WellPath Coverage for himself and any eligible Dependents through submission of an enrollment application and for whom, or on whose behalf, premiums have been received by Us.

12.47 "We/Us or Our" - The Health Plan.

12.48 "You/Your" - A Member Covered under this Certificate of Coverage.

SECTION 13
GENERAL PROVISIONS

Applicability. The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all benefits and privileges made available to You shall be available to Your Dependents.

13.2 Choice of Law. This Agreement will be administered under the laws of the State of North Carolina.

13.3 Entire Agreement. This Agreement shall constitute the entire agreement between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate Coverage of a Member shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

13.4 Nontransferable. No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by Us under this Agreement. Such right to health care service Coverage or other benefits is not transferable.

13.5 Relationship Among Parties Affected by Agreement. The relationship between WellPath and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of WellPath, nor is WellPath or any employee of WellPath an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

Neither the Group nor You is an agent or representative of WellPath, and neither shall be liable for any acts or omissions of WellPath for the performance of services under

this Agreement.

13.6 Reservations and Alternatives. We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

13.7 Severability. In the event that any provision of this Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Agreement, which shall continue in full force and effect in accordance with its remaining terms.

13.8 Valid Amendment. No change in this Agreement shall be valid unless approved by an officer of WellPath, and evidenced by endorsement on this Agreement and/or by amendment to this Agreement. Such amendment will be incorporated into this Certificate of Coverage.

13.9 Waiver. The failure of WellPath, the Group, or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

WELLPATH SELECT, INC.
2801 Slater Road, Suite 200
Morrisville, North Carolina 27560
1-866-935-7284 or (919) 337-1800

AMENDMENT TO CERTIFICATE OF COVERAGE:

The Agreement which describes your WellPath Health Plan is hereby amended to reflect the changes indicated below. All other terms and conditions of the Agreement are unchanged.

A. Paragraph 2.6.A, **Special Enrollment Due to Loss of Other Coverage** of the Certificate of Coverage is hereby amended to read as follows:

A. Special Enrollment Due to Loss of Other Coverage. Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Health Plan if the employee waived Coverage under this Health Plan at the time Coverage was most recently made available because the employee or Dependent had other coverage at the time Coverage under this Health Plan was offered and the employee's or Dependent's other coverage:

- Was COBRA continuation coverage that has since been exhausted; or,
- If not COBRA continuation coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term "loss of eligibility for such coverage" includes (1) a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or (2) in the case of coverage offered through an HMO, loss of coverage because the employee or dependent no longer lives or works in the HMO's service area. This term does not include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation); or,
- A situation in which the employee or dependent incurs a claim that would meet or exceed a lifetime limit on all benefits offered under the other coverage.

Required Length of Special Enrollment Notification. An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date that the other coverage was lost, or in the case where the employee or dependent has exceeded a lifetime limit on all benefits offered under the other coverage, no later than thirty (30) days after a claim is first denied due to the operation of a lifetime limit on all benefits.

Effective Date of Coverage. If the employee or Dependent enrolls within the thirty-one (31) day period, Coverage under the Health Plan will become effective no later than the first (1^{st}) day of the 1st calendar month after the date the completed request for special enrollment is received.

All other provisions remain unchanged. Except as amended or supplemented herein, all provisions of this Agreement shall remain in full force and effect.

WELLPATH SELECT, INC.
SCHEDULE OF COPAYMENTS
$2,500 Deductible 100% QHDHPB

NOTICE: YOUR ACTUAL EXPENSES FOR COVERED SERVICES MAY EXCEED THE STATED COINSURANCE PERCENTAGE OR COPAYMENT AMOUNT BECAUSE ACTUAL PROVIDER CHARGES MAY NOT BE USED TO DETERMINE PLAN AND MEMBER PAYMENT OBLIGATIONS.

PLEASE NOTE: **This table is a cost sharing summary only, and does *not* include the rules, requirements, conditions, limitations, exclusions or other terms applicable to benefits covered by the Plan. Please refer to your Certificate of Coverage for more information on your Health Plan.**

Contract Year Deductible	**In-Network**	**Out-of-Network**
Individual	$2,500	$5,000
Family	$5,000	$10,000
Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
Individual	$2,500	$7,000
Family	$5,000	$14,000
Services and Expenses That Do Not Apply to the Out-of-Pocket Maximum	The following services and/or expenses do not apply to satisfy the In-Network Out-of-Pocket Maximum: • Services Covered under a Vision Rider **Please Note:** Your In-Network Out-of-Pocket (OOP) Maximum does not apply towards Your Out-of-Network OOP Maximum.	The following services and/or expenses do not apply to satisfy the Out-of-Network Out-of-Pocket Maximum: • Any expenses or charges in excess of the Out-of-Network Rate (ONR • Services Covered under a Vision Rider • any precertification penalties **Please Note:** Your Out-of-Network Out-of-Pocket (OOP) Maximum does not apply towards Your In-Network OOP Maximum.

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NOTICE: YOUR ACTUAL EXPENSES FOR COVERED SERVICES MAY EXCEED THE STATED COINSURANCE PERCENTAGE OR COPAYMENT AMOUNT BECAUSE ACTUAL PROVIDER CHARGES MAY NOT BE USED TO DETERMINE PLAN AND MEMBER PAYMENT OBLIGATIONS.

PLEASE NOTE: **This table is a cost sharing summary only, and does *not* include the rules, requirements, conditions, limitations, exclusions or other terms applicable to benefits covered by the Plan. Please refer to your Certificate of Coverage for more information on your Health Plan.**

Lifetime Maximum Benefit	**In-Network**	**Out-of-Network**
	Unlimited	Unlimited

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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
Preventive Services provided by Participating Providers are Covered 100%, No Copayment, No Coinsurance, No Deductible. Preventive Services provided by Non-Participating Providers are subject to the appropriate Copayment, Coinsurance, and/or Deductible. "Preventive Services" include the following: 1. Evidence-based items and services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; 2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Practices of the Centers of Disease Control and Prevention (Advisory Committee) 3. With respect to infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by Health Resources and Services Administration (HRSA) 4. With respect to women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA. If a condition is identified through a Preventive Service screening, any subsequent testing, diagnosis, analysis or treatment is Not a Preventive Service and is subject to the appropriate Copayment, Coinsurance and/or Deductible.		
Primary Care Physician/Provider (PCP) Office Services (Diagnostic and Treatment Services), including: • Diagnosis and treatment of illness or injury • Laboratory services provided in the PCP's office • X-rays, such as chest x-rays and standard plain film x-rays, provided in the PCP's office **<u>Please Note</u>:** *All other services not listed are subject to the applicable Copayment, Coinsurance and/or Deductible noted in Your Schedule of*	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible

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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
Copayments, in addition to Your regular PCP office visit Copayment, Coinsurance and/or Deductible.		
Specialist Office Services (Diagnostic and Treatment Services), including: • Diagnosis and treatment of illness or injury • Laboratory services provided in the Specialist's office • X-rays, such as chest x-rays and standard plain film x-rays, provided in the Specialist's office • Allergy testing **Please Note:** *All other services not listed are subject to the applicable Copayment, Coinsurance and/or Deductible noted in Your Schedule of Copayments, in addition to Your regular Specialist office visit Copayment, Coinsurance and/or Deductible.*	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible Allergy testing **not Covered** Out-of-Network
Ambulance	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.

*** Member is responsible for amounts in excess of Out-of-Network Rate (ONR) in addition to applicable Copayments and Coinsurance.**

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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
Blood and Blood Product Administration	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Breast Reconstruction (Post-Mastectomy)	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Cardiac and Pulmonary Rehabilitation Therapy	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Chemotherapy and Radiation Therapy	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Colonoscopy – Not Preventive	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Dental & Oral Surgical Services – Tumors of the Mouth	Your Coinsurance is 0% after Deductible	**Not Covered**
Dental & Oral Surgical Services – Accidental Injury	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Dialysis – Provided in the Home	Your Coinsurance is 0% after Deductible	**Not Covered**
Dialysis - Provided in Dialysis Center or Outpatient Hospital / Outpatient Facility	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Durable Medical Equipment (DME) and Associated DME Supplies	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Elective Sterilization	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.

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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
Emergency Services Note: These services must meet the definition of Medical Emergency to be Covered.	Your Coinsurance is 0% after Deductible	Covered as In-Network if it is an Emergency.
Emergency Department Services that Do Not Meet the Definition of Medical Emergency	**Not Covered**	Your Coinsurance is 30% of ONR, after Deductible.
Eyeglasses and Corrective Lenses following Cataract Removal Surgery when intraocular lens is not implanted	Your Coinsurance is 0% after Deductible	**Not Covered**
Family Health Planning – Diaphragm Fitting	Your Coinsurance is 0% after Deductible The cost of the diaphragm is not included	Your Coinsurance is 30% of ONR, after Deductible. The cost of the diaphragm is not included
Family Health Planning – Insertion / Removal of IUD	Your Coinsurance is 0% after Deductible The cost of the IUD is included	Your Coinsurance is 30% of ONR, after Deductible. The cost of the IUD is included
Family Health Planning – Insertion / Removal of Contraceptive Implants	Your Coinsurance is 0% after Deductible The cost of the contraceptive implant is included	Your Coinsurance is 30% of ONR, after Deductible. The cost of the contraceptive implant is included
Growth Hormone **Please Note:** Covered Service when used to treat a congenital anomaly such as Turner's Syndrome, but only if the growth hormone is approved by the FDA for treatment of the congenital anomaly	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.

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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
High Technology Diagnostic Services, Tests, and Procedures, including but not limited to: • MRI • MRA • CAT Scans • Nuclear Medicine Studies • PET Scans • Echocardiograms • Ultrasounds • Professional, anesthesia, ancillary services and supplies associated with the above services	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Home Health Care Limited to 30 days per Contract Year	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Home Infusion Services Limited to 90 days per Contract Year	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Hospice Limited to 210 days per Member per lifetime. Family counseling and bereavement limited to 5 visits per Contract Year.	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Injectable Drugs, such as: • Remicade • IV antibiotics • Analgesics • Allergy serum and shots	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Inpatient Hospital Care, Including Observation Stays	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.

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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
Inpatient Rehabilitation Facility Limited to 30 days per Contract Year. This is a combined In-Network and Out-of-Network limitation.	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Inpatient Skilled Nursing Facility Limited to 75 days per Contract Year. This is a combined In-Network and Out-of-Network limitation.	Your Coinsurance is 0% after Deductible	**Not Covered**
Laboratory and Reference Pathology Services	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Mammography – Not Preventive	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Maternity Services - Pre-Natal and Post-Natal Visits	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Occupational Therapy Limited to 20 visits per Contract Year. This is a combined In-Network and Out-of-Network limit.	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Outpatient Hospital and Outpatient Facility Services	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Outpatient Surgery	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.

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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
Physical Therapy Limited to 20 visits per Contract Year. This is a combined In-Network and Out-of-Network limit.	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Podiatry	Your Coinsurance is 0% after Deductible	**Not Covered**
Prosthetic, Orthotic and Corrective Devices (External)	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Pulmonary and Cardiac Rehabilitation Therapy	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Radiology Services (such as X-rays), when provided in a freestanding radiology facility.	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Speech Therapy Limited to 20 visits per Contract Year. This is a combined In-Network and Out-of-Network limit.	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Termination of Pregnancy	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
TMJ (Temporomandibular Joint)	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.
Transplants, including Evaluations	Your Coinsurance is 0% after Deductible	Your Coinsurance is 30% of ONR, after Deductible.

WELLPATH SELECT, INC.
SCHEDULE OF COPAYMENTS
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Service	Member Cost In-Network Deductible Applies	Member Cost Out-of-Network * Deductible Applies
Urgent Care Services	Your Coinsurance is 0% after Deductible	Covered as In-Network benefit when meets the definition of Emergency. Otherwise, Your Coinsurance is 30% of ONR, after Deductible
Wigs for Hair Loss Resulting From Cancer Treatment This is a combined in-network and out-of-network limitation.	The Plan will pay up to $500 maximum per Member per lifetime	The Plan will pay up to $500 maximum per Member per lifetime

WELLPATH SELECT, INC.
SCHEDULE OF COPAYMENTS
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OUT-OF-NETWORK RATE (ONR)

The "Out-of-Network Rate" or "ONR" is the amount We pay for Covered Services rendered by a Non-Participating Provider for Out-of-Network Benefits. When services are rendered by a Non-Participating Provider, benefits may be paid directly to You upon receipt of Your claim submission, unless You assign the benefit to the Non-Participating Provider. (Please see Section 1 of Your Certificate of Coverage for information on assignment of benefits.)

The ONR is the lesser of the Provider's billed charges or the current North Carolina Medicare fee schedule, as set forth below. (Please note that the Medicare fee schedule is updated April 1 of each year.) If there is no corresponding Medicare rate noted for a particular service, We will pay the amount that We would have paid if the Non-Participating Provider furnishing the services were a Provider contracting with Us.

Please Note: You are responsible for paying any expenses or charges in excess of the ONR.

The Out-of-Network Rates (ONR) under your Plan are as follows:

Covered Services	**Percentage of Current NC Medicare Fee Schedule**
Physician Services, except Anesthesiology	150%
Anesthesiology Administration	300%
Facility Services (including hospitals and surgery centers)	100%
All Other Covered Services	100%

Please see Your Point-of-Service (POS) Amendment for more information on ONR.

AMENDMENT TO
WELLPATH SELECT, INC.
CERTIFICATE OF COVERAGE

1. This Amendment (the "Amendment"), effective as of the effective date of the Agreement, amends the WellPath Select, Inc. Certificate of Coverage (the "COC") to comply with the federal Patient Protection and Affordable Coverage Act of 2010 and the federal Health Care and Education Reconciliation Act of 2010 (collectively, the "Act").

2. WellPath Select, Inc. is executing this Amendment pursuant to Sections 2.1.B Dependent Eligibility, 12 Definitions, and 13.8 Valid Amendment of the COC.

3. Capitalized terms not otherwise defined in this Amendment shall have the meaning set forth in the COC.

4. To the extent any provision of this Amendment conflicts with any of the provisions of the COC, the provisions of this Amendment shall govern. Except for the amendments made hereby, the COC remains in full force and effect.

5. Section 2.1.B of the COC is hereby deleted in its entirety and replaced with the following new Section 2.1.B:

"**2.1.B Dependent Eligibility -** To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Be the lawful spouse of the Subscriber or be a child of the Subscriber or the Subscriber's spouse including:
    - Children under age twenty-six (26) who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or placed for adoption or foster care with the Subscriber or Subscriber's spouse;
    - Children under age twenty-six (26) for whom the Subscriber or the Subscriber's spouse is required to provide health care coverage pursuant to Qualified Medical Child Support;
    - Children under age twenty-six (26) for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian; and
    - Children twenty-six (26) or older who are either the birth, adopted or foster children of the Subscriber or the Subscriber's spouse, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to Us by the Subscriber upon enrollment of the person as a Dependent child or at the onset of

the Dependent child's incapacity prior to age twenty-six (26) and annually thereafter.

Notwithstanding the above, We reserve the right to require that Your Spouse provide documentation demonstrating Your marriage, such as a certified copy of a marriage certificate."

6. Section 6.3 of the Certificate of Coverage is amended to include the following:

"We will not impose a Pre-existing Condition Exclusion for enrollees under age 19."

7. Section 4.1., paragraph G., Fraud, Material Misrepresentation and/or Criminal Behavior, of the Certificate of Coverage is amended to include the following:

We will not rescind Your Coverage retroactively unless You commit an act, practice, or omission that constitutes fraud, or You make an intentional misrepresentation of material fact. If We initiate retroactive rescission of Coverage because of fraud or intentional misrepresentation of material fact, We will give You at least thirty (30) days advance written notice of the rescission of Coverage.

If We initiate retroactive rescission of Your Coverage because of fraud or intentional misrepresentation of material fact, You have the right to appeal the rescission through Our Complaints and Grievances Process. In this instance, Your appeal will be considered an appeal of an Adverse Benefit Determination.

8. The definition "Preventive Care" is deleted in its entirety and replaced with the following new definition, which is added to the Definitions Section of the COC:

""Preventive Services" shall mean the services set forth in Section 2713(a)(1) of the federal Public Health Service Act."

9. To the extent any term or condition related to Covered Services and set forth in the COC (or any attachment, rider, or schedule of benefits) conflicts with the Act, such term or condition shall be interpreted to comply with the Act.

WellPath Select, Inc.

_____

By: Tracy Baker
Its: Chief Executive Officer

WellPath Select, Inc.

2801 Slater Road, Suite 200
Morrisville, North Carolina 27560
(866) 935-7284 or (919) 337-1800

AMENDMENT TO:

Certificate of Coverage - Direct Access Form WP-COC-Direct Access-2/2004
Form WP-MENTAL/SUBSTANCE-HSA-2004
Form WP-CHIRO-HSA-2004
Form WP-PHARM-HSA-2004

FOR POS HIGH DEDUCTIBLE HEALTH **PLANS**

In accordance with the Group Contract between WellPath Select, Inc. ("WellPath") and the Group, the Agreement which describes Your WellPath Certificate of Coverage is hereby amended to reflect the changes indicated below. All other terms and conditions of the Agreement are unchanged.

Section 1, "Using Your Benefits", of the Certificate of Coverage is hereby amended by the addition of the following:

Information About Your Point-of-Service (POS) Plan. As a Point-of-Service Member, You are Covered by two types of health care benefits at the same time:

- In-Network Benefits, which mirror the benefits available through an HMO Plan; and
- Out-of-Network Benefits, which are similar to traditional indemnity (major medical) insurance benefits. This type of Coverage is called "point-of-service" or "POS" Coverage because You choose whether to use Your In-Network Benefits or Out-of-Network Benefits at the point You decide to obtain a particular Covered Service.

Please note that the specific requirements which apply to a Covered Service may differ depending on whether You use Your In-Network Benefits or Your Out-of-Network Benefits.

Out-of-Network Benefits apply to Covered Services You receive from any Non-Participating Provider. You will have to satisfy a Deductible, and You may also have to make a Coinsurance payment for the Covered Service. For many Out-of-Network Benefits, You pay the Provider and then submit claim documents to Us. We then reimburse You for a portion of what You paid.

In deciding which type of benefits to use, You should keep in mind that:

- Using Your In-Network Benefits will usually cost You less than using Your Out-of-Network Benefits. Consult Your Schedule of Copayments, and any Riders or

amendments to Your Plan, to determine what You are required to pay for a particular service when obtaining In-Network Benefits, compared with Out-of-Network Benefits.

- **For some In-Network Covered Services, there are no Out-of-Network Benefits available.** If so, this will be indicated in Your Schedule of Copayments, and in any Riders or amendments to Your Certificate of Coverage.

- In-Network Benefits, whether they are received by a Participating or Non-Participating Provider, are available for Emergency Care and out-of-area Urgent Care that meet the definitions described in Your Certificate of Coverage.

Out-of-Network Benefit Rules.

(1) **Basic Rules.** Out-of-Network Benefits are available for Covered Services You receive from a Non-Participating Provider (other than Emergency Care and out-of-area Urgent Care that meet the requirements in Your Certificate of Coverage). For Out-of-Network Benefits, You can use any licensed Provider -- You do not have to use a Participating Provider. For some non-Emergency Services, You must obtain Prior Authorization of Coverage from Us. The penalty You must pay for failure to obtain the required Prior Authorization (in addition to any Coinsurance and Deductible payments You must make) is 50% of the charges up to a maximum of $500.

(2) **WellPath Prior Authorization Of Coverage for Non-Maternity Inpatient Admissions.** In order for You to receive Out-of-Network Benefits for Your admission to a Hospital or other inpatient facility, We must Prior Authorize Coverage of Your admission. We will Authorize Coverage of inpatient admissions only for a specific period of time. If You stay longer than the time We have authorized, You will have to pay the charges for Your additional stay. Before admission, You should verify with the WellPath Health Services Department that our Prior Authorization of Coverage has been provided to (1) Your attending Physician, and (2) the Hospital or treatment facility. Please note that Prior Authorization is not required for maternity admissions of up to 48 hours after vaginal delivery and up to ninety-six (96) hours after delivery by cesarean section. Prior Authorization is required for stays beyond the 48- or 96-hour minimum.

(a) If WellPath denies Prior Authorization of Coverage for Your inpatient admission, all services You receive during the admission will not be Covered. However, You may appeal the denial in accordance with the complaint and grievance procedures described in Your Certificate of Coverage.

(b) If Prior Authorization was not obtained from WellPath prior to Your inpatient admission, but WellPath would have Prior Authorized Coverage of the admission if the request had been made, then, as a penalty for failing to

obtain the required Prior Authorization, You will be responsible for paying, in addition to any Deductible and Coinsurance payments You must make, fifty percent (50%) of the charges up to a maximum of five hundred dollars ($500).

PLEASE NOTE: If You fail to request WellPath's Prior Authorization for Out-of-Network services, and We later determine that WellPath would not have Prior Authorized Coverage of the admission even if the request had been made, You will be responsible for paying the full cost of all services provided to You.

(3) **Member Payments.** NOTICE: Your actual expenses for Covered Services may exceed the stated Coinsurance percentage because actual Provider charges may not be used to determine Plan and Member payment obligations.

a) **Deductible**. The Deductible is the Contract Year dollar amount You must pay for Covered Services before any Benefits will be paid. Only payments for services that would otherwise be Covered Benefits will count toward the Deductible.

The following payments *do not* count toward the **In-Network Deductible**:

- Payments for Services not Covered
- Payments for Services Covered under a Vision Rider
- Payments for Preventive Care
- Payments for Out-of-Network Benefits

When You make a payment which counts toward the In-Network Deductible, You should submit the bill with proof of payment to Us so that We can keep track of the extent to which the Deductibles have been satisfied.

The individual and family Deductibles are indicated in the Schedule of Copayments. If You have single (Subscriber only) Coverage, **You must satisfy the individual In-Network Deductible before any In-Network Benefits will be paid, including Services Covered under any Rider such as Pharmacy/Prescription Drug, Chiropractic Services and Mental Health/Substance Abuse.** However, this does not include Preventive Care and Services Covered under a Vision Rider. If You have Subscriber, Spouse and/or Dependent Coverage, **You must satisfy the family In-Network Deductible before any In-Network Benefits will be paid for any Member, including Services Covered under any Rider such as Pharmacy/Prescription Drug, Chiropractic Services and Mental Health/Substance Abuse.** However, this does not include Preventive Care and Services Covered under a Vision Rider.

The following payments *do not* count toward the **Out-of-Network Deductible**:

- Payments for services not Covered
- Payments for In-Network Benefits

- Payments in Excess of the Out-of-Network Rate
- Prior Authorization Penalties
- Payments for Services Covered under a Vision Rider

When You make a payment which counts toward Your Out-of-Network Deductible, You should submit the bill with proof of payment to Us so that We can keep track of the extent to which Your Deductibles have been satisfied.

The individual and family Deductibles are indicated in the Schedule of Copayments. If You have single (Subscriber only) Coverage, **You must satisfy the individual Out-of-Network Deductible before any Out-of-Network Benefits will be paid, including Services Covered under any Rider such as Pharmacy/Prescription Drug, Chiropractic Services and Mental Health/Substance Abuse.** However, this does not include Preventive Care and Services Covered under a Vision Rider. If You have Subscriber, Spouse and/or Dependent Coverage, **You must satisfy the family Out-of-Network Deductible before any Out-of-Network Benefits will be paid for any Member, including Services Covered under any Rider such as Pharmacy/Prescription Drug, Chiropractic Services and Mental Health/Substance Abuse.** However, this does not include Preventive Care and Services Covered under a Vision Rider.

(b) **Coinsurance Payments.** In-Network Coinsurance means the percentage of the contracted rate for a Covered Service You must pay when You use Your In-Network Benefits. Out-of-Network Coinsurance means the percentage of the Out-of-Network Rate for a Covered Service You must pay when You use Your Benefits. Out-of-Network Rates are described below. Your Coinsurance amounts are stated in Your Schedule of Copayments. Your In-Network Out-of-Pocket Maximum, described below, sets a limit on the amount of In-Network Coinsurance that You can be required to pay for most In-Network Benefits in each Contract Year. Your Out-of-Network Out-of-Pocket Maximum, also described below, sets a limit on the amount of Out-of-Network Coinsurance that You can be required to pay for most Out-of-Network Benefits in each Contract Year.

(c) **Out-of-Network Rates (or "ONR").** The "Out-of-Network Rate" or "ONR" is the amount We pay for Covered Services rendered by a Non-Participating Provider for Your Out-of-Network Benefits. When services are rendered by a Non-Participating Provider, benefits may be paid directly to You upon receipt of Your claim submission, unless You assign the benefit to the Non-Participating Provider. (Please see Section 1 of Your Certificate of Coverage for information on assignment of benefits.)

The ONR is the lesser of the Provider's billed charges or the current North Carolina Medicare fee schedule, as set forth in Your Schedule of Copayments. (Please note that the Medicare fee schedule is updated April 1 of each year.) If there is no corresponding Medicare rate noted for a particular service, We will pay the amount that We would have paid if the Non-Participating Provider furnishing the services were a Provider contracting with Us.

If the amount You are charged for a service is equal to or less than the Out-of-Network Rate (ONR), then the charges should be completely Covered by Us, except for any Prior Authorization penalties, Deductible and/or Coinsurance payments You must make. However, if the amount You are charged is in excess of the ONR for a particular service, then You must pay the excess.

The examples below illustrates how ONR works:

Assume Your Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and the ONR for the Hospital is $3,000. In this example, We would **not** take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 ONR. We would pay 80% of the $3,000 ONR, which is $2,400. You would pay 20% of the $3,000 ONR, which is $600, ***PLUS*** the $2,000 of actual charges that exceed the $3,000 ONR, for a total cost to You of $2,600. Please note that any payments You make in excess of the ONR do not count towards Your Out-of-Pocket Maximum.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and the ONR for the Specialist is $80. In this example, We would **not** take into account $60 of the Specialist's bill because it exceeds the $80 ONR. We would pay $30 (the ONR minus Your Copayment amount). You would pay the $50 Copayment ***PLUS*** the $60 of actual charges that exceed the $80 ONR, for a total cost to You of $110. Please note that any payments You make in excess of the ONR do not count towards Your Out-of-Pocket Maximum.

Please see Your Schedule of Copayments for the Out-of-Network Rates (ONR) for Your Plan.

By way of contrast, the examples below illustrate how In-Network Covered Services would be paid:

Assume Your In-Network Hospital Coinsurance is 20%, the Hospital bill is $5,000 (actual charges), and Our contracted rate for the Hospital is $3,000. In this example, We would **not** take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 contracted rate. We would pay 80% of the $3,000 contracted rate, which is $2,400. You would pay 20% of the $3,000 contracted rate, which is $600. The amount in excess of the contracted rate would **not** be Your responsibility.

Assume Your Specialist visit Copayment is $50. The Specialist's bill is $140 (actual charges) and Our contracted rate for the Specialist is $80. In this example, We would **not** take into account $60 of the Specialist's bill because it exceeds the $80 contracted amount. We would pay $30 (the contracted rate minus Your Copayment amount). You would pay the $50 Copayment. The amount in excess of the contracted rate would **not** be Your responsibility.

Section 1.4 , "Submission of Bills and Claims", of the Certificate of Coverage is hereby deleted in its entirety and replaced with the following :

1.4 Submission of Bills and Claims. Once You have met the Deductible, Providers may bill Us directly for all Covered Services (except Coinsurance). If You receive a bill or claim from a Provider after You have met the Deductible, please send it to Us. You should submit a bill or a claim to Us within one hundred eighty (180) days of the date of service. Except in the absence of the Member's legal capacity, We will not accept claims or bills later than one year from the time submittal of the claim is otherwise required.

For inpatient services, payment arrangements should be made when You obtain Prior Authorization of Coverage from Us, so that We can pay the amount Covered by Your Benefits directly to the Provider. Payment for Covered Out-of-Network inpatient services may be made directly to the You, at Our discretion.

Section 1.6 , "Out-of-Pocket Maximum", of the Certificate of Coverage is hereby deleted in its entirety and replaced with the following :

Out-of-Pocket Maximums. The individual In-Network Out-of-Pocket Maximum is a limit on the amount You must pay out of Your pocket for specified In-Network Covered Services in a Contract Year. The family In-Network Out-of-Pocket Maximum is the limit on the total amount Members of the same family Covered under the Plan must pay for specified Out-of-Network Covered Services in a Contract Year. The amount of the In-Network Out-of-Pocket Maximum is listed in the Schedule of Copayments.

Once the In-Network Out-of-Pocket Maximum is met, Covered Services are paid at 100% without any additional payments for the remainder of the Contract Year. However, certain services and expenses are not subject to and do not count toward the In-Network Out-of-Pocket Maximum. Any payments You make for those services and expenses will not be applied to satisfy the In-Network Out-of-Pocket Maximum. The following services and expenses *do not* count toward the In-Network Out-of-Pocket Maximum and will remain Your responsibility after You reach the In-Network Out-of-Pocket Maximum.

- Payments for Services not Covered
- Payments made when using Your Out-of-Network Benefits
- Ancillary Charges
- Payments for Services Covered under a Vision Rider

The individual Out-of-Network Out-of-Pocket Maximum is a limit on the amount You must pay out of Your pocket for specified Out-of-Network Covered Services in a Contract Year. The family Out-of-Network Out-of-Pocket Maximum is the limit on the total amount Members of the same family Covered under the Plan must pay for specified Out-of-Network Covered Services in a Contract Year. The amount of the Out-of-Network Out-of-Pocket Maximum is listed in the Schedule of Copayments.

Once the Out-of-Network Out-of-Pocket Maximum is met, Covered Services are paid at 100% without any additional payments for the remainder of the Contract Year. However, certain services and expenses are not subject to and do not count toward the Out-of-Network Out-of-Pocket Maximum. Any payments You make for those services and expenses will not be applied to satisfy the Out-of-Network Out-of-Pocket Maximum. The following services and expenses *do not* count toward the Out-of-Network Out-of-Pocket Maximum and will remain Your responsibility after You reach the Out-of-Network Out-of-Pocket Maximum.

- Payments for Services not Covered
- Payments for In-Network Benefits
- Payments in Excess of the Out-of-Network Rate
- Prior Authorization Penalties
- Payments for Services Covered under a Vision Rider

Section 12, "Definitions", of the Certificate of Coverage is hereby amended by the addition of the following :

"Preventive Care" - Includes the following:

Periodic health evaluations, testing and diagnostic procedures ordered in connection with routine examinations, such as physicals
Annual gynecological examinations
Child and adult immunizations
Screening services

Preventive Care does not include any service or benefit intended to treat an existing illness, injury or condition.

Please note that some Covered Services that you receive during a Preventive service office visit may not qualify as Preventive services under the Group Contract and, consequently, will be subject to applicable Deductibles. In order to be exempt from applicable Deductibles, Preventive services must be described as Preventive services under the Group Contract and qualify as a Preventive services under Section 223 of the Internal Revenue Code.

Form WP-PHARM-HSA-2004 is hereby amended by the addition of the following:

Benefits under this Rider are subject to the medical plan Deductible. Member Copayments and Coinsurance under this Rider apply to the medical plan Out-of-Pocket Maximum.

Form WP-MENTAL/SUBSTANCE-HSA-2004 is hereby amended by the addition of the following:

"Member Coinsurance under this Supplemental Benefit applies to the medical plan Out-of-Pocket maximum. Benefits under this Supplemental Benefit are subject to the medical plan Deductible."

Form WP-CHIRO-HSA-2004 is hereby amended to include the following:

"Benefits under this Supplemental Benefit are subject to the medical plan Deductible. Member Copayments under this Supplemental Benefit count toward the Out-of-Pocket Maximum."

All other provisions remain unchanged. Except as amended or supplemented herein, all provisions of the Agreement shall remain in full force and effect.

WELLPATH SELECT, INC.
2801 Slater Road, Suite 200
Morrisville, North Carolina 27560
(866) 935-7284 or (919) 337-1800

In accordance with the terms of the Agreement between WellPath Select, Inc. (Health Plan) and the Subscriber, this Amendment (the "Amendment"), amends the WellPath Select, Inc. Certificate of Coverage. The purpose of this Amendment is to add Coverage for Hearing Aids for Members under twenty-two (22) years of age.

Section 6 of the Certificate of Coverage is amended to add Section 6.7 Hearing Aids

Hearing Aids
The Plan Covers Medically Necessary hearing aids and related services that are ordered by a Physician or a licensed audiologist for each Member under twenty-two (22) years of age.
Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the Member's needs. This benefit is limited to once every 36 months.

The initial evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds are Covered as part of this benefit.

This benefit is limited to a maximum of $2,500 per hearing-impaired ear every 36 months.

A hearing aid is an electroacoustic device which typically fits in or behind the wearer's ear, and is designed to amplify and modulate sound for the wearer. This definition also includes bone-anchored hearing aids (BAHA).

Member Payment Responsibility:

Your Copayment, Coinsurance, and/or Deductible for services received from a Participating Provider is the same as the Copayment, Coinsurance, and/or Deductible for Durable Medical Equipment on Your Schedule of Copayments.

Your Copayment, Coinsurance, and/or Deductible for services received from a Non-Participating Provider is the same as Your Copayment, Coinsurance, and/or Deductible for Durable Medical Equipment on Your Schedule of Copayments. You are responsible for amounts over the Out-of-Network Rate.

All other provisions of the contract remain unchanged. Except as amended or supplemented in this amendment, all provisions of the contract shall remain in full force and effect.

WELLPATH SELECT, INC.
2801 Slater Road, Suite 200
Morrisville, North Carolina 27560
(866) 935-7284 or (919) 337-1800

AMENDMENT TO:

Certificate of Coverage, Form WP-COC-DirectAccess-2/2004

In accordance with the terms of the contract between WellPath Select, Inc. (Health Plan) and the Group, the Agreement that describes Your Plan is amended as indicated below.

Section 13, General Provisions of the Certificate of Coverage is amended to add a new section:

13. 10 Discounts and Rebates. Member understands and agrees that Health Plan, and/or its affiliate(s), may receive a discount or rebate following payment of the claims from a Participating Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Health Plan and its affiliates. Member shall not share in such volume-based discounts or rebates. However, such rebates will be considered, in total, in Health Plan's future premium calculations.

All other provisions of the contract remain unchanged. Except as amended or supplemented herein, all provisions of the contract shall remain in full force and effect.