2021 Group Comprehensive Health Insurance Policy

This group policy does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance agent, a stand-alone dental insurance provider, or Your Health Idaho if you wish to purchase a stand-alone dental product.

2021 ID Group Policy

Mountain Health CO-OP
1545 E Iron Eagle Dr. Suite 101
Eagle, ID 83616
Customer Service 855-447-2900

Group Comprehensive Health Insurance Policy

GROUP POLICYHOLDER: Lumsden Restaurants, LLC

GROUP POLICY NUMBER: 7113006

EFFECTIVE DATE OF POLICY: October 1, 2021

PREMIUM DUE DATE: First day of each month

POLICY RENEWAL DATE: October 1, 2022, and every October 1 thereafter

POLICY ANNIVERSARY DATE: October 1 of each year

POLICY DELIVERY STATE: Idaho

In this Group Policy, the Policyholder is referred to as "You" or "Your". Mountain Health CO-OP is referred to as "We", "Our", "Us", or "the Company.

This is a legal contract between the Policyholder and Mountain Health CO-OP. We will pay Covered Medical Expenses for Covered Benefits provided under this Group Policy for Insured Employees in accordance with the terms, conditions, limitations and exclusions set forth in this Group Policy.

This Group Policy is issued in consideration of the application and payment of the initial premium by the Policyholder.

This Group Policy will take effect at 12:00 a.m. on the Policy Effective Date of this Group Policy as set forth above, provided that it has been signed by the authorized officers of Mountain Health CO-OP, and the Policyholder has signed the attached application and Group Policyholder Acceptance form for this Group Policy.

PLEASE READ YOUR POLICY CAREFULLY.

Signed for Mountain Health CO-OP

Chief Executive Officer

Richard Miltenberger

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IMPORTANT INFORMATION

Mountain Health CO-OP is pleased to provide this Group Policy for Covered Persons. This group Policy provides a Provider Network through which Covered Persons may obtain medical care and services while maximizing Your Covered Benefits. However, Covered Persons also may elect to receive services from an Out-of-Network Provider. When Covered Persons receive services from an In-Network Provider, generally benefits will be payable at a higher level. When services are provided by an Out-of-Network Provider, generally, benefits are payable at a lower level. You can obtain a list of In-Network Provider Directory on the Mountain Health Cooperative Website at www.mhc.coop.

POLICY AND CUSTOMER SERVICES – UNIVERSITY OF UTAH HEALTH INSURANCE PLANS

Our Third-Party Administrator, the University of Utah Health Insurance Plans (also referred to as "U of U Health Plans" in this Policy) administers the following services for this Policy

- Benefit Inquiries
- Claims & Customer Service
- Complaints, Grievances and Appeals
- Preauthorization
- Utilization Review Management Program
- Population Health Management
- Complex Case Management
- Prescription Drug Benefit Program

Contact U of U Health Plans Customer Service:

- Customer Service phone number: 844-262-1560
- Address: U of U Health Plans, PO Box 45180, Salt Lake City, UT 84145
- Address for Claim Submissions: University of Utah Health Insurance Plans, c/o MHC, P.O. Box 45180, Salt Lake City, UT 84145
- Address for Complaints, Grievances and Appeals: University of Utah Health Insurance Plans Appeals Committee Chairperson, 6053 Fashion Square Dr., Suite 110, Murray, UT 84107. https://app.healthcare.utah.edu/uhealthPlans/forms/montanaHealth_appeal
- **U.S. Employee Benefits Security Administration:** 866-444-EBSA (3272)

VISION CUSTOMER SERVICES – VSP

- Our Third-Party Administrator, VSP Vision Care, Inc. (VSP), administers the Pediatric Vision Care Benefit and Vision Network for this Policy.
  - Contact VSP for Customer Service: Telephone – (800) 877-7195 or (916) 851-5000
  - Address: VSP, 3333 Quality Drive, Rancho Cordova, CA 95670

CONTACT MOUNTAIN HEALTH CO-OP

Please contact Mountain Health CO-OP for questions or problems:

- Telephone Number: 855-447-2900
- Address: Mountain Health CO-OP, P.O. Box 5358, Helena, MT 59604 or 1545 E Iron Eagle Dr. Ste 101, Eagle, ID 83616
- Website Address: www.mhc.coop

IMPORTANT NOTICE:
NOTICE OF WOMEN'S HEALTH CANCER RIGHTS ACT

In accordance with The Women's Health and Cancer Rights Act of 1998 (WHCRA), the Policy covers mastectomy in the treatment of cancer and reconstructive surgery after a mastectomy. If the Insured is receiving benefits in connection with a mastectomy, coverage will be provided according to the Group Policy's benefit and Utilization Review Management Program criteria and in a manner determined in consultation with the attending Physician and the patient, for

1. All stages of reconstruction on the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable deductibles and copayment limitations consistent with those established for other benefits.

All benefits are payable according to the Policy's Schedule of Benefits. Regular Preauthorization requirements apply.

IMPORTANT NOTICE:
Pediatric Dental Coverage Not Included

The policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and care be purchased as a stand-alone product. Please contact your insurance agent, your health insurance company or Your Health Idaho if you wish to purchase a stand-alone dental care product.

IMPORTANT NOTICE:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL OBLIGATIONS

Mountain Health CO-OP (MHC) is required by law to maintain the privacy of all medical information within its organization; provide this notice of privacy practices to all Policyowners; inform Policyowners of our legal obligations; and advise Policyowners of additional rights concerning their medical information. MHC must follow the privacy practices contained in this notice from its **effective date of January 1, 2021**, and continue to do so until this notice is changed or replaced.

MHC reserves the right to change its privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes were made. All Policyowners will be notified of any changes by receiving a new Notice of Privacy Practices.

You may request a copy of this notice of privacy practices at any time by contacting our Compliance Officer, Mountain Health CO-OP, P.O. Box 5358, Helena, MT 59604, (406) 447-9510.

USES AND DISCLOSURES OF MEDICAL INFORMATION

As a condition of accepting coverage under this Policy, You agree that MHC may obtain your medical records for review. Your medical information may be used and/or disclosed for treatment, payment and health care operations. For example:

TREATMENT: Your medical information may be disclosed to a doctor or hospital that requests it to provide treatment to you or for disease and case management programs.

PAYMENT: Your medical information may be used or disclosed to pay claims for services which are covered under your health care coverage.

HEALTH CARE OPERATIONS: Your medical information may be used and disclosed to conduct quality assessment and improvement activities, to engage in care coordination or case management, to pursue Right of Recovery and Reimbursement/ Subrogation, accreditation, conducting and arranging legal services, underwriting and rating, and for other administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time but this revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to you or to a

family member, friend or other person to the extent necessary to assist with your health care or with payment for your health care but only if you agree we may do so or if they have the legal right to act for you, as described in the Individual Rights section of this notice.

RESEARCH: Your medical information may be used or disclosed for research purposes provided that certain established measures to protect your privacy are in place.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal law. For example, we will use and disclose your Personal Health Information in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of Health and Human Services and state regulatory authorities.

COURT OR ADMINISTRATIVE ORDER: Medical information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

MATTERS OF PUBLIC INTEREST: Medical information may be released to appropriate authorities under reasonable assumption that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. Medical information may be released to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. Medical information may be disclosed when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody. Medical information may be disclosed for purposes of child abuse reporting.

MILITARY AUTHORITIES: Medical information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Medical information may be disclosed to federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

BUSINESS ASSOCIATES: We engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your Personal Health Information. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

ACCESS: The Insured Employee has the right to receive or review copies of the Insured Employee's medical information, with limited exceptions. The Insured Employee may, at any time during the filing period, receive reasonable access to and copies of all documents, records, and other information upon request and free of charge. The Insured Employee may also request that MHC mail copies of all documentation. Any request to obtain access to the Insured Employee's medical information must be made in writing. The Insured Employee may obtain a form to request access by using the contact information above or you may send us a letter requesting access to the address located above. If the Insured Employee's Personal Health Information is maintained in an electronic health record ("EHR"), you also have the right to request that an electronic copy be sent to you or to another individual or entity you so authorize.

ACCOUNTING: You have the right to receive an accounting of the disclosures of your medical information made by our company or by a business associate of our company. This accounting will list each disclosure that was made of your medical information for any reason other than

treatment, payment, health care operations and certain other activities since January 1, 2016; however, if disclosures for purposes of treatment, payment, or health care operations were made through an EHR, you have the right to request an accounting for such disclosures made during the previous three years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosed, the reason for the disclosure, and certain other information. If you request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to these additional requests. For a more detailed explanation of the fee structure, please contact our office using the information at the end of this notice.

DESIGNATION OF PERSONAL REPRESENTATIVE: You have the right to designate a family member, friend or other person as your personal representative. Your medical information may be disclosed to your personal representative to the extent necessary to help with your health care or with payment for your health care. You may obtain a form to designate a personal representative by using the contact information at the end of this notice, or on our website www.mhc.coop.

RESTRICTIONS ON DISCLOSURES: You have the right to request restrictions on our use or disclosure of your medical information. Generally, we are not required to agree to these additional requests. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. Any agreement to restrictions on the use and disclosure of your medical information must be in writing and signed by a person authorized to make such an agreement on behalf of the company; such restrictions shall not apply to disclosures made prior to granting the request for restrictions. The company will not be bound unless the agreement is so memorialized in writing.

CONFIDENTIAL COMMUNICATIONS: You have the right to request confidential communications about your medical information by alternative means or alternative locations. You must inform the company that confidential communication by alternative means or to an alternative location is required to avoid endangering you. You must make your request in writing and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location requested. The company must accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premium and pay claims under your health plan.

AMENDMENT: You have the right to request that the company amend your medical information. Your request must be in writing and it must explain why the information should be amended. The company may deny your request if the medical information you seek to amend was not created by our company or for certain other reasons. If your request is denied, the company will provide a written explanation of the denial. You may respond with a statement of disagreement to be appended to the information you wanted amended. If the company accepts your request to amend
the information, the company will make reasonable efforts to inform others, including the people you name, of the amendment and to include the changes in any future disclosures of that information.

BREACH NOTIFICATION: You have the right to receive notice of a breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information

by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Personal Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- A brief description of the breach, including the date of the breach and the date of its discovery, if known;
- A description of the type of Unsecured Personal Health Information involved in the breach;
- Steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of the actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, Web site, or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date, we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services. We also are required to submit an annual report to the Secretary of Health and Human Services of a breach that involves less than 500 individuals during the year, and we will maintain a written log of breaches involving less than 500 patients.

If you receive this notice on the MHC website or by any other electronic means, you may request a written copy of this notice by using the contact information at the end of this notice.

IMPORTANT INFORMATION
COMPLAINTS, QUESTIONS AND CONCERNS

If you want more information concerning our privacy practices, or you have questions or concerns, please contact our Privacy Office.

If you are concerned that: (1) the company has violated your privacy rights; (2) you disagree with a decision made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information; (3) to request that the company communicate with you by alternative means or at alternative locations, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

The company supports your right to protect the privacy of your medical information. There will be no retaliation in any way if you choose to file a complaint with Mountain Health CO-OP or with the U.S. Department of Health and Human Services.

The Privacy Office Mountain Health CO-OP
P.O. Box 5358, Helena, MT 59604
(406) 447-9510

E-mail: info@mhc.coop

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043

1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

IMPORTANT NOTICE:
RIGHTS AND RESPONSIBILITIES STATEMENT

In this Notice, "Organization" means the Mountain Health CO-OP.

The organization's member rights and responsibilities statement specifies that members have:

1. A right to receive information about the organization; its services; its practitioners and providers; and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

IMPORTANT NOTICE:
MEMBER INFORMATION

In this Notice, "Organization" means the Mountain Health CO-OP.

The organization provides the following written information to its subscribers upon enrollment and annually thereafter:

1. Benefits and services included in, and excluded from, coverage.
2. Pharmaceutical management procedures, if they exist.
3. Copayments and other charges for which members are responsible.

4. Benefit restrictions that apply to services obtained outside the organization's system or service area.
5. How to obtain language assistance.
6. How to submit a claim for covered services, if applicable.
7. How to obtain information about practitioners who participate in the organization.
8. How to obtain primary care services, including points of access.
9. How to obtain specialty care and behavioral healthcare services and hospital services.
10. How to obtain care after normal office hours.
11. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.
12. How to obtain care and coverage when subscribers are out of the organization's service area.
13. How to voice a complaint.
14. How to appeal a decision that adversely affects coverage, benefits or a member's relationship with the organization.
15. How the organization evaluates new technology for inclusion as a covered benefit.

SECTION 1—DEFINITIONS

The following are key words used in this Group Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within the Schedule of Benefits or the provisions in which they appear in this Group Policy.

Accident means an unexpected traumatic incident causing bodily injury to the Insured that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while coverage under this Policy is in force for the Insured. It does not include injuries for which: Benefits are provided under workers' compensation, employers' liability, or similar law; or Under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the Insured is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

Advanced Practice Nurse a registered professional nurse who has completed educational requirements related to the nurse's specific practice role, in addition to basic nursing education, as specified by the board pursuant to state law.

Affordable Care Act means the federal Patient Protection and Affordable Care Act (PPACA) that was signed into law on March 23, 2010.

Allowable Fee/Allowed Amount means the maximum amount on which payment is based for covered health services for both In-Network and Out-of-Network Providers. The allowable fee will be based on but not limited to one or more of the following:

1. Medicare RBRVS based is a system established by Medicare to pay physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure.

2. Diagnosis-related group (DRG) methodology is a system used to classify hospital cases into groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range.

3. Provider's billed charge or a discount from the Provider's billed charge.

4. Case rate methodology which provides an all inclusive rate for an episode of care.

5. Per diem methodology which provides an all inclusive daily rate paid to a facility.

6. Flat fee or a flat rate.

7. The amount negotiated with the pharmacy benefit manager or manufacturer or the actual price for prescription or drugs.

Ancillary Charge means a charge which the Covered Employee is required to pay to a Preferred Pharmacy for a covered Brand-Name Prescription Drug Product for which a Generic substitute

is available. The Ancillary Charge is determined by subtracting the contracted price of the Generic drug from the contracted price of the Brand-Name drug. Any Copayment amounts are in addition to the Ancillary Charge.

Annual Out-of-Pocket Maximum The most that Covered Employee will have to pay for covered services in a plan year. After Covered Employee spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums.

The Annual Out-of-Pocket Maximum includes the following:

1. Policy Year Deductible;
2. Copayments; and
3. Coinsurance.

Family Limit for the Annual Out-of-Pocket Maximum

The Family Annual Out-of-Pocket Maximum is reached when two or more Family members, who are insured under this Group Policy, have incurred and paid deductibles, copays, and co-insurance equal to the amount listed in the Schedule of Benefits for that specific plan. When the total out-of-pocket expense is reached within the Policy Year of the effective policy, We then will pay 100% of Covered Medical Expenses incurred by all Family members for the remainder of the Policy Year. The total of out-of-pocket medical expenses returns to zero at the end of the Plan Year, and the accumulation would begin again for the new Policy Year

Balance Billing means a provider bills you for the difference between the provider's charge and the Allowable Amount. For example, if the provider's charge is $100 and the Allowable Amount is $70, the provider may bill you for the remaining $30. An In-Network Provider may not Balance Bill you for covered services.

Certificate means the evidence of coverage document issued to Insured Employees of the Policyholder. We provide the Policyholder with the Certificates to be delivered to Insured Employees. The Certificate includes the Policy and is also called "Evidence of Coverage".

Certificateholder means the Eligible Employee who is actively enrolled under this Group Policy and who has been issued a Certificate of coverage.

Coinsurance means a percentage amount a member is responsible to pay out-of-pocket for health care services after satisfaction of the applicable deductibles or copayments, or both. The Coinsurance is applied to the Allowable Fee for Covered Medical Expenses incurred for Covered Benefits. The Coinsurance amount is shown in the Schedule of Benefits, and applies to the Out-of Pocket Maximum. No further co-insurance is assessed when the Out-of Pocket Maximum is met.

Complication of Pregnancy means involuntary complications of pregnancy, diagnoses that are distinct from pregnancy or caused by pregnancy, but are adversely affected by pregnancy, are covered when medically necessary. This includes but is not limited to cesarean section, ectopic pregnancy which is terminated, spontaneous termination of pregnancy, acute nephritis, and cardiac decompensation

Copay or Copayment means a fixed dollar amount the Covered Employee is required to pay for specifically listed Covered Benefits as shown in the Schedule of Benefits. Copayments are generally paid to the Provider at time of service. Copayments apply towards the satisfaction of the Out-of-Pocket Maximum.

Convalescent Home means an institution, or distinct part of such institution, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is: (1) a Skilled Nursing Facility; (2) an Extended Care Facility; (3) an Extended Care Unit; or (4) a Transitional Care Unit.

The facility must be licensed under the laws; be approved to receive Medicare payment; provide twenty-four hour per day skilled nursing care under the supervision of a licensed physician; maintain daily medical records; the care provided is under the supervision of a registered nurse. The facility is not a home or part of a home, is not primarily used for rest, substance or alcohol abuse treatment, mental disease, education or custodial care.

Covered Benefits means all Medically Necessary services, supplies, medications and devices covered under this Group Policy as provided under *Section 5, Covered Benefits*. Covered Benefits are payable as shown in the Schedule of Benefits.

Covered Dependent means Your lawful spouse [or domestic partner], and any of Your dependent children (as defined in this Policy) who are covered under this Policy. A Covered Dependent must be listed as Your Dependent in Your Application for this Policy and approved by Us. The required premium for the Covered Dependent's coverage under this Policy must be paid.

Covered Medical Expense means expenses incurred for Medically Necessary Covered Benefits that are based on the Allowable Fee and:

1. Covered under this Policy;
2. Provided to the Covered Employee by and/or prescribed by a Covered Provider for the diagnosis or treatment of an active Illness, Injury, or maternity care.

The Insured Employee must be charged for such services, supplies and medications.

Covered Provider means a licensed or certified health care practitioner or licensed facility that qualifies to treat the Covered Employee for an Illness or Injury for the Covered Benefits provided under this Policy. The services rendered by a provider may, because of the limited scope of the Covered Provider's practice, be covered under this Policy only for certain services provided. To determine if a covered provider is covered under this Policy, We will: (1) review the nature of the services rendered; (2) the extent of licensure; and (3) Our recognition of the provider in connection with the benefits provided under this Policy.

Covered Providers are In-Network Providers and Out-of-Network Providers who have been recognized by Us as a provider of services for Covered Benefits provided under this Policy.

Services provided by the professional provider must be within the scope of the Covered Provider's license or certification and appropriate for the care and treatment of the Insured Employee's Illness

or Injury as provided by the Covered Benefits in this Group Policy. Services provided by a professional provider other than a Physician may require recommendation by a Physician. The professional provider may not be a member of the Insured Employee's Immediate Family.

A facility that is a Covered Provider is also referred to as a "Covered Facility".

Custodial Care means providing a sheltered, family-type setting for an aged person or disabled adult so as to provide for the person's basic needs of food and shelter and to ensure that a specific person is available to meet those basic needs.

Deductible means the amount Covered Employee pays for covered health care services before We begin to pay for Covered Benefits. With a $2,000 deductible, for example, Covered Employee pays the first $2,000 of covered services. After Covered Employee pays the deductible, Covered Employee usually pays only a copayment or coinsurance for covered services.

The Deductible is shown in the Schedule of Benefits. The following do not apply towards satisfaction of the Deducible:

1) Services, treatments or supplies that are not covered under this Group Policy;
2) Co-pay amounts paid by the Insured;
3) The premium payments paid by the Insured; and
4) Amounts billed by Out-of-Network provide above the Allowable Fee.

Family Deductible

The Family Deductible is an aggregate Deductible as is shown in the Schedule of Benefits. The Family Deductible must be satisfied by two of more family members, who are insured under this Group Policy, during the Policy Year the policy is in force. Once the Family deductible is met for the Plan Year, no further payments toward the Family Deductible from Family members will be required for the remainder of that Plan Year.

Dependent means the Insured Employee's:

1. Lawful spouse [or domestic partner]; and
2. Dependent Child as defined in this Group Policy.

Dependent Child or Dependent Children means the Insured Employee's children who are:

1. Under age 26, regardless of their place of residence, marital status or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children placed for adoption with the Policyowner in accordance with applicable state or federal law; (e) foster children; and (f) children for whom the Insured Employee is a legal guardian substantiated by a court or administrative order; and

2. Unmarried dependent Handicap Children age 26 and over. Refer to the definition of *Handicapped Child.*

[Domestic Partner means an interpersonal relationship between two individuals who live together and share a common domestic life, but are neither joined by marriage nor civil union.]

Effective Date of Coverage means the date coverage becomes effective under this Group Policy for the Insured Employee or the Insured Dependents of the Insured Employee.

Eligible Dependent means the following dependents of the Eligible Employee:

1. The Eligible Employee's lawful spouse [or domestic partner];
2. The Eligible Employee's Dependent Child(ren).

Eligible Employee means an Employee of the Policyholder who is a full-time active Employee working a minimum of [20] hours per week for the Policyholder.

Emergency Medical Condition means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. The Insured Employee's health would be in serious jeopardy;
2. The Insured Employee's bodily functions would be seriously impaired; or
3. A bodily organ or part would be seriously damaged.

Emergency Care Services means health care items or services furnished or required to evaluate and treat an Emergency Medical Condition. Such emergency care services must be provided by or ordered by a licensed health care provider.

Employee means a person who is employed by the Policyholder.

Enrollment Form means a form or application that must be completed in full by the Eligible Employee before the Eligible Employee will be considered for coverage under this Group Policy.

Evidence of Coverage means the Certificate document issued to Insured Employees of the Policyholder. We provide the Policyholder with the Certificates to be delivered to Insured Employees. The Evidence of Coverage is also called "Certificate".

Exchange means Your Health Idaho through which qualified consumers can compare and purchase insurance from insurance companies.. Exchanges are required by the Affordable Care Act.

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

Health Insurance Marketplace means: (1) a State-based Exchange (Your Health Idaho); (2) a Federally-Facilitated Exchange; or (3) an Exchange in partnership with the federal Department of Health and Human Services.

Home Health Agency means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the place where they live.

Home Health Services means a professional nursing services provided to a homebound Insured Employee that can only be rendered by a licensed registered nurse (R.N.) or license practical nurse (L.P.N.) provided such nurse does not ordinarily reside in the Insured Employee's household or is not related to the Insured Employee by blood or marriage.

Home Infusion Therapy Agency means a health care facility that provides home infusion therapy services.

Home Infusion Therapy Services means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the patient, the patient's caregiver, or the patient's family member.

Hospice means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

1. An Inpatient hospice facility, which is a facility managed directly by a Medicare-certified hospice that meets all Medicare certification regulations for freestanding inpatient hospice facilities; and
2. A residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

Hospital means a facility licensed under state law, primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and providing twenty-four (24) hour nursing service by or under the supervision of registered nurses.

The term "Hospital" does not include the following even if such facilities are associated with a Hospital:

1. A nursing home;
2. A rest home;
3. A hospice facility;
4. A Rehabilitation/Habilitation facility;
5. A skilled nursing facility;
6. A Convalescent Home;
7. Facilities used primarily for the care of custodial patients, education, aged, drug addicts, alcoholics or facilities contracted for and operated by national government or government agency for treatment of ex-members of the armed services except on an emergency basis.

Idaho Resident An individual is an Idaho Resident if the individual is able to provide satisfactory proof of currently residing in Idaho, including without a fixed address, and does not have residency status in any other state. For purposes of this definition, an individual who intends to reside in Idaho may submit an application for insurance, but the individual would not be eligible

to begin coverage prior to the individual physically residing in Idaho.

Illness means any sickness, infection, disease or any other abnormal physical condition which is not caused by an Injury. Illness includes pregnancy, childbirth and related medical conditions.

Indian has the same meaning as defined by Section 4 of the Indian Health Care Improvement Act.

Indian Services mean services for Covered Benefits that are provided directly by:

1. An Indian Health Service;
2. An Indian Tribe;
3. A Tribal Organization;
4. An Urban Indian Organization; or
5. Services provided through referral under contract health services;

to Insured Employees who are Indians as defined in this Group Policy.

Indian Tribe means any Indian:

1. Tribe;
2. Band;
3. Nation; or
4. Other organized group or community, including:

    a. Any Alaska Native village; or
    b. Any regional or village corporation;

as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Injury means physical damage to the Insured Employee's body, caused directly and independently of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

In-Network Provider means a Covered Provider who has a participation contract in effect with the Group PPO Network to provide services to Insureds under this Policy. The In-Network Provider's participation contract must be in effect at the time services are provided for Covered Benefits in order for Covered Medical Expenses to be eligible for In-Network benefits.

Inpatient or Inpatient Care means care and treatment provided to an Insured Employee who has been admitted to a facility as a registered bed and who is receiving services, supplies and medications under the direction of a Covered Provider with staff and privileges at the facility. Such facilities include:

1. Hospitals, including state designated Critical Access Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent homes; or
5. Freestanding inpatient facilities.

Such facilities must be licensed or certified by the state in which it operates.

Investigational/Experimental Service means any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by Us, it fails to meet any one of the following criteria:

(a) The service/technology has final approval from the appropriate government regulatory bodies;
(b) Medical or scientific evidence regarding the service/technology is sufficiently comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the service/technology;
(c) The service/technology's overall beneficial effects on health outweigh the overall harmful effects on health;
(d) The service/technology is as beneficial as any established alternative; and
(e) The service/technology must show improvement that is attainable outside the investigational setting improvements must be demonstrated when used under the usual conditions of medical practice If a service/technology is determined to be investigational, all services associated with the service/technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

When used under the usual conditions of medical practice, the service/technology should be reasonably expected to satisfy the criteria of paragraphs (c) and (d) of this subsection.

For Members enrolled in approved clinical trials, medically necessary routine care furnished in connection with participation in an approved clinical trial will be covered.

Approved clinical trials are phase I, phase II, phase III or phase IV clinical trials conducted in relation to the prevention, detection, or treatment of
disease or conditions and:

1. The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:
    a. The national institutes of health;
    b. The centers for disease control and prevention;
    c. The agency for healthcare research and quality;
    d. The centers for Medicare and Medicaid services;
    e. A cooperative group or center of any of the entities through the department of defense or the department of veteran’s affairs; or
    f. A qualified nongovernmental research entity identified in the guidelines issued by the national institutes of health for center support grants;
2. The study or investigation is conducted under an investigational new drug application reviewed by the food and drug administration;
3. The study or investigation is not a new drug trial and therefore exempt from having such an investigational new drug application by the food and drug administration; or
4. The study or investigation has been reviewed and approved by an institutional review board of an institution that has an agreement with the office for human research protections of the United States department of health and human services.

Benefits may be subject to deductible, coinsurance, or copayment requirements.

Medically Necessary or **Medical Necessity** means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: 1. in accordance with generally accepted standards of medical practice in the United States; 2. clinically appropriate in terms of type, frequency, extent, site, and duration; 3. not primarily for the convenience of the patient, physician, or other health care provider; and covered under the contract;5. not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results to the diagnosis, injury, disease, or symptoms. When a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence. For established interventions, the effectiveness shall be based on: 1. scientific evidence; 2. professional standards; and 3. expert opinion.

Medically Necessary for autism spectrum disorders is defined in the Autism Spectrum Benefit below or means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to: (a) prevent the onset of an illness, condition, injury, or disability; (b) reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (c) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

We reserve the right to review medical care and/or treatment plans. We may rely on Our independent medical reviewer to determine if treatment is Medically Necessary. The fact that a Physician may order treatment does not, in itself, make it Medically Necessary, or make the expense a Covered Medical Expense.

Medical Policies means the policy and utilization review program guidelines used for this Group Policy. The policy and guidelines are used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Mental or Nervous Disorders means disorders or diseases including neurosis, psychoneurosis, psychosis, and emotional and mental conditions of any kind as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Such disorders include but are not limited to: (1) schizophrenia; (2) schizoaffective disorder; (3) bipolar disorder; (4) major depression; (5) panic disorder; (6) obsessive-compulsive disorder; and (7) autism.

Out-of-Network Provider means a Covered Provider who does not have a participation contract in effect with the Mountain Health CO-OP In-Network Organization to provide services to Covered Employee and Dependents under this Policy. When services are provided by an Out-of-Network Provider, the services provided are Out-of-Network and an Out-of-Network Provider Differential will be applied. Covered Employee and Dependents will be subject to reduced benefits under the plan and

will be subject to Balance Billing by the Out-of-Network Provider.

To maximize the plan's benefits, always make sure your healthcare provider is a MHC In-Network Provider and do not assume all services at an In-Network facility are performed by an In-Network provider.

Out-of-Network Provider Differential means the percentage by which the Allowable Fee is reduced to determine the amount this Policy will pay for Covered Benefits provided by Out-of- Network Providers.

Policyholder means the employer named on the cover page of this Group Policy. The Policyholder is the owner of this Group Policy, which means the Policyholder may exercise the rights set forth in this Group Policy.

Physician means a person licensed to practice medicine in the state where the service is provided. A Physician is also a Covered Provider.

Physician Specialist means a Physician who: (1) has obtained advanced training in various areas of a medical specialty; and (2) is board-certified in that specialty. Physician Specialist includes, but is not limited to: (1) Anesthesiologists; (2) Dermatologists; (3) Ophthalmologists; (4) Orthopedic Surgeons; (5) Psychiatrists; (6) Radiation Oncologist; and (7) Surgeons. Physician Specialist does not include: (1) a Family Practice Physician; (2) an Internal Medicine Physician; or (3) an obstetrician; or (4) gynecologist.

Plan year means the twelve month period of time this Group Policy is in force beginning on the Policy Effective Date.

Policy Effective Date **or Effective Date** means the date on which this Group Policy becomes effective. The Policy Effective Date is shown in the Schedule of Benefits.

Preferred Mail Order Pharmacy as listed in our provider directory means a mail order pharmacy which has a participation contract in effect with U of U Health Plans.

Primary Care Physician (PCP) means a provider who is acting within the scope of the Provider's license and includes the following providers: (1) Family Practice (FP); (2) Internal Medicine (IM); (3) Pediatrician (MD); (4) Obstetrics and Gynecology (OBGYN); (5) Gynecologist (GYN); (6) Geriatrician (MD); (7) Osteopath (DO); and (8) other providers performing services for Insureds in connection with the services provided by preceding specified providers, listed in (1) through (7), including: (a) Registered Nurse (RN); (b) Advanced Practical Registered Nurse (APRN); (c) Nurse Practitioner (NP); (d) Certified Nurse Midwife (CNM); and (e) Physician's Assistant (PA).

Professional Call means an interview between the Insured Employee and the covered professional provider in attendance. The covered professional provider must examine the Insured Employee and provide or prescribe medical treatment. "Professional Call" does not include telephone calls or any other communication where the Insured Employee is not examined by the covered professional provider.

Outpatient means treatment or services that are provided when the Insured Employee is not confined as a bed patient in a Covered Facility. This includes outpatient treatment at a Covered Facility as well as visits to a Physician or other Covered Providers.

Rehabilitation means health care services and devices that help a person regain, relearn, maintain or prevent deterioration of skills and functioning that have been acquired but then lost or impaired due to illness, injury or disabling condition. These services may include physical and occupational therapy, speech-language pathology in a variety of inpatient and/or outpatient settings.

Scientific Evidence means:

1. Scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

2. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

Scientific Evidence does not include published, peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer, or a single study without other supportable studies.

Skilled Nursing Facility *(Refer to the definition of Convalescent Home).*

Surgery means manual procedures that: (a) involve cutting of body tissue; (b) debridement or permanent joining of body tissue for repair of wounds; (c) treatment of fractured bones or dislocated joints; (d) endoscopic procedures; and (e) other manual procedures when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Tier may be used to define value. Tier 1 provides the best value from the perspective of Copays and Deductible. Tier 2 will represent a higher out of pocket costs.

Treatment means medical care, services or treatment or course of treatment which is ordered, prescribed and/or provided by a Physician to diagnose or treat an Injury or Illness, including:

1. Confinement, Inpatient or Outpatient services or procedures; and
2. Drugs, supplies, equipment, or devices.

The fact that a Treatment was ordered or provided by a Physician does not, of itself, mean that the Treatment will be determined to be Medically Necessary.

Urgent Care Centers means:

Freestanding Facilities for Acute Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

If a condition requiring Urgent Care develops, the Insured Employee may go to the nearest Urgent Care Center, Physician's office, or any other Provider for treatment. This treatment may be subject to a Copayment and/or Coinsurance. Examples of Urgent Care conditions include fractures, lacerations, or severe abdominal pain.

SECTION 2—WHEN COVERAGE TAKES EFFECT AND TERMINATES

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

EMPLOYEES

If the Employee is an Eligible Employee, such Employee will be eligible for coverage under this Group Policy on the first day of the month following the Employee's date of hire (or according to the Employer's internal policy, but no more than 90 days following the Employee's date of hire).

Eligible Employees who have met the eligibility requirements on the Policy Effective Date will be eligible to enroll under the Group Policy on the Policy Effective Date.

The Eligible Employee must: (1) complete and submit an Enrollment Form to the Policyholder; and (2) remit any premium payment required for the Eligible Employee's coverage.

DEPENDENTS

The Dependent of an Eligible Employee is eligible for insurance under this Group Policy if:

1. The Dependent is an Eligible Dependent on the date the Eligible Employee is effective for coverage under this Group Policy; or
2. The Dependent becomes an Eligible Dependent after the Eligible Employee's Effective Date of Coverage.

The Eligible Dependent must be included on an Enrollment Form and any premium payment required for the Eligible Dependent's coverage must be remitted.

ELIGIBLE DEPENDENTS

Dependents who are eligible for insurance under this Group Policy are:

1. The Eligible Employee's lawful spouse [or domestic partner];
2. The Eligible Employee's, or Employee's lawful spouse [or Domestic Partner's] Dependent Children, which include:
    a. The Eligible Employee's natural children;
    b. The Eligible Employee's adopted children;
    c. The Eligible Employee's foster children who have been placed in the Eligible Employee's home provided the Eligible Employee has assumed the legal obligation for total or partial support with the intent that the child resides with the Eligible Employee's on more than a temporary or short-term basis;
    d. The Eligible Employee's step-children provided the Eligible Employee is married to the parent of the child;
    e. A child for whom the Eligible Employee is the legal guardian substantiated by a court order; and

f. A child who is the subject of an administrative or court order and for whom the Eligible Employee must provide coverage based on such administrative or court order.

CONTINUED COVERAGE FOR HANDICAPPED CHILDREN

An Insured Dependent Child, whose insurance under this Group Policy would otherwise terminate solely due to the attainment of age 26 (the limiting age), will continue to be an Insured Dependent Child while such Insured Dependent Child is and continues to be both:

1. Incapable of self-sustaining employment by reason of intellectual disability or physical disability; and
2. Chiefly dependent upon the Insured Employee for support and maintenance.

Proof of the intellectual or physical disability, and dependency must be furnished to Us by the Employer within thirty-one (31) days of the Insured Dependent Child's attainment of the limiting age and subsequently as may be required by Us. However, We may not require such proof more frequently than annually after the two-year period following the Insured Dependent Child's attainment of the limiting age.

WHEN COVERAGE BECOMES EFFECTIVE FOR NEW ELIGIBLE DEPENDENTS

The Insured Employee must enroll Eligible Dependents for insurance under this Group Policy. Eligible Dependents who are listed in the Insured Employee's application for this Group Policy will be insured under this Group Policy on the Policy Effective Date. Eligible Dependents who are acquired after the Policy Effective Date may be insured under this Group Policy as provided under the *New Eligible Dependents* provision.

NEW ELIGIBLE DEPENDENTS

If the Insured Employee acquires a new Eligible Dependent after the Policy Effective Date, the Insured Employee may enroll the new Dependent under this Group Policy by providing Us with the following:

1. Written notification of the new Eligible Dependent; and
2. Payment of any additional premium required for the new Eligible Dependent's coverage under this Group Policy.

Such written notification must be given to Us within thirty-one (31) days of acquiring the new Eligible Dependent, unless otherwise specified in the Enrollment Requirements for Newly Adopted and Newborn Children provision in this Section.

The effective date of coverage under this Group Policy for the new Eligible Dependent will be the first of the month following the date We receive notification and any due premium for the new Eligible Dependent's coverage, except as provided under the Enrollment Requirements for Newly Adopted and Newborn Children provision in this Section. Coverage will begin at 12:01 a.m. local time at the Covered Employee place of residence, on the Eligible Dependent's effective date of coverage.

The effective date of coverage under this Group Policy for the new Eligible Dependent will be the first of the month following the date the Dependent qualifies as an Eligible Dependent. Coverage will begin at 12:01 a.m. local time at the Insured Employee's place of residence, on the Eligible Dependent's effective date of coverage.

ENROLLMENT REQUIREMENTS FOR NEWLY ADOPTED AND NEWBORN CHILDREN

Adopted Child

Coverage under this Group Policy for Your newly adopted child will become effective from and after moment of birth if placed within 60 days of birth, or from the date of Placement, if placed more than 60 days after birth for the purpose of adoption and will continue unless:

1. Placement is disrupted prior to legal adoption; and
2. The child is removed from Placement.

"Placement" means physical placement in the care of the adopting health plan Member. If physical placement is prevented due to the medical needs of the child, "placed" means the date the adopting health plan Member signs an agreement for adoption of the child and assumes financial responsibility for the child.

In order for the newly adopted child to be insured under this Group Policy, the Employer must:

1. Provide us with written notification of the Placement within sixty (60) days from the earlier of the date of adoption or placement for adoption; and
2. Pay any additional premium; the appropriate premium must be received by Us within 31 days of the date the monthly premium invoice is received by the Group and a notice of premium (if any) is provided to the Plan Member by the Group.

Newborn Child

In order for the newborn child to be insured under this Group Policy, the Employer must:

1. Provide us with written notification of the birth within sixty (60) days of the date of birth; and
2. Pay any additional premium; the appropriate premium must be received by Us within 31 days of the date the monthly premium invoice is received by the Group and a notice of premium (if any) is provided to the Plan Member by the Group.

ENROLLMENT PERIODS

An Eligible Employee or an Eligible Dependent who did not enroll when first eligible under this Group Policy may enroll under this Group Policy if:

1. The Eligible Employee or Eligible Dependent was covered under another group health plan or had other health insurance coverage at the time that coverage was previously offered to the Eligible Employee or Eligible Dependent;
2. The Eligible Employee stated in writing at the time that coverage under another group health plan or health insurance coverage was the reason for declining enrollment, but only if the Policyholder or We required the statement at the time and provided the Eligible Employee with notice of the requirement and the consequences of the requirement at the time;

3. The Eligible Employee's or Eligible Dependent's coverage described in paragraph 1. was:

    a. Under a COBRA continuation provision and was exhausted; or

    b. Not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage or because Policyholder's employer payments toward the coverage were terminated; and

    c. Under the terms of this Group Policy, the Eligible Employee requests the enrollment not later than 30 days after the date of exhaustion of COBRA coverage or termination of coverage or Group Policyholder premium payment.

OPEN ENROLLMENT PERIODS

The Policyholder may establish open enrollment period(s) as agreed upon by Us. During this period, Eligible Employees or Eligible Dependents who are not enrolled under this Group Policy may enroll for coverage under this Group Policy. Such enrollment under this Group Policy will be effective on the date of the Open Enrollment Period. Notification of enrollment must be provided on an Enrollment Form and any premium payment required by the Eligible Employee must be paid. We will have the right to limit the number of enrollment periods to be provided during a PolicyYear.

TERMINATION OF INSURANCE

GROUP POLICY TERMINATION BY THE COMPANY

This Group Policy will terminate at 11:59p.m. local time at the Policyholder's place of business on the earliest of:

1. The end of the period for which no premium is paid, subject to the Grace Period; refer to Section 3;
2. The premium due date following the date We receive the Policyholder's written request to terminate this Group Policy; or
3. The date no Eligible Employees are insured under this Group Policy.

NOTICE OF CANCELLATION FOR NONPAYMENT OF PREMIUM

We will provide at least 15 days prior notification of cancellation for nonpayment of premium for this Group Policy.

We will send the notice of cancellation to the Policyholder at the Policyholder's last-known address. The notice will specify the date of cancellation of this Group Policy. We will attach a properly executed proof of mailing to this notice and maintain a copy of the proof of mailing in Our records.

We will hold for processing of payment any claims for Covered Medical Expenses incurred for Covered Benefits during the grace period for nonpayment of premium for group health insurance coverage. Upon receipt of the premium, claims held for the grace period will be

processed for payment.

This Group Policy will continue in full force and effect, subject to the requirements of the preceding paragraph, until the proper notification has been given, unless this Group Policy has already been replaced.

We may collect premiums for any time period that this Group Policy remains in effect.

When this Group Policy is actually canceled, notice must also be mailed to all Insured Employee's at:

1. Their last-known home addresses if available; or
2. The business address of the Policyholder.

TERMINATION OF COVERAGE OF INSURED EMPLOYEES

An Insured Employee's coverage under this Group Policy will terminate at 11:59:59 p.m. on the earliest of the following:

1. The date the Insured Employee no longer qualifies as an Eligible Employee;
2. The date the Insured Employee fails to make any premium payments required for the Insured Employee's coverage under this Group Policy;
3. The date this Group Policy is terminated.

TERMINATION OF COVERAGE OF INSURED DEPENDENTS

An Insured Dependent's coverage will terminate at 11:59:59 p.m. at the Insured Employee's place of residence on the earliest of:

1. The end of the period for which premium for the Insured Dependent's coverage is not paid, subject to the Grace Period;
2. The premium due date following the date an Insured Dependent Child ceases to be an Eligible Dependent as defined in this Group Policy;
3. The date the Insured Employee's coverage terminates under this Group Policy;
4. The premium due date following the date We receive the Insured Employee's written request to terminate the Insured Dependent's coverage under this Group Policy; or
5. The date of death of the Insured Dependent.

Also, refer to *Termination of Coverage for Handicapped Child* provision regarding additional termination provisions for disabled children.

Termination of Coverage for Disabled Child

In addition to the termination provisions indicated above, insurance coverage for an Insured Dependent Child who is a disabled child age 26 and over will end on the earliest of:

1. The date the Dependent marries;
2. The date the Dependent obtains self-sustaining employment;
3. The date the Dependent ceases to be disabled;

4. The date the Dependent ceases to be dependent upon You for support and maintenance;
5. Sixty (60) days after a written request for proof of disabled, if proof is not provided within such 60-day period;
6. The date Insured Employee refuses to allow Us to examine the Dependent Child; or
7. The date We receive notification to terminate the Dependent's coverage under this Group Policy.

SPECIAL ENROLLMENT PERIOD

Should the individual(s) covered under this Group Policy encounter certain life events, such as death in the family, marriage, [domestic partnership,] divorce, or adoption or birth of a child (as defined by the ACA), the individual(s) will be allowed a Special Enrollment Period of 60 days from the month of the qualifying event to make appropriate changes in coverage. In the case of marriage [or domestic partnership], the effective date of coverage will be not later than the first day of the first month beginning after the date the completed request for enrollment is received.

SUSPENSION OF COVERAGE DURING MILITARY SERVICE

If an Insured Employee enters into active duty status for the military or naval service of the United States or any other country, coverage will be suspended as of the first date of active duty status. The Policyholder must notify Us of the Insured Employee's active duty status within sixty (60) days of the first date of the Insured Employee's active duty status; however, coverage will be suspended regardless of receipt of notification. When We receive notification of the active duty status, any required adjustment of premium will be made, including refund of premium if necessary.

Upon termination of active duty status, the Insured Employee may request a resumption of coverage if the Insured Employee:

1. Meets the eligibility requirements for Eligible Employee or Eligible Dependent as provided in this Group Policy;
2. Makes the request for resumption of coverage in writing within sixty (60) days of the Insured Employee's termination of active duty status; and
3. Pays any required premium for the Insured Employee's coverage under this Group Policy. Coverage under this Group Policy will resume on the date immediately following Our receipt and verification of the above requirements.

GROUNDS FOR NONRENEWAL OR DISCONTINUATION OF THIS GROUP POLICY

Except as provided in this provision, if We offer health insurance coverage in the group market in connection with a group health plan, We will renew or continue the coverage in force at the option of the Policyholder.

We may cancel, nonrenew or discontinue health insurance coverage offered in connection with this Group Policy in the group market if:

1. The Policyholder has failed to pay premiums or payments in accordance with the terms of this Group Policy or if We have not received timely premium payments;

2. The Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of this Group Policy coverage;
3. The Policyholder has failed to comply with a material plan provision relating to employer payment or group health plan participation rules;
4. We are ceasing to offer coverage in that group market in accordance with this provision and applicable state law; or
5. There is no longer any enrollee in connection with this Group Policy who lives, resides, or works in the service area of the Provider Network provided for this Group Policy.

We may not discontinue offering a particular type of group health insurance coverage offered in the group market unless in accordance with applicable state law and unless:

1. We provide notice to each Policyholder, participant, and beneficiary provided coverage of this type in that group market of the discontinuation at least 90 days prior to the date of the discontinuation of the coverage;
2. We offer to each Policyholder provided coverage of this type in the market the option to purchase any other health insurance coverage currently being offered by Us to a group health plan in the market; and
3. We act uniformly without regard to the claims experience of those Policyholders or any health status-related factor of any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

We may not discontinue offering all health insurance coverage in the group market, unless in accordance with applicable state law and unless:

1. We provide notice of discontinuation to the Idaho Department of Insurance and to each Policyholder, participant, and beneficiary covered at least 180 days prior to the date of the discontinuation of coverage;
2. We provide notice to the Director of the Idaho Department of Insurance at least three (3) working days prior to the notice to the affected employers
3. All health insurance issued or delivered for issuance in Idaho in the group market or markets is discontinued and coverage under the health insurance coverage in the group market or markets is not renewed.

We may modify upon renewal, health insurance coverage for a product offered to a group health plan in the market if, for coverage that is available in the group market other than only through one or more bona fide associations, modification is consistent with applicable state law and effective on a uniform basis among group health plans with that product.

COBRA CONTINUATION OF COVERAGE

If this Group Policy remains in effect, but the Insured Employee's or an Insured Dependent's coverage under this Group Policy would otherwise terminate, We may be required to offer such Insured Employee or Insured Dependent the right to continue coverage under this Group Policy. This right is referred to as "Continuation Coverage" and may occur for a limited time subject to the terms of this provision and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA only applies to this Group Policy if the Policyholder covers at least 20 Eligible Employees under this Group Policy.

ELIGIBILITY

If Insured Employee or Insured Dependent has been covered under this Group Policy on the day before a qualifying event, the Insured Employee or Insured Dependent may be eligible for COBRA Continuation Coverage. The following are qualifying events for such COBRA Continuation Coverage if, under the terms of this Group Policy, the event causes the Insured Employee or Insured Dependent to lose coverage:

1. For Insured Employees, loss of coverage because of:
    a. The termination of employment except for gross misconduct; or
    b. A reduction in the number of hours worked by the Insured Employee.
2. For Insured Dependents, loss of coverage because of:
    a. The termination of the Insured Employee's coverage under this Group Policy
    b. The death of the Insured Employee;
    c. The divorce or legal separation from the Insured Employee;
    d. The Insured Employee becomes entitled to Medicare, if applicable; or
    e. The Insured Dependent reaches the limiting age for coverage under this Group Policy.

ENROLLING FOR COBRA CONTINUATION COVERAGE

The Insured Employee or Insured Dependent has 60 days from the later of the date of:

1. The qualifying event; or
2. The date that the Insured Employee or Insured Dependent receives notice of the right to COBRA Continuation Coverage to enroll for such Coverage.

If the Insured Employee or Insured Dependent does not send the written notification form to Us within the 60-day period, the Insured Employee or Insured Dependent will lose their right to COBRA Continuation Coverage. If the Insured Employee or Insured Dependent qualifies for COBRA Continuation Coverage and receives services that would be for Covered Benefits, before enrolling and paying the premium for COBRA Continuation Coverage, the Insured Employee or Insured
Dependent will be required to pay for those services. We will reimburse the Insured Employee or

Insured Dependent for Covered Medical Expenses incurred for Covered Benefits, less required cost-sharing or other payments required by to be paid by the Insured Employee or Insured Dependent, after the Insured Employee or Insured Dependent enrolls and pays the required premium for the COBRA Continuation Coverage, and submit a claim for those Covered Medical Expenses incurred for the Covered Benefits provided under this Group Policy.

CONTINUATION OF COVERAGE

CONTINUATION OF COVERAGE AFTER REDUCTION OF REGULAR WORK SCHEDULE

An Insured Employee may, for a period of one (1) year, with the consent of the Policyholder, continue coverage under this Group Policy during the Insured Employee's employment notwithstanding any reduction of the Insured Employee's regular work schedule to less than the minimum time required to qualify for coverage under this Group Policy, and the premium charged such Insured Employee will be equal to that charged other Insured Employees with the same risk class.

EXTENSION OF BENEFITS

Benefits are extended for 12 months for Insured Employees who became disabled or pregnant and continue to be disabled at the date of discontinuance of this Group Policy, provided the premiums are paid current for the Insured Employee.

REPLACEMENT CONTRACTS

If this Group Policy is replacing prior group coverage within 60 days of discontinuance of the prior policy, the plan will cover all employees and dependents validly covered on the date of discontinuance.

SECTION 3—PREMIUMS

PAYMENT OF PREMIUM

All premium, any charges or fees for this Group Policy (hereinafter referred to as "premium") must be paid to Us. The premium for this Group Policy is shown in the Schedule of Benefits. If You do not pay premiums when due, this Group Policy will terminate subject to the Grace Period. The Premium Due Date is shown in the Schedule of Benefits.

GRACE PERIOD

After the first due premium payment, if a premium is not paid on or before the date it is due, it

may be paid during the next thirty-one (31) days. These thirty-one (31) days are called the Grace Period. Coverage under this Group Policy will remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, this Group Policy will automatically terminate at the end of the Grace Period. However, We will not terminate this Group Policy until We have mailed or delivered to You at Your last-known business address shown in Our records a written notice, in addition to any billing statement, stating the date this Group Policy's termination will become effective, which will not be earlier than:

1. The beginning of the period for which premiums have not been paid in full if the notice of termination for nonpayment of premiums is mailed or delivered within fifteen (15) days after the due date of the missed premiums for that period; or
2. The date of mailing or delivery of notice of termination for nonpayment of premiums if the notice of termination for nonpayment of premiums is not mailed or delivered within fifteen (15) days after the premium due date for the applicable policy period.

We will give such termination notice to You at least thirty (30) days in advance of termination for nonpayment of premiums.

We will give such termination notice to You at least thirty (30) days in advance of termination for nonpayment of premiums.

PREMIUM RATE CHANGES

Subject to rate requirements applicable in the state of Idaho, where this Group Policy is issued, We may change the rates for this Group Policy on any Policy Anniversary Date after this Group Policy has been in force for 12 months. However, the rates may be changed sooner than 12 months if a premium increase is necessitated by: (1) a state or federal law; (2) court decision; or (3) rule adopted by an agency of competent jurisdiction of the state or federal government. Any rate change will be made only when We change the rates for all policies in the same rate class on the same form as this Group Policy that are issued in the state of Idaho.

We will give You at least 45 days prior written notice before the effective date of any rate change. The rates will never be changed due to a change in The Insured Person's age or health. Such notice will be mailed to the Insured Employee's last known address as shown in Our records. If We fail to provide the notice as stated in this provision, this Group Policy will remain in effect at the existing rate with the existing benefits until: (1) the full notice period has expired; or (2) the effective date of the replacement coverage is obtained by You, whichever occurs first.

PREMIUM REFUND

In the event of termination of this Group Policy, We will refund the prorata portion of the unearned premium to the beginning of the next billing cycle.

SECTION 4—PREFERRED PROVIDER NETWORK OPTION

PREFERRED PROVIDER ORGANIZATION NETWORK

The Preferred Provider Network (also referred to as "PPO Network") shown on page 4, *Important Information*, is the Preferred Provider Network being used for this Group Policy to provide In-Network services for Covered Benefits.

The Insured may choose to go to any Covered Provider. However, there are advantages when receiving services from a Preferred Provider participating in the PPO Network. The Preferred Provider network for those covered by this Policy is the Group Network.

FREEDOM OF CHOICE OF PROVIDER

The Insured is not required to go to a Preferred Provider. At the time of service, Treatment may be obtained from a Preferred Provider or a Non-Preferred Provider. However, to maximize benefit reimbursement level under this Group Policy, a Preferred Provider must be used. Insureds do not have to obtain Preauthorization to use the services of any Preferred Provider, however, Preauthorization may be required for certain Treatments or services as specified in this Group Policy.

Please refer to *"Using a Preferred Provider"* and *"Using a Non-Preferred Provider"* in this Section, and the Schedule of Benefits for more details regarding the benefit amounts that will be paid under this Group Policy when using a Preferred Provider (In-Network) or Non-Preferred Provider (Out-of-Network).

A list of the Preferred Provider Network's participating Covered Providers may be obtained from the Preferred Provider Network by:

1. Calling the PPO Network at the telephone number shown on page 4, *Important Information*; or
2. Retrieving Preferred Provider information on our Website, as shown on page 5, *Important Information*.

The list of Preferred Providers will be updated periodically, at least monthly. The Insured must confirm current Preferred Provider status of a Covered Provider prior to receiving services from such Covered Provider. A Preferred Provider's contract with the PPO Network must be in effect at the time services are received by the Insured.

BENEFITS OF USING A PREFERRED PROVIDER

If the Insured uses the services of a Preferred Provider, benefits will generally be reimbursed at a higher level ("In-Network" level benefits) as shown in the Schedule of Benefits. The Preferred Provider's contract with the PPO Network must be in effect at the time the Preferred Provider provides services to the Insured in order for In-Network level benefits to apply.

Preferred Providers have agreed to accept the Allowable Fee as full payment for their payment for services rendered to Insureds for Covered Benefits under this Group Policy. The Insured is not responsible for charges exceeding the Allowable Fee when services are provided by a Preferred Provider.

USING A NON-PREFERRED PROVIDER

If the Insured uses the services of a Non-Preferred Provider:

1. Covered Medical Expenses will generally be reimbursed at a lower level ("Out-of-Network" level benefits) as shown in the Schedule of Benefits; and
2. The Insured will be responsible for paying the difference between the Non- Preferred Provider's billed amount and the Allowable Fee. We will only pay benefits up to the Allowable Fee for services provided by the Non-Preferred Provider.

OUT-OF-NETWORK EMERGENCY SERVICES

If the Covered Person requires Emergency Services for an Emergency Medical Condition, while the Covered Person is traveling outside of the Service Area of the In-Network Organization, but cannot reasonably reach an In-Network Provider, the benefits payable for Emergency Services received from an Out-of-Network Provider will be the same as would be payable for the services of an In-Network Provider. Your covered expenses are based on our Allowable Fee and You are subject to Balance Billing by the Out-of-Network Provider.

If you are admitted to a hospital as an inpatient following the stabilization of your emergency condition, your physician or hospital should contact our Medical Management team at (855) 447-2900 as soon as possible to make a benefit determination on your admission. If you are admitted to an Out-of-Network hospital, MHC may require you to transfer to an In-Network facility once your condition is stabilized in order to continue receiving benefits at the In-Network provider level. Refer to the Schedule of Benefits for Emergency Services.

WHY IT'S IMPORTANT TO CHOOSE A PRIMARY CARE PHYSICIAN

We strongly encourage all Covered Persons to select an In-Network Primary Care Physician (PCP). Note that once the In-Network Primary Care Physician is selected by the Covered Person or assigned by MHC the Covered Person has no further responsibility to the Primary Care Physician. The assignment of the In-Network Primary Care Physician allows MHC to better track the quality of care being provided and enables MHC and In-Network Physicians to provide educational and medical advice specifically tailored to the needs of that Covered Person.

The In-Network Primary Care Physician is an advisory service to the Covered Person and does not control the medical service a Covered Person may seek. Covered Benefits provided under this Policy are described in Section 5. However, by seeing your PCP on a regular basis and calling him or her first when You have an urgent concern, You will stay healthier and experience fewer medical and ER visits, which means lower Out-of-Pockets costs for You. Your PCP can help You manage any chronic conditions You may have and make personalized recommendations to improve your health.

SECTION 5—COVERED BENEFITS

This Group Policy will pay Covered Medical Expenses for the following Covered Benefits when services are provided by a Covered Provider.

Payment to providers is based on the Allowable Fee. In-Network Providers agree to accept payment of the Allowable Fee for Covered Medical Expenses as full payment. We generally pay In-Network Providers directly.

Out-of-Network Providers have not agreed to accept the Allowable Fee as full payment for Covered Medical Expenses. Out-of-Network Providers can bill the difference between the amount that We pay, if any, and the amount of their billed charge (the balance billed amount). Covered Person will be responsible for the balance billed amount. We may pay you directly for

Out-Network Providers.

Covered Person will be responsible for all copayments, coinsurance and deductibles. Covered Person may be fully responsible for any medical expenses that are not Covered Medical Expenses/Covered Benefits, are not Medically Necessary, are Investigational, and/or for medical expenses for which a benefit maximum has been reached, regardless of whether the provider is an In-Network Provider or an Out-of-Network provider.

PAYMENT OF BENEFITS

Payment of Covered Medical Expenses will be:

1. Based on the Allowable Fee; and
2. Subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum stated in the Schedule of Benefits, unless otherwise stated in the Schedule of Benefits or this Section for specified Covered Benefits.

EXCEPTIONS

When Services Are Provided By An Indian Service

If the Insured who is an Indian, as defined in this Group Policy, receives services for Covered Benefits directly by:

1. An Indian Health Service;
2. An Indian Tribe;
3. A Tribal Organization;
4. An Urban Indian Organization; or
5. through referral under contract health services;

this Group Policy will pay Covered Medical Expenses incurred for Covered Benefits on an In-Network basis without the application of: (1) the Deductible; (2) Coinsurance; (3) Annual Out-of-Pocket Maximum; and (4) any applicable Copayments.

However, if services for Covered Benefits shown in Section 5, Covered Benefits, are not rendered directly by an Indian Health Service, an Indian Tribe, a Tribal Organization, an Urban Indian Organization, or through referral under contract health services, this Group Policy will pay benefits on:

1. An In-Network basis if the Insured, who is an Indian as defined in this Group Policy, obtains services from an In-Network; or
2. An Out-of-Network basis if the Insured, who is an Indian as defined in this Group Policy, obtains services from a Non-In-Network; and

the Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable Copayments will apply.

Benefits Paid Without Cost-Sharing Requirements for Certain Insureds Who Are Indians

The Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable

Copayments will not apply to an Insured who is an Indian, as defined in this Group Policy, and who:

1. Meets the specific federal government guidelines to exempt such Insured from the cost-sharing requirements of this Group Policy; and
2. Obtains services from either an In-Network Providers or Out-of-Network Providers.

Third Party Payments for Premiums, Co-Payments, Coinsurance

Providers may not waive, rebate, give, pay or offer to waive, rebate, give or pay all of part of the Insured's deductible or other out of pocket costs including co-payments, coinsurance, or premiums. We will accept third party payments of premiums and cost sharing from:

- A Ryan White HIV/AIDS Program
- An Indian tribe or tribal organization
- Local, state or federal government programs, including grantees directed by a government program to make payments on its behalf

We will also accept third party payments from individuals such as family and friends, religious institutions and other not-for-profit organizations when all of the following criteria are met:

- The assistance is provided on the basis of the insured's financial need
- The institution/organization is not a healthcare provider
- The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

We do not count any financially interested third party cost-sharing payments toward deductibles or out of pocket maximums. If We discover financially interested third party payments of this type after the fact and these payments have already been counted toward the deductible or out of pocket maximum, We will exclude the financially interested third party from the accumulation toward the deductible or out of pocket maximum.

Should We reject a payment from a third party, we will inform you in writing of the reason for our rejection and your right to file a complaint with the Idaho Department of Insurance.

BENEFITS ELIGIBLE FOR PAYMENT

Benefits will be eligible for payment if Covered Medical Expenses are:

1. Incurred for Covered Benefits while the Insured is insured under this Group Policy; and
2. The Treatment for which the Covered Medical Expenses are incurred is:
    a. The result of an Illness or Injury; and
    b. Medically Necessary, unless the Covered Benefit is for educational purposes only, as provided under this Group Policy; and
    c. Prescribed or treated by a Physician or other Covered Provider as provided under this Group Policy; and
    d. Meets Our Medical Policy.

Covered Benefits provided under this Group Policy are subject to the exclusions, limitations

and all terms and conditions specified in this Group Policy.

ACCIDENT BENEFIT

Coverage will be provided for services rendered for bodily Injuries resulting from an Accident which occur after the Group Policy's Effective Date of Coverage.

AMBULANCE SERVICES

Coverage will be provided for local transportation provided by a licensed ambulance service to the nearest Hospital with the appropriate staff and facilities to treat the Emergency Medical Condition of the Insured.

ANESTHESIA SERVICES

Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist. Services include: (1) the administration of spinal anesthesia; and (2) the injection or inhalation of a drug or other anesthetic agent. No benefits will be paid for:

1. Local anesthesia or intravenous (IV) sedation that is considered to be an inclusive service or procedure.
2. Hypnosis;
3. Anesthesia consultations before surgery that are considered to be inclusive services and procedures because the Allowable Fee for the anesthesia performed during the surgery includes the anesthesia consultation; or
4. Anesthesia for dental services.

Important Note: To avoid Balance Billing, it is important for Covered Person to seek services from an In-Network Anesthesiologist when possible.

APPROVED CLINICAL TRIAL

Clinical Trials Charges for unproven medical practices or care, treatment, devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by MHC and our Third-Party Administrator, UUHP.

MHC does not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in approved clinical trials. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Patient costs do not include the investigational item, device, or service, itself; items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

AUTISM SPECTRUM DISORDER COVERAGE

Coverage will be provided for the diagnosis and treatment of autism spectrum disorders for a Covered Dependent Child 18 years of age or younger. Coverage under this Benefit will be provided for such Covered Dependent Child who is diagnosed with one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic Spectrum Disorder;
2. Asperger's Syndrome; or
3. Pervasive Developmental Disorder not otherwise specified.

Coverage will include:

1. Habilitative or rehabilitative care that is prescribed, provided, or ordered by a Physician or a licensed psychologist, including but not limited to: (1) professional, counseling, and guidance services; and (2) Treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
2. Medications prescribed by a Physician;
3. Psychiatric or psychological care; and
4. Therapeutic care that is provided by: (1) a speech-language pathologist; (2) audiologist; (3) occupational therapist; or (4) physical therapist licensed in this state.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, such as Applied Behavior Analysis (ABA) Therapy.

Applied behavior analysis covered under this provision must be provided by an individual who is: (a) licensed by the behavior analyst certification board; or (b) certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

When Continued Services Are Required

When treatment is expected to require continued services, We may request that the treating Physician provide a Treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The Treatment plan must be based on evidence-based screening criteria. We may ask that the Treatment plan be updated every 6 months.

As used in this provision, "Medically Necessary " means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to:

1. Prevent the onset of an illness, condition, injury, or disability;
2. Reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

For Covered Persons who are over the age of 18 and have autism, coverage is provided under the *Mental Illness* benefit.

BLOOD TRANSFUSIONS

Blood transfusions, including: (1) the cost of blood; (2) blood plasma; (3) blood plasma expanders; and (4) packed cells. Storage charges for blood are paid when the Insured has blood drawn and stored for the Insured's own use for a planned surgery.

CENTERS OF EXCELLENCE (COE)

Our Centers of Excellence (COE) program promotes MHC's high standards for quality and value of care, which results in improved patient outcomes. COE partners must demonstrate rigorous quality control measures, positive patient outcomes and cost-efficient healthcare delivery.

Our Centers of Excellence medical categories include, but are not limited to: knee, hip, back, cardiac, cancer, transplants, tertiary care, and other specialty care outside Covered Person's geographic.

The use of Our COE program is directed through the Medical Management prior authorization process.

Things you need to know before accessing a COE

- Members must be pre-approved to use a designated COE facility or practitioner.
- Designated COE providers may be located out of MHC's primary service area, members may be eligible for travel benefits.

- When Covered Person is pre-approved for services at Our COE facilities and receives pre-approved care at one of Our COE facilities, Covered Person's deductible will be waived.

If you have questions, please contact Customer Service at 855-447-2900.

CHEMICAL DEPENDENCY

Coverage for the diagnosis and Treatment of Chemical Dependency will be provided on the same basis as any other Illness. Treatment for Chemical Dependency will consist of both Inpatient and Outpatient Treatment. Preauthorization is required for Inpatient Residential Chemical Dependency Treatment; refer to *Section 6, Utilization Review Management Program*.

"Chemical Dependency" means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance and includes alcohol and substance abuse.

"Chemical Dependency Treatment Center" means a treatment facility that:

1. Provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan approved and monitored by a Physician or addiction counselor licensed by the state; and
2. Is licensed or approved as a treatment center by the Department of Public Health and Human Services or is licensed or approved by the state where the facility is located.

Inpatient Treatment Services

Benefits will be payable for the necessary Treatment of Chemical Dependency when provided in or by:

1. A Hospital;
2. A Physician; or
3. A Freestanding Inpatient Facility which is a part of a Chemical Dependency Treatment Center. Such facility must be approved by the Department of Public Health and Human Services.

Coverage will be provided under this Group Policy for:

1. Medically monitored and medically managed intensive Inpatient Care services; and
2. Clinically managed high-intensity residential services.

Inpatient Care Services are subject to Plan Notification and Preauthorization. Please refer to Section 6, Utilization Review Management Program.

Outpatient Treatment Services

Benefits will be payable for Outpatient Treatment of Chemical Dependency when such Treatment is provided in or by:

1. A Hospital;
2. A Chemical Dependency Treatment Center;

3. A Physician or prescribed by a Physician;
4. A licensed psychiatrist;
5. A psychologist;
6. A licensed social worker;
7. A licensed professional counselor; or
8. An addiction counselor licensed by the state.

Outpatient Treatment of Chemical Dependency is subject to the following conditions:

1. The Treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Chemical Dependency;
2. The Treatment must be provided to diagnose and treat recognized Chemical Dependency;
3. No benefits will be provided for: (a) marriage counseling; (b) hypnotherapy; or (c) services given by a staff member of a school or halfway house.

CHEMOTHERAPY

Medical Treatment for Cancer using medical/pharmaceutical therapies. Coverage includes the use of drugs approved for use in humans by the U.S. Food and Drug Administration (FDA).

CHIROPRACTIC SERVICES

Coverage will be provided for services provided by a licensed chiropractor within the scope of the chiropractor's license and practice. Benefits include chiropractic services provided in connection with the detection or correction of manual or mechanical means of:

1. Structural imbalance;
2. Distortion or subluxation in the human body for the purpose of removing nerve interference; and
3. The effects of such, where such interference is the result of or related to the distortion, misalignment, or subluxation in the vertebral column.

Benefits are subject to the Maximum Number of Visits per Policy Year shown in the Schedule of Benefits.

CHRONIC DISEASE MANAGEMENT

Coverage will be provided for chronic disease management services for: (a) diabetes; (b) hypertension (high blood pressure); (c) high cholesterol; and (d) any other chronic disease required by the federal Affordable Care Act. The Insured must be diagnosed and receiving treatment for the chronic disease, and the Chronic Disease Management must be prescribed by a Physician.

CONGENITAL ANOMALY, INCLUDING CLEFT LIP/PALATE

Coverage will be provided for reconstruction of a congenital anomaly condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Group Policy, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of the cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies. Also included is surgical cochlear implant. Coverage for all these treatments is under the applicable benefit type, such as surgery, prescription drug, habilitative services, etc.

CONVALESCENT HOME SERVICES

Coverage will be provided for services of a Convalescent Home as an alternative to Hospital Inpatient Care when:

1. Prescribed by a Physician; and
2. Preauthorization is obtained.

Coverage will be provided for Convalescent Home Physician visits.

No benefits will be payable for Convalescent Home Services if the Insured remains an Inpatient at the Convalescent Home when a skilled level of care is not Medically Necessary.

This Group Policy does not pay for custodial care services.

Benefits will be limited to the Maximum Number Days of Convalescent Home Services per Policy Year as shown in the Schedule of Benefits.

DENTAL SERVICES RELATED TO ACCIDENTAL INJURY

Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, sound natural tooth, mouth or face. Such services are covered only for the twelve (12) month period immediately following the date of injury providing the Policy remains in effect during the twelve (12) month period. Injury as a result of chewing or biting and temporomandibular joint (TMJ) disorder are not considered accidental injuries. No benefits are available under this section for orthodontia or orthognathic services.

Benefits are provided for repair of damage to a sound natural tooth, lips, gums and other portions of the mouth, including fractures of the maxilla or mandible. Repair or replacement of damaged dentures, bridges, or other dental appliances is not covered, unless the appliance must be modified or replaced due to accidental injury to a sound natural tooth which are abutting the bridge or denture.

Benefits for accidental dental services under this provision shall be primary to dental benefits available to an Insured under another benefit section of this Group Policy or available under a dental policy of insurance, contract, or underwriting plan that is separate and distinct from this policy.

DENTAL EXAM

Your plan provides up to a $100 reimbursement towards one routine dental examination per enrollee each Policy Year. Reimbursable services include exams, cleanings and fluoride treatment. Any licensed dental office may be used.

For instructions on how to be reimbursed for this benefit, please visit our website at https://www.mhc.coop/members/forms/

DURABLE MEDICAL EQUIPMENT

Coverage will be provided for the purchase or rental of Durable Medical Equipment. The equipment must be appropriate for therapeutic purposes where the Insured resides. Benefits will include repairs and necessary maintenance of purchased equipment, not otherwise provided under a manufacturer's warranty or purchase agreement.

"Durable Medical Equipment" means equipment or FDA approved medical devices that are Medically Necessary to aid in the Insured's recovery, mobility and/or support of life.

Durable Medical Equipment must be: (a) prescribed by a Physician; (b) be able to withstand repeated use (consumables are not covered); (c) primarily used to serve a medical purpose rather than for comfort or convenience; and (d) generally not useful to a person who is not ill or injured.

If a type of equipment is specifically excluded under this Group Policy, it will not be covered under this Durable Medical Equipment benefit.

Durable Medical Equipment includes, but is not limited to: (a) canes; (b) crutches; (c) walkers; (d) standard manual or electric wheelchairs; and (e) standard hospital beds.

No benefits will be payable for the following: (1) exercise equipment; (2) car lifts or stair lifts; (3) biofeedback equipment; (4) self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition; (5) air conditioners and air purifiers; (6) whirlpool baths, hot tubs, or saunas; (7) waterbeds; (8) other equipment which is not always used for healing or curing; (9) computerized and "deluxe" equipment life motor-driven wheelchairs or beds when standard equipment is adequate. We will have the right to determine when standard equipment is adequate; (10) durable medical equipment required primarily for use in athletic activities; (11) replacement of lost or stolen durable medical equipment; (12) repair to rental equipment; and (13) duplicate equipment purchased primarily to the Insured's convenience when the need for duplicate equipment is not medical in nature.

Preauthorization is recommended for the original purchase or replacement of durable medical equipment over the amount indicated in the Schedule of Benefits. Please refer to *Section 6, Utilization Review Management Program.*

EDUCATION SERVICES

Coverage will not be provided for education services other than diabetic education that are related to the Covered Person's medical condition.

EMERGENCY SERVICES

Coverage will be provided for emergency services provided in a Hospital's emergency room for an Emergency Medical Condition. Preauthorization is not required for Emergency Services; however, we recommend that the Insured notify Us within 48 hours of the Emergency Service to allow utilization review management to begin working with the Insured.

HABILITATIVE CARE

Coverage will be provided for habilitative care services including devices, are provided for a person to attain, maintain or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. These services include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) other services for people with disabilities. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

Inpatient and Outpatient benefits are subject to the Maximum Number of Visits per Group Plan Year shown in the Schedule of Benefits.

HEARING, PEDIATRIC

Coverage will be provided for hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device.

HOME HEALTH CARE SERVICES

Coverage will be provided for Home Health Care when prescribed by a Physician. Home Health Care services must be provided by a licensed home health agency to a home bound Insured in the Insured's place of residence and is prescribed by the Insured's attending Physician as part of the Insured's treatment plan.

Services for home health care include: (1) nursing services; (2) home health aide services; (3) hospice services; (4) physical therapy; (5) occupational therapy; (6) speech therapy; (7) medical social worker; (8) medical supplies and equipment suitable for use in the home; and (9) Medically Necessary personal hygiene, grooming, and dietary assistance. Home health care services do not include prescription drugs or medicines.

Benefits will be limited to the maximum number of home visits, per Policy Year, shown in the Schedule of Benefits.

No benefits will be payable for:

1. Maintenance or custodial care visits;

2. Domestic or housekeeping services;
3. "Meals-on-Wheels" or similar food arrangements;
4. Visits, services, medical equipment, or supplies not approved or included as part the Insured's treatment plan for Home Health Care;
5. Services for mental or nervous conditions; or
6. Services provided in a nursing home or skilled nursing facility.

HOME INFUSION THERAPY SERVICES

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to the Insured by a Home Infusion Agency, includes:

1. Education for the Insured, the Insured's caregiver, or a Family Member;
2. Pharmacy;
3. Supplies;
4. Equipment; and
5. Skilled nursing when billed by the Home Infusion Therapy Agency.

Note: Skilled nursing services billed by a licensed Home Health Agency will be covered under the Home Health Care Benefit.

Home Infusion Therapy Services must be ordered by a Physician and provided by a licensed Home Infusion Therapy Agency. A licensed Hospital, which provides Home Infusion Therapy Services, must have a Home Infusion Therapy Agency license or an endorsement to its Hospital facility license for Home Infusion Therapy Services.

HOSPICE CARE SERVICES

Coverage will be provided for Hospice Care Services. Hospice Care Services is a coordinated program of home care and Inpatient Care that provides or coordinates palliative and supportive care to meet the needs of a terminally Ill Insured and the Insured's Immediate Family. Benefits include:

1. Inpatient and Outpatient care;
2. Home care;
3. Skilled nursing care;
4. Respite care provided to a homebound Insured as part of a Hospice plan of treatment. The purpose of respite care is to provide the primary care giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Insured at home.
5. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally-ill Insured; and

6. Instructions for care of the Insured, counseling and other support services for the Insured's Immediate Family.

No benefits will be payable under this Covered Benefit for:

1. Services that do not require skilled nursing care, including Custodial Care for the convenience of the Insured or the Insured's Immediate Family; and
2. Prescription Drugs.

HOSPITAL SERVICES – FACILITY AND PROFESSIONAL

INPATIENT CARE SERVICES BILLED BY A FACILITY PROVIDER

Coverage will be provided for Inpatient Care Services provided in a Hospital or a state designated Critical Access Hospital. We will not cover Inpatient Care Services and related Covered Medical Expenses if You were inpatient prior to the effective date of a policy provided by Us, (ii.) you had coverage by another insurance plan, and (iii.) that plan is responsible for the payment of the entire inpatient stay. Benefits include the following:

1. Room and Board Accommodations:
   a. Room and board, which includes special diets and nursing services;
   b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.
2. Miscellaneous Hospital Services:
   a. Laboratory procedures;
   b. Operating room, delivery room, and recovery room;
   c. Anesthetic supplies;
   d. Surgical supplies;
   e. Oxygen and use of equipment for the administration;
   f. X-rays;
   g. Intravenous Injections and setups for intravenous solutions;
   h. Special diets when Medically Necessary;
   i. Respiratory therapy, chemotherapy, radiation therapy, dialysis therapy;
   j. Physical therapy, speech therapy, and occupational therapy;
   k. Drugs and medicines which:
      1) Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;
      2) Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
      3) Require a Physician's written prescription.
3. Inpatient Hospital Physician visits.

Inpatient Care is subject to Plan Notification and Preauthorization. Please refer to *Section 6, Utilization Review Management Program*.

Inpatient Care Services are subject to the following conditions:

1. Days of care:
    a. The number of days of Inpatient Care provided is 365 days.
    b. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day the Insured is admitted to a Hospital is counted, but the day the Insured is discharged is not. If an Insured is discharged on the day of admission, one day is counted.
    c. The day the Insured enters a Hospital is the day of admission. The day the Insured leaves a Hospital is the day of discharge.
2. The Insured will be responsible to the Hospital for payment of its charges if the Insured remains as an Inpatient when Inpatient Care is not Medically Necessary. No benefits will be provided for a bed reserved for the Insured. No benefits will be paid for Inpatient Care provided primarily for diagnostic or therapy services.

OBSERVATION BEDS/ROOMS

Payment will be made for observation beds when Medically Necessary, and in accordance with Medical Policy guidelines, subject to the following limitations:

1. When the observation bed is provided for less than 48 hours;
2. Benefits for observation beds will not exceed the semi-private room rate that would be billed for an Inpatient Care stay.

OUTPATIENT HOSPITAL SERVICES

Coverage will be provided for ambulatory patient services rendered in the Hospital's outpatient facilities and equipment for: (1) surgery; (2) respiratory therapy; (3) chemotherapy; (4) radiation therapy; and (5) dialysis therapy. Outpatient Hospital facilities include a licensed Hospital's Ambulatory Care Facility or licensed Free-Standing Surgical Facility.

LABORATORY SERVICES

Coverage will be provided for:

1. Diagnostic x-ray examinations;
2. Laboratory and tissue diagnostic examinations; including allergy, generic and pregnancy testing; and
3. Medical diagnostic procedures (machine tests such as EKG, EEG).

Laboratory services include, but are not limited to, the following:

1. Laboratory X-ray Examinations;

2. Other Radiology Tests, including but not limited to: (a) computerized tomography scan (CT Scan); (b) MRIs; (c) nuclear medicine; and (d) Ultrasound;

3. Laboratory Tests, including but not limited to: (a) urinalysis; (b) blood tests; and (c) throat cultures;

4. Diagnostic Testing, including but not limited to: (a) Electroencephalograms (EEG); and (b) Electrocardiograms (EKG or ECG).

Such laboratory services must be:

1. Prescribed by a Physician;

2. Medically Necessary to find the cause or diagnose an Illness or the extent of an Injury; and

3. Administered by a professional provider who is trained and licensed to perform such services.

This benefit does not include diagnostic services, such as biopsies, which are services that are routinely covered under the *Surgical Services Benefit*.

MATERNITY AND NEWBORN CARE SERVICES

Coverage will be provided for maternity services to the Insured Employee and the Insured Employee's Insured Dependents, including: (1) prenatal care; (2) delivery of one or more newborn children; (3) postpartum care and benefits for childbirth; and (4) Hospital Inpatient Care for conditions related directly to pregnancy.

Coverage will include at least:

1. 48 hours of Inpatient Care following a vaginal delivery; and

2. 96 hours of Inpatient Care following delivery by cesarean section for the mother and newborn infant;

for the mother and newborn infant in a Hospital or other Covered Facility. A decision to shorten the length of Inpatient stay to less than that provided above must be made by the newborn's attending Covered Provider and the mother.

Preauthorization will be required if a decision is made to lengthen the time of Inpatient stay to more than the above required period.

Under Federal law, benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than: (1) 48 hours following a vaginal delivery; or (2) 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Covered Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under Federal law, Covered Providers may not be required to obtain Preauthorization from the Utilization Review Management Program for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Payment for any maternity services by the professional Covered Provider is limited to the Allowable Fee for total maternity care, which includes: (1) delivery; (2) prenatal care; and (3) postpartum care.

COMPLICATIONS OF PREGNANCY

Involuntary complications of pregnancy, diagnoses that are distinct from pregnancy or caused by pregnancy, but are adversely affected by pregnancy, are covered when medically necessary. This includes but is not limited to cesarean section, ectopic pregnancy which is terminated, spontaneous termination of pregnancy, acute nephritis, and cardiac decompensation.

NEWBORN INITIAL CARE

Coverage will be provided for the following:

1. The initial health care of a newborn child birth provided by a Physician;
2. Standby care provided by a pediatrician at cesarean section; and
3. Nursery Care – Hospital nursery care of newborn infants.

MEDICAL SUPPLIES

Coverage will be provided for the following supplies for use outside of a Hospital:

1. Diabetic supplies, syringes, test strips, glucagon, and other supplies. It is recommended that the Insured purchase these supplies under the Prescription Drug Benefit;
2. One insulin pump and pump supplies for each warranty period are covered under the Durable Medical Equipment Benefit;
3. Sterile dressings for conditions such as cancer or burns;
4. Catheters;
5. Splints;
6. Colostomy bags and related supplies; and
7. Supplies for renal dialysis equipment or machines.

Medical supplies will be covered only when: (1) Medically Necessary to treat the Insured's condition for which benefits are payable under this Group Policy; and (2) prescribed by Physician.

MENTAL HEALTH SERVICES

Coverage will be provided for the necessary care and treatment of Mental Illness and Severe Mental Illness that is no less favorable than the level of benefits provided for other physical Illnesses under this Policy. Benefits will include, but are not limited to:

1. Inpatient Care services, Outpatient services, Emergency Services, Rehabilitation services, and medications for the treatment of Mental Illness.
2. Services provided by: (a) a licensed Physician; (b) a licensed Advanced Practice Registered Nurse with a specialty in mental health; (c) a licensed social worker; (d) a licensed psychologist; or (e) a licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed

Physician; and

3. Services provided by a licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health.

"Mental Illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with: (1) present distress or a painful symptom; (2) a disability or impairment in one or more areas of functioning; or (3) a significantly increased risk of suffering: (a) death; (b) pain; (c) disability; or (d) an important loss of freedom. Mental Illness includes Severe Mental Illness.

Mental Illness must be considered as a manifestation of a behavior, psychological, or biological dysfunction in a person.

"Severe Mental Illness" means the following as defined by the American Psychiatric Association: (1) schizophrenia; (2) schizoaffective disorder; (3) bipolar disorder; (4) major depression; (5) panic disorder; (6) obsessive-compulsive disorder; and (7) autism.

"Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by an interdisciplinary team, including a licensed physician, psychiatric social worker, and psychologist, and a treatment facility that is: (1) licensed as a Mental Health Treatment Center by the state; (2) funded or eligible for funding under federal or state law; or (3) affiliated with a hospital under a contractual agreement with an established system for patient referral.

Coverage will be provided for Inpatient and Outpatient Treatment of Mental Illness. Benefits will be paid on the same basis as any other Illness.

INPATIENT CARE SERVICES

Coverage for Inpatient Care Services of Mental Illness, while the Covered Person is covered under this Policy, when such Inpatient Care Services are provided in: (1) a Hospital; (2) a Freestanding Inpatient Facility; or (3) a Physician. Inpatient Care Services must be Preauthorized; refer to Section 6, Utilization Review Management Program. Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services are covered under this Policy. Medically monitored and medically managed intensive Inpatient Care Services and clinically managed high-intensity residential services provided at a Residential Treatment Center are covered under this benefit.

PARTIAL HOSPITALIZATION

Partial Hospitalization coverage will be provided for care and treatment of Mental Illness when Partial Hospitalization services are rendered by: (1) a Hospital; (2) a Freestanding Inpatient Facility; or (3) a Physician. Partial Hospitalization is considered to be Inpatient Care and must be Preauthorized; refer to Section 6, Utilization Review Management Program.

Benefits include Partial Hospitalization services for the Treatment of Mental Illness. Such services must be preauthorized; refer to Section 6, Utilization Review Management Program.

OUTPATIENT CARE SERVICES

Outpatient care and treatment of Mental Illness will be covered under this Policy if the Covered

Person is not receiving Inpatient Mental Illness treatment and the Outpatient care and treatment is provided by: (1) a Hospital; (2) a Physician or prescribed by a Physician; (3) a Mental Health Treatment Center; (4) a Chemical Dependency Center; (5) a psychologist; (6) a licensed psychiatrist; (7) a licensed social worker; (8) a licensed professional counselor; or (9) a licensed addiction counselor.

Outpatient Mental Illness Treatment must be:

1. Provided to diagnose and treat recognized Mental Illness; and
2. Reasonably expected to improve or restore the level of functioning that has been affected by the Mental Illness.

No benefits will be payable for: (1) marriage counseling; (2) hypnotherapy; or (3) services given by a staff member of a school or halfway house.

PEDIATRIC DENTAL

This Group Policy does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance agent, a stand-alone dental insurance provider or Your Health Idaho if you wish to purchase a stand-alone dental care product.

PEDIATRIC SERVICES

Coverage will be provided for Pediatric preventive care services for Insured Dependent Children under age nineteen (19). Benefits include, but are not limited to: (1) appropriate immunizations as defined by Standards of Child Health Care issued by the American Academy of Pediatrics or other guidelines required by the state; (2) developmental assessments, which includes Physician visits for child health supervision services; (3) laboratory services; and (4) well baby visits and care; and (5) any other care and services mandated by the federal Affordable Care Act.

PEDIATRIC VISION CARE PROGRAM

Coverage will be provided for vision care services for Insured Dependent Children under age 19. Vision Care services and the vision care In-Network used for this benefit are administered by VSP as shown on page 5, *Important Information*. A directory listing of the VSP In-Network Providers can be obtained from the VSP website, or You contact VSP by telephone or mail; the VSP contact information is shown on page 5.

Benefits will be provided for the covered services shown in the Schedule of Benefits for the stated frequency of services. The frequency of service for each covered service is once every 12 months, unless otherwise stated in the Schedule of Benefits.

The Insured may choose either eyeglasses or contact lenses during any Policy Year; however, no benefits will be provided for both eyeglasses and contact lenses during the same Policy Year period. Benefits payable under this Pediatric Vision Care Program benefit are subject to the terms, conditions, exclusions, limitations outlined in this Covered Benefit and this Group Policy.

EYE EXAMINATIONS

Benefits will be provided for one eye examination for each eligible Insured Dependent Child during the Policy Year. The eye examination may be for one of the following: (1) eyeglasses; (2) contact lenses; or (3) for both eyeglasses and contact lenses during one examination. No benefits will be payable for another eye examination performed during the Policy Year. No benefits will be payable for separate eye examinations for eyeglasses and contact lenses during the Policy Year.

VISION CARE MATERIALS: EYEGLASS LENSES, COATINGS, AND FRAMES

Benefits will be provided for: (1) eyeglass lenses; (2) eyeglass coatings; and (3) eyeglass frames. The benefits payable are shown in the Schedule of Benefits.

CONTACT LENSES

In lieu of eyeglasses, the Insured may elect to receive Vision Care Materials for contact lenses as shown in the Schedule of Benefits. Either eyeglasses or contact lenses may be elected during the Policy Year, but not both.

Benefits are payable for Necessary Contact Lenses for Insureds who have specific conditions for which contact lenses provide better visual correction. The Necessary Contact Lenses must be recommended and prescribed by the Vision Physician.

The following service limitations apply to In-Network benefits for Contact Lenses:

1. Standard hard lens (one pair of contact lenses per Policy Year): Benefits are limited to one (1) contact lens per eye (total 2 lenses);
2. Monthly (six-month supply): Benefits are limited to six (6) lenses per eye (total 12 lenses);
3. Bi-weekly (3 month supply): Benefits are limited to six (6) lenses per eye (total 12 lenses); and
4. Daily Wear (one month supply): Benefits are limited to thirty (30) lenses per eye (total 60 lenses.

The following items are not covered under this contact lens benefit provision:

1. Service agreements;
2. Artistically painted or non-prescription lenses;
3. Additional office visits for contact lens pathology;
4. Contact lens modification, polishing or cleaning; and
5. Orthoptics, vision training, or supplemental testing.

See Coordination of Benefits in Section 7 below.

PAYMENT OF BENEFITS

Benefits will be paid as shown in the Schedule of Benefits.

When services are received from an In-Network Provider, the benefits are fully covered at no cost to the Insured. Therefore, no claims have to be submitted to Us or VSP. The In- Network Provider will not require payment for the Vision Care services provided to the Insured Dependent Child.

When services are received from an Out-of-Network Provider, the Insured will be responsible for paying the difference between the benefit payable under this Vision Care benefit and the amount billed by the Out-of Network Provider. The Insured will have to submit a claim to VSP to obtain reimbursement for any amount the Insured pays that is covered under this Vision Care benefit.

CLAIMS AND APPEALS FOR DENIED CLAIMS

VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Insured or Insured's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Denial of Preauthorization Requests. If VSP denies the Physician's request for Preauthorization, the Physician, The Insured or the Insured's authorized representative may request an appeal of the denial. Please refer to the "Claim Appeals" provision below, for details on how to request an appeal. VSP will provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP will resolve any second level appeal within thirty (30) calendar days. The Insured may designate any person, including the provider, as the Insured's authorized representative.

Request for Appeals: If the Insured Dependent Child's claim for benefits is denied by VSP in whole or in part, VSP will notify the Insured in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, The Insured may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Insured and the Insured Dependent Child for whom a claim for benefits was denied, including: (1) The Insured's VSP Member Identification Number; (2) the Insured Dependent Child's name and date of birth; (3) the name of the provider of services; and (4) the claim number. The Insured may state the reasons The Insured believes that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give The Insured the opportunity to: (1) review pertinent documents; (2) submit any statements, documents, or written arguments in support of the claim; and (3) appear personally to present materials or arguments. The Insured or the Insured's authorized representative should submit all requests for appeals to VSP.

VSP contact information for claims is shown on page 5, Important Information.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply only to this Pediatric Vision Care benefit. No coverage will be provided under this Vision Care benefit for:

1. The purchase of two pairs of glasses instead of bifocals. Only one pair of glasses are payable under this Vision Care benefit per Policy Year.
2. Replacement of lenses, frames or contacts.
3. Medical or surgical treatment.
4. Orthoptics or vision training and any associated supplemental testing; plano lenses

(less than ± .50 diopter power); or two pair of glasses in lieu of bifocals.

5. Replacement of lenses and frames furnished under This Plan which are lost or broken except at the normal intervals when services are otherwise available.
6. Medical or surgical treatment of the eyes.
7. Corrective vision treatment of an Experimental Nature.
8. Costs for services and/or materials above the benefits payable for the Covered Vision Care services.
9. Services or materials not indicated as Covered Vision Care benefit.

PHYSICIAN MEDICAL SERVICES

Coverage will be provided for medically necessary services provided by a Physician (non-specialist or specialist) in a medically appropriate environment.

POST-MASTECTOMY CARE AND RECONSTRUCTIVE BREAST SURGERY

POST-MASTECTOMY CARE

Coverage will be provided for Inpatient Hospital care for a period of time determined by the Attending Physician in consultation with the Insured, to be Medically Necessary following:

1. A mastectomy;
2. A lumpectomy; or
3. A lymph node dissection;

for the Treatment of breast cancer.

RECONSTRUCTIVE BREAST SURGERY

Coverage will be provided for all stages of Reconstructive Breast Surgery after a mastectomy including, but not limited to:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses and physical complications of all stages of mastectomy and breast reconstruction, including lymphedemas; and
4. Chemotherapy.

The above treatments must be provided in a manner determined in consultation with the Attending Physician and the Insured.

Coverage will be provided for breast prostheses as the result of a mastectomy.

For specific benefits related to postmastectomy care, please refer to that specific Covered Benefit, e.g., *Surgical Services, Hospital Services – Facility and Professional*.

"Mastectomy" means the surgical removal of all or part of a breast.

"Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes, but is not limited, to augmentation mammoplasty, reduction mammoplasty, and mastopexy.

PRESCRIPTION DRUGS BENEFIT

Preventive, Preferred Generic, Brand-Named and Specialty Prescription Drugs are covered under this Policy, as provided in this Covered Benefit provision. All Prescription Drugs must be prescribed by a Physician and purchased at a Preferred Pharmacy (retail) or the Preferred Mail Order Pharmacy.

Covered Prescription Drugs are provided in the Prescription Drug Formulary for this Policy. The formulary may be obtained on Our website, https://www.mhc.coop/explore-plans/drug-list/, or by calling the Customer Service number appearing on page 4, *Important Information*.

We have the discretion to determine if a medication will be covered under medical pharmacy or retail pharmacy.

Prescription drugs benefits described in the Summary of Benefits are arranged by Tiers to provide a structure for member cost-sharing in each category. Generally, the relationship is as follows: Tier 0 = Preventive; Tier 1 = Preferred Generic; Tier 2 = Preferred Brand; Tier 3 = Non-Preferred Brand and Non-Preferred Generic; Tier 4 = Preferred Specialty Drugs.

DRUG FORMULARY, PREAUTHORIZATION, AND PRESCRIPTION DRUG SUPPLY LIMITS

The Prescription Drugs provided under this Policy are based on the Drug Formulary for this Policy. Therefore, only those prescription drugs listed in such Drug Formulary will be covered under this Policy.

Some Prescription Drugs may require preauthorization or have quantity limits. Others require step therapy or have special handling requirements. These measures are to promote safety and cost-effectiveness. The information related to these requirements is on the searchable Formulary on our Website, https://www.mhc.coop/explore-plans/drug-list/. You can also get information by calling Customer Service (contact information as shown on page 5, Important Information), or by receiving a hard copy of the formulary on request.

If the Covered Person does not obtain Preauthorization for a Prescription Drug listed in the Prescription Drug Preauthorization List, reimbursement may be denied. For reimbursement consideration, the Covered Person must submit a claim with supporting documentation to Customer Service. Our Customer Service contact information is shown on page 2, Important Information.

A 30-day supply of non-specialty prescribed medications is allowed at any in-network retail pharmacy. Specialty medications must be filled through a designated specialty pharmacy. A 90-day supply is allowed on non-specialty prescribed medications at certain Preferred Pharmacies (retail) and the Preferred Mail Order Pharmacy, as allowed by applicable state or federal law.

The supply limits for Prescription Drugs are as follows:

1. Per prescription or refill at a retail Participating Provider Pharmacy or non-Preferred Provider Pharmacy is limited to a maximum of a 31-day supply;
2. Per prescription or refill received from the Participating Provider Mail Order Pharmacy or Non-Preferred Provider Mail Order Pharmacy is limited to a maximum of a 90-day supply based on the FDA-approved dosage regardless of the manufacturer packaging. However, Self-Administered Injectable Drugs are limited to a maximum of a 31-day supply per prescription or refill received from the In-Network or Out-of-Network Provider Mail Order Pharmacy.

Exclusions

No benefits will be payable for the following:

1. Non-legend drugs other than insulin.
2. Anabolic Steroids.
3. Fluoride supplements, except pediatric use as defined by PPACA.
4. Over-the-counter drugs that do not require a prescription with the exception of those covered under the preventive benefit of the Affordable Care Act.
5. Any drug used for the purpose of weight loss.
6. Prescription Drugs for cosmetic purposes, including the Treatment of alopecia (hair loss), e.g., Minoxidil, Rogaine.
7. Prescription Drugs used for the treatment of erectile dysfunction.
8. Therapeutic devices (excluding insulin needles or syringes) or appliances, including:
    a. Needles;
    b. Syringes;
    c. Support garments; and
    d. Other nonmedicinal substances;

regardless of intended use, unless otherwise specified as a Covered Benefit under this provision.

9. Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (3) one insulin-pump during the warranty period. Diabetic-infusion sets, pumps and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.
10. Drugs or items labeled "Caution – limited by federal law to investigational use, or experimental drugs even though the Covered Person is charge for the item.
11. Off-label use of a medication;
12. Drugs in drug trials;
13. Biological sera;
14. Blood or blood plasma;

15. Prescription Drugs which are to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is a patient in: (a) a Hospital; (b) rest home; (c) sanitarium; (d) extended care facility; (e) convalescent hospital; (f) nursing home; or (g) similar institution which operates or allows to be operated on its premises; or (h) a facility for dispensing pharmaceuticals; medications in these situations is part of the facility's charge;
16. Replacement prescription Drugs or Prescription Drugs due to loss, theft or spoilage;
17. Non-formulary and non-covered drugs.

PRESCRIBED CONTRACEPTIVE SERVICES

Covered Benefits for contraceptive services identified by the FDA include barrier methods, hormonal methods and implanted devices, as well as patient education and counseling as prescribed by a health care provider. Barrier methods, implanted devices and hormonal methods are covered in accordance with the medical or pharmacy benefits. There is no coverage for contraception for men.

The contraceptive methods for women currently identified by the FDA include: 1) sterilization surgery for women; 2) surgical sterilization implant for women: 3) implantable rod; 4) IUD copper; 5) IUD with progestin; 6) shot/injection; 7) oral contraceptives (combined pill); 8) oral contraceptives (progestin only); 9) oral contraceptives extended/continuous use; 10) patch; 11) vaginal contraceptive ring; 12) diaphragm; 13) sponge; 14) cervical cap; 15) female condom; 16) spermicide; and 17) emergency contraception.

PURCHASE AND PAYMENT OF PRESCRIPTION DRUGS

To maximize Your benefits, Prescription Drugs may be obtained using a Participating Provider Pharmacy or the In-Network Mail Order Pharmacy. Prescription drugs can also be obtained by using an Out-of-Network Provider Pharmacy or Out-of-Network Mail Order Pharmacy at a higher cost to the member. The Prescription Drug Coinsurance and/or Copayment, if any, is shown in the Schedule of Benefits. The Prescription Drug Coinsurance and Copayments apply towards the satisfaction of the Annual Out-of-Pocket Maximum required under the Policy.

If Prescription Drugs are purchased at a retail Participating Provider Pharmacy, the Covered Person must present the Covered Person's Identification Card (ID) at the time of purchase and pay the required Prescription Drug Deductible, Coinsurance and/or Copayment as shown in the Schedule of Benefits.

If Prescription Drugs are purchased through the In-Network Mail Order Pharmacy, the Covered Person must provide the In-Network Mail Order Pharmacy with the completed order form, Deductible and/or Copayment amount, and the signed Physician prescription.

If Prescription Drugs are purchased at a Out-of-Network Provider Pharmacy, retail or mail order, the Covered Person must pay out-of-network coinsurance for the prescription at the time of purchase.

Brand-Generic Charge is applied if you receive a Brand name drug, regardless of reason or medical necessity, or if your provider prescribes a Brand name drug when a generic is available. A Brand-Generic Charge is the difference in cost from the Generic to the Brand name drug. This charge is added to the regular cost sharing outlined in your benefits summary. The Brand-Generic Charge does not apply towards any Deductibles or Out-of-Pocket Maximum.

THIRD PARTY PAYMENTS FOR PRESCRIPTION DRUGS

Third party service providers may not waive, rebate, give, pay or offer to waive, rebate, give or pay all of part of the Covered Person's deductible or other out of pocket costs for prescription drugs. We will accept third party payments of cost sharing from:

- A Ryan White HIV/AIDS Program
- An Indian tribe or tribal organization
- Local, state or federal government programs, including grantees directed by a government program to make payments on its behalf

We will also accept third party payments from individuals such as family and friends, religious institutions and other not-for-profit organizations when all of the following three criteria are met:

- The assistance is provided on the basis of the Covered Person's financial need
- The institution/organization is not a healthcare provider
- The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

We do not count any financially interested third party cost-sharing payments toward deductibles or out of pocket maximums. If We discover financially interested third party payments of this type after the fact and these payments have already been counted toward the deductible or out of pocket maximum, We will exclude the financially interested third party from the accumulation toward the deductible or out of pocket maximum.

Should We reject a payment from a third party, we will inform you in writing of the reason for our rejection and your right to file a complaint with the Idaho Department of Insurance.

Phenylketonuria (PKU) Coverage. Coverage will be provided for the treatment of inborn errors of metabolism: (a) that involve: (1) amino acid; (2) carbohydrate; and (3) fat metabolism; and (b) for which medically standard methods of: (1) diagnosis; (2) treatment; and (3) monitoring exist.

Coverage for PKU will include expenses of: (a) diagnosing; (b) monitoring; and (c) controlling the disorders by nutritional and medical assessment, including but not limited to: (1) clinical services; (3) biochemical analysis; (3) medical supplies; (4) prescription drugs; (5) corrective lenses for conditions related to the inborn error of metabolism; (6) nutritional management; and (7) medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

"Medical foods" means nutritional substances in any form that are: (a) formulated to be consumed or administered enterally under supervision of a physician; (b) specifically processed or formulated to be distinct in one or more nutrients present in natural food; (c) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and (d) essential to optimize growth, health, and metabolic homeostasis.

"Treatment", as used in this benefit provision, means licensed professional medical services under the supervision of a physician.

PREVENTIVE HEALTH CARE SERVICES BENEFIT

Preventive Health Care Services for health care screenings or preventive purposes submitted with a routine diagnosis will be covered at 100% of the Allowable Fee. This means that these Benefits are not subject to the Deductible, Coinsurance, Copayments, or Annual Out-of- Pocket Maximum when services are provided by an In-Network Provider. However, if Preventive Health Care Services are rendered for an established medical condition or by a Non-In-Network, the Preventive Health Care Services provided will be subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum.

Preventive Health Care Services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's current recommendations;
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention;
3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;
4. Current recommendations of the United States Preventive Service Task Force;
5. One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age;
6. A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician;
7. A mammogram every year for any woman who is fifty (50) years of age or older;
8. A mammogram for any woman desiring a mammogram for medical cause; and
9. Any other Preventive Health Care Services required by the federal Affordable Care Act.
10. A Provider recommended, medically appropriate, preventive service for an Insured person regardless of sex assigned at birth, gender identity, or gender of the Insured person otherwise recorded by Us.

Educational training for Preventive Health Care Services that is necessary and prescribed by a Physician will be covered. However, Preauthorization will be required for all prescribed educational training for Preventive Health Care services.

The following are some of the services provided under this Preventive Health Care Services Benefit. Coverage will be provided in accordance with the requirements of the federal Affordable Care Act:

1. **Blood Pressure Screening.**
2. **Breast Feeding support and supplies including a breast pump.**
3. **Cancer Screenings.** Coverage for cancer screenings includes, but is not limited to: (a) Breast Cancer Screenings (Mammograms); (b) Colorectal Cancer Screenings; (c) Prostate Cancer Screenings; and (d) any other cancer screenings required by the federal Affordable Care Act.

4. **Cholesterol Tests.**

5. **Counseling Services.** Coverage for counseling will be provided on such topics as: (a) quitting smoking; (b) losing weight; (c) eating healthfully; (d) treating depression; (e) reducing alcohol use; and (f) any other counseling services mandated by the federal Affordable Care Act.

6. **Diabetes Management and Supplies.** Coverage will be provided for Diabetes Self-Management, Equipment and Supplies. Benefits will be payable for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a Covered Provider with expertise in diabetes.

   Benefits will be provided for diabetic equipment and supplies; however, such equipment and supplies are limited to the following: (1) insulin; (2) syringes; (3) injection aids; (4) devices for self-monitoring of glucose levels (including those for the visually impaired); (5) test strips; (6) visual reading and urine test strips; (7) one insulin pump for each warranty period; (8) accessories to insulin pumps; (9) one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration; and (10) glucagon emergency kits. Diabetic equipment and supplies that are payable under the Prescription Drug Benefit will be paid under the Prescription Drug Benefit only.

7. **Flu and Pneumonia Shots.**

8. **Healthy Pregnancy Counseling.** Coverage will include, but not limited to, counseling, screening, and vaccines.

9. **Smoking/Tobacco Cessation.** Coverage will be provided for tobacco cessation interventions for Insureds who use tobacco products. Such interventions, which must be recommended by the U.S. Preventive Services Task Force (USPSTF), include:

   a. Counseling: The following counseling sessions, based on the "5-A" counseling format recommended by the USPSTF, include: (1) A brief one-time counseling session of 10 minutes; or (2) when needed, longer counseling sessions over 10 minutes or multiple counseling sessions; and (3) augmented pregnancy tailored counseling for pregnant women;

   b. Pharmacotherapy: FDA-approved pharmacotherapy, which is a combination therapy with counseling and medication, will be covered. FDA-approved pharmacotherapy includes: (1) nicotine replacement; and (2) sustained- release bupropion and varenicline.

10. **Vaccinations.** Coverage will be provided for routine vaccinations against diseases such as measles, polio, or meningitis, or other diseases specified for vaccination in the federal Affordable Care Act.

11. **Well-Baby and Well-Child Care Visits.** Coverage will be provided for regular well- baby and well-child care visits, from birth to age 19, unless otherwise stipulated in the federal Affordable Care Act. Benefits will include, but not limited to, the following: (a) a history; (b) physical examination; (c) developmental assessment; (d) anticipatory guidance; (e) laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided in the Idaho State Medicaid law; and (f) routine immunizations according to the schedule for immunizations

recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services or as recommended by the American Committee on Immunization Practices.

Services for Well-Baby and Well-Child Care:

a. Must be provided by a Physician or other Covered Provider supervised by a Physician; and

b. Will be limited to one visit payable to one provider for all of the services provided at each visit.

"Developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American Academy of Pediatrics.

For more detailed information on Preventive Health Care Services, contact Customer Service at the telephone number or website shown on page 4, *Important Information*.

PROSTHETIC DEVICES (NON-DENTAL)

Coverage will be provided for appropriate non-dental prosthetic devices used to replace a body part missing because of an Accident, Injury or Illness. Such non-dental prosthetic devices include: (1) artificial limbs; (2) eyes; or (3) other prosthetic appliances. Replacement of such devices will be covered only if: (1) functionally necessary; or (2) as required by a change in the Insured's physical structure.

When placement of a prosthesis is part of a surgical procedure, it will be paid under the Surgery Services benefit.

Payment for deluxe prosthetics and computerized limbs will be based on the Allowable Fee for a standard prosthesis.

No benefits will be paid for:

1. Computer-assisted communication devices; and
2. Replacement of lost or stolen prosthesis.

Preauthorization is recommended for the original purchase or replacement of prosthetics over $500. Please refer to Section 7, Utilization Review Management Program.

Note: The prosthesis will not be considered a replacement if the prosthesis no longer meets the medical needs of the Insured due to physical changes or a deteriorating medical condition.

RADIATION THERAPY SERVICES

Coverage will be provided for these services which include:

1. Chemotherapy used in conjunction with radiation therapy. Coverage includes the use of drugs approved for use in humans by the U.S. Food and Drug Administration (FDA);
2. X-rays;

3. Radiation therapy; and
4. Radioactive isotope therapy;

for the treatment of benign or malignant disease conditions. All Radiation Therapy Services must be prescribed by the Attending Physician and performed by a Covered Provider for the treatment of disease.

THERAPY SERVICES – FACILITY AND PROFESSIONAL SERVICES

Habilitative services are defined as health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at an expected age.

Rehabilitative services help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt of disabled.

Benefits will be payable for Rehabilitation/Habilitation Therapy and other covered services, as provided in this Covered Benefit, that are billed by a Rehabilitation/Habilitation Facility provider or a Professional Provider.

Coverage will be provided for services and devices required for rehabilitative care when prescribed by a Physician to improve, maintain or restore the Insured to the Insured's best possible physical functional level due to an Illness or Injury.

No benefits will be payable when the primary reason for Rehabilitation/Habilitation is any one of the following:

1. Custodial care;
2. Diagnostic admissions;
3. Maintenance, nonmedical self-help, or vocational educational therapy;
4. Social or cultural Rehabilitation/Habilitation;
5. Learning and developmental disabilities; and
6. Visual, speech, or auditory disorders because of learning and developmental disabilities.

Benefits will not be provided under this Rehabilitation/Habilitation benefit for treatment of

Chemical
Dependency or Mental Illness as they are provided under the *Chemical Dependency* and *Mental Illness* benefits provided under this Group Policy.

Benefits will be provided for services, supplies and other items that are within the scope of this Rehabilitation/Habilitation benefit as described in this Rehabilitation/Habilitation benefit only as provided in and subject to the terms, conditions and limitations applicable to this Rehabilitation/Habilitation benefit and other applicable terms, conditions and limitations of this Group Policy. Other Covered Benefit provisions of this Group Policy, such as but not limited to Hospital Services, do not include benefits for any services, supplies or items that are within the scope of this Rehabilitation/Habilitation benefit as provided in this

Rehabilitation/Habilitation benefit.

REHABILITATION/HABILITATION FACILITY INPATIENT CARE SERVICES BILLED BY A FACILITY PROVIDER

Benefits will be payable for the following services when the Insured receives Rehabilitation/Habilitation Inpatient Care and billed by the Rehabilitation/Habilitation Facility:

1. Room and Board Accommodations. Such room and board accommodations include, but are not limited to: (a) dietary and general; and (b) medical and Rehabilitation/Habilitation nursing services.

2. Miscellaneous Rehabilitation/Habilitation Facility Services (whether or not such services are Rehabilitation/Habilitation Therapy or are general, medical or other services provided by the Rehabilitation/Habilitation Facility during the Insured's admission), including but not limited to:

    a. Rehabilitation/Habilitation Therapy services and supplies, including but not limited to: (1) Physical Therapy; (2) Occupational Therapy; and (3) Speech Therapy.

    b. Laboratory procedures;

    c. Diagnostic testing;

    d. Pulmonary services and supplies, including but not limited to: (1) oxygen; and (2) use of equipment for its administration;

    e. X-rays and other radiology;

    f. Intravenous injections and setups for intravenous solutions;

    g. Special diets when Medically Necessary;

    h. Operating room, recovery room;

    i. Anesthetic and surgical supplies;

    j. Drugs and medicines which:

        1) Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;

        2) Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and

        3) Require a Physician's written prescription.

3. Rehabilitation/Habilitation Facility Inpatient Care Services do not include services, supplies or other items for any period during which the Insured is absent from the Rehabilitation/Habilitation Facility for purposes not related to Rehabilitation/Habilitation, including, but not limited to, intervening Inpatient admissions to an acute care Hospital. Preauthorization is recommended for Rehabilitation/Habilitation Facility Inpatient Care. Refer to Section 6, Utilization Review Management Program.

"Rehabilitation/Habilitation Facility" means a facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation/Habilitation Therapy including:

1. A facility that primarily provides Rehabilitation/Habilitation Therapy, regardless of

whether the facility is also licensed as a Hospital or other facility type;

2. A freestanding facility or facility associated with or located within a Hospital or other facility;

3. A designated Rehabilitation/Habilitation unit of a Hospital;

4. For purposes of the Rehabilitation/Habilitation Therapy Benefit, any facility providing Rehabilitation/Habilitation Therapy to an Insured, regardless of the category of facility licensure.

"Rehabilitation/Habilitation Therapy" means a specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy, and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation/Habilitation Therapy program is:

1. Provided by a Rehabilitation/Habilitation Facility in an Inpatient Care or Outpatient setting;

2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;

3. Designed to restore the patient's maximum function and independence; and

4. Medically Necessary to improve or restore bodily function and the Insured must continue to show measurable progress.

Rehabilitation/Habilitation Facility Inpatient Care is subject to the following conditions:

1. The Insured will be responsible to the Rehabilitation/Habilitation Facility for payment of the Facility's charges if the Insured remains as an Inpatient when Rehabilitation/Habilitation Facility Inpatient Care is not Medically Necessary. No benefits will be provided for a bed reserved for the Insured.

2. The term "Rehabilitation/Habilitation Facility" does not include:

    a. A Hospital when the Insured is admitted to a general medical, surgical or specialty floor or unit (other than a Rehabilitation/Habilitation unit) for acute Hospital care, even though Rehabilitation/Habilitation services are or may be provided as a part of acute care;

    b. A nursing home;

    c. A rest home;

    d. Hospice;

    e. A skilled nursing facility;

    f. A Convalescent Home;

    g. A place for care and treatment of Chemical Dependency;

    h. A place for treatment of Mental Illness; or

    i. A long-term, chronic-care institution or facility providing the type of care listed above in this subparagraph.

REHABILITATION/HABILITATION FACILITY INPATIENT CARE SERVICES BILLED BY A

PROFESSIONAL PROVIDER

Coverage will be provided for all Professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Insured's Rehabilitation/Habilitation Therapy. Such professional services include: (1) care planning and review; (2) patient visits and examinations; (3) consultation with other Physicians, nurses or staff; and (4) all other professional services provided with respect to the Insured. Professional services provided by other Covered Providers (i.e., who are not the Physician directing the Insured's Rehabilitation/Habilitation Therapy) are not included in this Rehabilitation/Habilitation benefit, but are included to the extent provided in and subject to the terms, conditions and limitations of other Covered Benefits under this Group Policy.

OUTPATIENT REHABILITATION/HABILITATION SERVICES

Coverage will be provided for Rehabilitation/Habilitation Therapy delivered on an outpatient basis by a Facility or Professional Provider.

RENAL DIALYSIS

Coverage will be provided for medically necessary care and treatment related to renal failure. Most patients with End Stage Renal Disease (ESRD) are eligible for Disability and Medicare. If You are enrolled in Medicare based on ESRD, it is illegal for Us to knowingly sell or issue an individual QHP with tax credits or individual policy to You. If You develop ESRD while a member under this Group Policy, it may be to your advantage to seek coverage through the Medicare ESRD program. You can continue this coverage as well, however it will be subject to Coordination of Benefits. (Section 7)

SKILLED NURSING SERVICES

Coverage will be provided for skilled nursing services when medically necessary to provide the most cost effective treatment of a condition and functional recovery.

SURGICAL SERVICES

Coverage will be provided for Medically Necessary surgical procedures performed by a Physician in a Hospital or a licensed surgical facility. Preauthorization is required for all surgeries.

SURGICAL SERVICES BILLED BY A PROFESSIONAL PROVIDER

Services by a professional provider for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery. The charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.

SURGICAL SERVICES BILLED BY AN OUTPATIENT SURGICAL FACILITY OR FREESTANDING SURGERYCENTERS

Services of a surgical facility or freestanding (surgery centers) licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to assure quality and appropriate patient care. The surgical procedure performed in a surgical facility or freestanding

(surgery centers) is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

This Group Policy will pay for a Recovery Care Bed when Medically Necessary and provided for less than 24 hours. Payment will not exceed the semiprivate room rate that would be billed for an Inpatient stay.

SURGICAL SERVICES BILLED BY A HOSPITAL (INPATIENT AND OUTPATIENT)

Coverage will be provided for services provided by a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or Inpatient setting, including the usual care before and after surgery.

THERAPEUTIC SERVICES – OUTPATIENT

Coverage will be provided for the following Outpatient therapeutic services: (1) Physical Therapy; (2) Speech Therapy; and (3) Occupational Therapy.

Therapeutic Services must be prescribed by a Physician. The therapist providing the services must be licensed or certified in the state in which services are provided. Preauthorization is recommended for Outpatient Therapeutic Services; refer to Section 6, *Utilization Review Management Program*.

Therapeutic Services must be to aid the Insured in the restoration of normal physical function that the Insured once had, but later lost.

TRANSPLANT BENEFITS

Transplant Benefits include:

1. Autotransplants: Autotransplants of arteries, veins, ear bones (ossicles), cartilage, muscles, skin and tendons; teeth or tooth buds:

    A. The applicable benefits provided for hospital and Surgical/Medical Services are provided only for a recipient of Medically Necessary Autotransplant services. Autologous blood transfusion, heart valves, regardless of their source; and implanting of artificial or mechanical pacemakers are not considered Transplants and are a Covered Service if Medically Necessary.

    B. No benefits are available for services, expenses, or other obligations of or for a deceased donor (even if the donor is an Insured.)

2. Transplants: Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, heart/lung and pancreas/kidney combinations:

    A. The applicable benefits provided for Hospital and Surgical/Medical Services are provided for a recipient of Medically Necessary Transplant services.

    B. Benefits for a recipient of a cornea, kidney, bone marrow, liver, heart, lung, heart/lung or pancreas/kidney combination Transplant(s) are subject to the following conditions:

        1. The Transplant must be preauthorized by Us, whether in or out of network.

2. For in-network benefits, the recipient must have the Transplant performed at an appropriate in-network Center of Excellence.
3. Members receiving a transplant from an out of network provider should review the out of network payment policy carefully, being sure to note that providers' charged amounts greater than Our Allowed Amount may be billed directly to the Member.

C. If the recipient is eligible to receive benefits for these transplant services, Organ Procurement charges are paid for the donor (even if the donor is not an Insured). Benefits for the donor will be charged to the recipient's coverage.

No benefits will be payable for:

1. Experimental or investigational procedures;
2. Transplants of a nonhuman organ or artificial organ transplant; and
3. Donor searches.

Travel benefits are only available for heart, lung, liver, kidney, pancreas, heart/lung and pancreas/kidney combinations and allogeneic bone marrow Transplant services, when traveling to and from an approved Center of Excellence.

Covered travel benefits are limited to transportation, lodging and food costs that are associated with a prior authorized organ transplant at an approved Center of Excellence.

URGENT CARE

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

If a condition requiring Urgent Care develops, We recommend that You go to the nearest In-Network Urgent Care Center or Physician's office. This treatment may be subject to a Copayment and/or Coinsurance. Examples of Urgent Care conditions include fractures, lacerations, or severe abdominal pain.

VISION EXAM

Your plan providers up to a $60 reimbursement towards one routine vision examination per enrollee each Policy Year. Any licensed optometrist or ophthalmologist may be used. This allowance may be used towards the following services routine eye exam services:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular function testing
- Routine tests of color vision, peripheral vision, and intraocular pressure
- Case history, recommendations, and prescriptions

LENSES: no benefits for contact lenses, eyeglass lenses, or frames are available with this benefit.

For instructions on how to be reimbursed for this benefit, please visit our website at https://www.mhc.coop/members/forms/

WELL-CHILD CARE

Coverage will be provided for Well-Child Care for Insured Dependent Children under age nineteen (19) provided by a Physician or a health care professional supervised by a Physician. Coverage will include the following:

1. Histories;
2. Physical examinations;
3. Developmental assessments;
4. Anticipatory guidance;
5. Laboratory tests; and
6. Routine immunizations.

WELLNESS SERVICES

Coverage for Wellness Services are listed under Preventive Services.

SECTION 6—UTILIZATION REVIEW MANAGEMENT PROGRAM

Our Utilization Review Management Program is administered by U of U Health Plans. Our Utilization Review Management Program provides for Prospective Utilization Review to assure that certain prescribed Treatments and elective procedures are Medically Necessary and appropriate.

Prospective Utilization Review requires the Insured to obtain Preauthorization for certain prescribed Treatments and elective procedures before the Treatments and procedures are rendered. Prior Authorization is a request by the Insured's In-Network Provider to Us, for authorization of an Insured's proposed treatment. We may review medical records, test results and other sources of information to ensure that the proposed treatment is a Covered Benefit and make a determination as to medical necessity or alternative treatments. The insured cannot be held liable if the participating provider fails to obtain prior authorization.

The Insured is financially responsible for non-medically necessary services provided by an Out-of-Network Provider. The Insured can be penalized if the non-participating provider does not obtain prior authorization.

HOW TO USE THE UTILIZATION REVIEW PROGRAM

To use the Utilization Review Management Program, the Insured need only to call the Customer Service toll-free telephone number listed on page 4, Important Information. The Insured may have the Insured's representative place the call. A representative may be the Physician, the Covered Facility, or the Insured's authorized representative (e.g., family member). The Utilization Review Management Program representative will give the individual who calls a reference number to verify that the call has been received and a file started.

The individual who calls the Utilization Review Management Program will need to provide the following information:

1. The name and member number of the Insured for whom Treatment has been prescribed and requires Preauthorization;
2. The name and telephone number of the attending Physician;
3. The name of the Covered Facility where the Insured will be admitted, if applicable;
4. The proposed date of admission, if applicable; and
5. The proposed Treatment.

PLEASE NOTE: Authorization by the Utilization Review Management Program representative does not verify an Insured's eligibility for coverage under this Group Policy, nor is it a guarantee that benefits will be paid for a proposed Treatment. Benefit payment will be made for an Insured only in accordance with all the terms and conditions of this Group Policy.

This Utilization Review Management Program does not include routine claim administration.

UTILIZATION REVIEW DEADLINES

- For prospective determinations (service not yet occurred): fifteen (15) days;
- For retrospective determinations (service has already occurred): thirty (30) days;
- For expedited determinations (urgent care): as soon as possible (72-hour maximum)

The insurer may seek a 15-day deadline extension for prospective and retrospective determinations.

PLAN NOTIFICATION

Plan Notification is recommended for any Inpatient admission, including admissions to a Hospital, Chemical Dependency Treatment Center, Mental Illness Treatment Center, Chemical Dependency or psychiatric residential treatment facility, intensive Outpatient programs, or other medical procedures or services, (or as may be noted for a Covered Benefit), as soon as the Covered Provider recommends or schedules to allow the Utilization Review Management Program to begin working with the Covered Person on the benefit management for the service. Plan Notification requires contacting the Utilization Review Management Program in writing or by telephone. Contact information can be found on our website at https://www.mhc.coop/providers/provider-login/

MEDICAL TREATMENTS REQUIRING PREAUTHORIZATION

Preauthorization must be obtained for:

1. Benefits that specify that Preauthorization is required; and
2. Procedures listed in the Preauthorization Medical Treatments List.

To request a preauthorization Covered Person or Covered Person's provider must call the Preauthorization phone number provided on the website. Preauthorization does not guarantee that services/supplies/medications Covered Person receives are Covered Medical Expenses or that those medical expenses will be paid.

PREAUTHORIZATION MEDICAL TREATMENT LIST

Prior authorization is prior approval from for certain Services and is considered a Preservice Claim. Prior authorization is not required when your plan is secondary to another primary commercial and documentation of primary coverage is verified.

Prior authorization is required for injectable drugs and inpatient services when Medicare is your primary insurance.

Obtaining Preauthorization does not guarantee coverage. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan.

General Services Requiring Prior Authorization

The following services require prior authorization for elective circumstances; notification is required for urgent /emergent circumstances within 24 hours of admission or provision of the service. These include:

- Inpatient Acute Care Hospitals
- Observation stays, Acute Care Hospitals
- Long-Term Acute Care Hospitals
- Inpatient Behavioral Health and Substance Use
- Inpatient Hospice
- Acute Rehabilitation
- Skilled Nursing Facility
- Home Health/Outpatient Hospice Services
- Air Medical Transport

Specific Services Requiring Prior Authorization

In addition to general Services requiring prior authorization certain procedures and specific Services may also require prior authorization in addition to the general authorizations above. The following partial list of Services requiring prior authorization for coverage is outlined below. This list reflects some Services which may be covered if prior authorization is obtained. A full list of these services can be found at https://uhealthplan.utah.edu/for-providers/pdf/medical-pa-list-12-31-19.pdf.
Common Services Requiring Prior Authorization

- Durable medical equipment with total price or individual components exceed $1000.00
- Gender Reassignment Surgery
- Certain Genetic Tests or Therapies
- Certain outpatient behavioral health services
- Joint Replacement Procedures
- Certain Arthroscopic Procedures
- Spine Surgeries
- Certain Diagnostic and Therapeutic Cardiac Procedures
- Certain Medical Drugs, a full list can be found at https://uhealthplan.utah.edu/for-providers/pdf/pharmacy/commercial-individual-mhc-website-list-1-01-20-.pdf
- Proton/Neutron Beam/Stereotactic Radiosurgery Therapy
- Neurostimulation
- Out-of-Network Services
- Reconstructive/Cosmetic Surgeries
- Solid organ and Stem Cell Transplants and associated services

This list does not reflect those services which are excluded from coverage due to benefit exclusion or not covered as they are considered investigational.

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UTILIZATION REVIEW PROCESS

When the Utilization Review Management Program representative conducts Utilization Reviews, the Utilization Review will include the following:

UTILIZATION REVIEW FOR MENTAL HEALTH TREATMENT

When Utilization Review is conducted for outpatient mental health Treatment, the Utilization Review Management Program representative will only request information that is relevant to the payment of the claim.

DISCLSOURE OF PERSONAL INFORMATION

When a Utilization Review requires disclosure of personal information regarding the patient or client, including:

1. Personal and family history; or
2. Current and past diagnosis of a mental disorder;

the Utilization Review Management Program representative will conceal the identity of that individual from anyone having access to that information in order that the patient or client may remain anonymous.

DETERMINATIONS MADE ON APPEAL OR RECONSIDERATION

An Utilization Review determination that is:

1. Made on appeal or reconsideration; and
2. Adverse to a patient or to an affected health care provider;

may not be made on a question relating to the necessity or appropriateness of a health care Treatment without prior written findings, evaluation, and concurrence in the Adverse Determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence will be provided to the patient upon the Insured's written request to the Utilization Review Management Program within thirty (30) days of determination.

A determination made on appeal or reconsideration that health care Treatment rendered or to be rendered is medically inappropriate may not be made unless the health care professional performing the utilization review has made a reasonable attempt to consult with the patient's attending health care provider concerning the necessity or appropriateness of the health care Treatment.

Also, refer to the Complaints, Grievances and Appeals provision, in Section 9, regarding appeals for adverse determinations.

SECTION 7—COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when the Insured has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. 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 and nongroup insurance contracts and subscriber contracts; uninsured group or group-type coverage arrangements; group and nongroup coverage through closed panel plans; group-type contracts; the medical care components of long-term care contracts, such as skilled nursing care; Medicare or other governmental benefits, except as provided in Section 7, Paragraph (A) (2) below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; the medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts. No plan is required to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it shall do so in compliance with the provisions of this chapter.

2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage as defined in IDAPA 18.01.30, "Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule," Sections 012 and 029; school accident type coverage, such as contracts that cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis; benefits provided in long-term care insurance policies for non-medical service; Medicare supplement policies; a state plan under Medicaid; or a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan

Each contract for coverage under (1) or (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. "This Plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is Primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that This Plan does not make payments that would exceed 100% of this Plan's total Allowable expense.

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

The following are examples of expenses that are not Allowable expenses:

1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3) If a person is covered by two 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.

4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

5) The amount of any benefit reduction by the Primary Plan because an Insured has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and In-Network arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Insureds primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Policy Year excluding any temporary visitation.

Coordination with Medicare

In the event the Insured have Medicare coverage and to the extent Medicare pays for benefits, any benefits paid under Medicare will be determined **before** benefits are paid under this contract or Group Policy. Therefore, the benefits under this contract or Group Policy are **secondary** to Medicare. In the event Medicare does not pay benefits, then this contract or Group Policy will pay benefits as **primary**. Please note that the combined payments made by Medicare and this plan will not exceed the maximum allowance of the primary payer for the covered services provided to the member.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

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

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or

retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

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

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

i. The Plan of the parent whose birthday falls earlier in the Policy Year is the Primary Plan; or

ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

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

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

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

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

c. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of (a) or (b) above shall determine the order of benefits as if those individuals were the parents of

the child.

3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid- off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

4) COBRA. If a person whose coverage is provided pursuant to COBRA is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA is the Secondary Plan. If the other
Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.

5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If an Insured 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.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Our Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Our Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Our Claims Administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

SECTION 8—EXCLUSIONS AND LIMITATIONS

All benefits provided under this Group Policy are subject to the exclusions and limitations in this Section and as stated under Section 5, Covered Benefits. No benefits will be paid under this Group Policy that are incurred by or results from any of the following:

1. Inpatient or Outpatient custodial care, rest cures, or transportation if not medically necessary;

2. Any condition, disease, illness or accidental injury to the extent that the Insured is entitled to benefits under occupational coverage provided through an employer, or under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries, conditions, or occupational disease. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party;

3. War, or act of war, whether declared or not, riot, or insurrection;

4. Service in the Armed Forces or any auxiliary units of the Armed Forces;

5. Vision services, including, but not limited to, (a) fitting of eyeglasses or contact lenses; (b) purchase of eyeglasses and contact lenses; (c) Lasik surgery; or (d) radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism). This exclusion does not apply to the Pediatric Vision Care benefit provided under this Group Policy or to the preventive eye exam benefit, if any, provided under this Group Policy;

6. Hearing aids and examinations for the prescription or fitting of hearing aids except as specified as a Covered Service in the Contract. This exclusion does not apply to Covered Pediatric Care;

7. Cosmetic Surgery - Surgery primarily for the purpose of improving appearance, except for reconstructive surgery. Such reconstructive surgery must be: (a) incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; or (b) because of congenital disease or anomaly of a covered Dependent Child;

8. Services, supplies, drugs and devices for the treatment of illness, injury, or complications, resulting from services that are not Covered Benefits, except for any services, supplies, drugs and devices which are incurred in connection with an Approved Clinical Trial;

9. For cosmetic foot care, and other foot care including but not limited to, treatment of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain and toenails (except for surgical care of ingrown or diseased toenails);

10. Foot orthotic appliance provided for the treatment of any medical condition;

11. Treatment for infertility and fertilization procedures, including, but not limited to, ovulation induction procedure and pharmaceuticals, artificial insemination, invitro fertilization, embryo transfer or similar procedures, including but not limited to laboratory services, radiology services or similar services, drugs or devices related to treatment for fertility or fertilization procedures;

12. Any injury incurred while committing a felony;

13. Treatment provided in a government hospital, except Idaho residents who are confined in state medical institutions; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law;

14. Behavioral Health and Substance Abuse or Addiction services and treatments not recognized by the American Psychiatric and American Psychological Association

15. Services performed by You or a member of Your Immediate Family;

16. Services for which there is no legal obligation for the Insured to pay or for which no charge would be made if insurance did not exist, unless such charge is regularly and customarily made in similar amount by the provider of such to other non-indigent patients, or unless, in either case, We are required by law to pay to the Government of the United States;

17. Nonsurgical Treatment for malocclusion of the jaw, including services for anterior or internal dislocation, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances;

18. Unless otherwise included under this Group Policy as a Covered Benefit, dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;

19. Private duty nursing;

20. Reversal of an elective sterilization;

21. Transplants of a non-human organ or artificial organ transplant;

22. Any services, supplies, drugs and devices which are: (a) investigational/Experimental Service/Technology; (b) not accepted medical practice; (c) not a Covered Medical Expense; (d) not Medically Necessary and (e) not covered under Medical Policy. We may consult with Physicians or national medical specialty organizations for advice determining whether the service or supply is accepted medical practice; Medical necessity is determined by using internal policies which can be found here: https://www.mhc.coop/Idaho/providers/policies/

23. For travel by the Insured or a provider, except as allowed under this Policy;

24. Orthodontics;

25. Services, supplies and devices relating to any of the following treatments or related

procedures: a) acupressure; (b) homeotherapy; (c) rolfing; (d) holistic medicine; (e) marriage counseling; (f) religious counseling; (g) self-help programs; or (h) stress management;

26. Vitamins. NOTE: Certain vitamins may be covered for specific conditions in accordance withMedical Policy;

27. Food supplements and/or medical foods, except when used for Inborn Errors of Metabolism or Enteral Nutrition services as defined in the Medial Policy;

28. Surgery for weight control or treatment of obesity or morbid obesity, except that services to treat medical conditions such as diabetes, high blood pressure, etc., related to obesity are covered;

29. Reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition;

30. Education services, unless otherwise specified as a Covered Benefit, or tutoring services;

31. Any services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature;

32. Non-medically necessary durable medical equipment, communication devices and prosthetic limbs;

33. Elective abortions except if recommended by a consulting physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape, as defined in section 18-6101, Idaho Code, or incest as determined by the courts; or

34. For any of the following:

    a. Appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Policy;
    b. Orthognathic surgery, including services and supplies to augment or reduce the upper or lower jaw;
    c. Implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
    d. Alveolectomy or alveoloplasty when related to tooth extraction
    e. Continuous passive motion devices
    f. TENS units.

35. Services, supplies, drugs or devices provided before the Policy Effective Date of coverage or after the termination of coverage except for individuals that are deemed totally disabled at the date of discontinuation of this policy.

36. Charges associated with health clubs.

37. Any service, supply, drug, device or medical expense not provided by a Covered Provider.

38. Non-Emergent Services, supplies, drugs, devices or medical expense provided outside the United States.

39. Surrogacy

40. Services, supplies, drugs, devices or medical expenses not submitted within twelve (12) months after received or provided.

41. Services, supplies, drugs, devices or medical expenses which are not Covered Benefits, not Covered Medical Expenses, or for which benefit maximums have been reached.

SECTION 9—CLAIM PROVISIONS

No claims have to be submitted by the Insured when services are provided by an In-Network Provider. However, the Insured will need to submit a claim to Our Claims Administrator for reimbursement considerations when the Insured receives services from an Out-of-Network Provider.

HOW TO FILE A CLAIM

When a Covered Person receives services from of an In-Network, no claim form is required to be submitted to Us. However, if the Covered Person uses the services of a Out-of-Network, the Covered Person should file a claim with Us only if the Out-of-Network Provider does not file one for the Covered Person. Instructions on how to file a claim are found on our website at https://www.mhc.coop/members/forms/

In-Network Providers will automatically file a claim directly to Us on behalf of the Covered Person for whom they provide services. Therefore, the Covered Person is not required to complete and submit a claim to Us.

NOTICE OF CLAIM

Written notice of claim must be given to Us within twelve (12) months after the occurrence or commencement of any loss covered by this Group Policy or as soon after that date as is reasonably possible. Notice given by or on behalf of the Insured or the beneficiary to Us at Our Claims Administration office address shown under *Important Information*.

CLAIM FORMS

We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss upon request. You can also receive such form by visiting our website at https://www.mhc.coop/members/forms/

PROOF OF LOSS

Written proof of loss must be furnished to Us at Our Claims Administrator's address is shown

on page 4, *Important Information*, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

TIMELY PAYMENT OF CLAIMS

Benefits payable under this Group Policy for any covered loss will be processed as outlines in this section.

Timely Settlement of Claims

We will pay or deny a claim within thirty (30) days after receipt of a proof of loss unless We make a reasonable request for additional information or documents in order to evaluate the claim. If We make a reasonable request for additional information or documents, We will pay or deny the claim within sixty (60) days of receiving the proof of loss unless We have notified You, Your assignee, or the claimant of the reasons for failure to pay the claim in full or unless We have a reasonable belief that insurance fraud has been committed and We have reported the possible insurance fraud to the Director of Insurance. We will have the right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

If We fail to comply with the above provision and We may be liable for payment of the claim, We will pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim payment was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after Our receipt of the proof of loss or 60 days
after receipt of the proof of loss if We made a reasonable request for information or documents. Interest payments must be made to the person who receives the claim payment. Interest is payable under this provision only if the amount of interest due on a claim exceeds $5.

PAYMENT OF CLAIMS

Benefits payable under this Group Policy will be paid to the Insured.

If any benefit payable under this Group Policy is payable to the estate of the Insured or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such benefits, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by Us to be equitably entitled to such benefit payment. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

PHYSICAL EXAMINATIONS AND AUTOPSY

We, at Our own expense, will have the right and opportunity to examine the person of the Insured when and as often as We may reasonably require during the pendency of a claim under this Group Policy and to make an autopsy in case of death where it is not forbidden by law.

RIGHT TO RECOVER

After We pay any claim under this Group Policy, We have the right to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim within twelve (12) months. The twelve (12)-month period for Our review or audit will not begin until:

We have actual knowledge of:

a. An invalid claim;
b. Claim overpayment; or
c. Other incorrect payment if We have paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person; and

However, We may perform a review or audit to reconsider the validity of a claim and may request reimbursement for an invalid or overpaid claim in a time period greater than 12 months from the date upon which We received notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by:

1. Medicare;
2. A workers' compensation insurer;
3. Another health insurance issuer or group health plan;
4. A liable or potentially liable third party; or
5. A health insurance issuer that is domiciled in a state other than Idaho under an agreement among plans operating in different states when the agreement provides for payment by the Idaho health insurance issuer as host plan to Idaho providers for services provided to an individual under a plan issued outside of the state of Idaho.

SUBROGATION

We will be entitled to subrogate against a judgment or recovery received by the Insured from a third party found liable for a wrongful act or omission that caused the Injury necessitating benefit payment under this Group Policy. Such subrogation will be to the extent necessary for reimbursement of benefits paid under this Group Policy to or on behalf of the Insured.

The Insured will be required to furnish any necessary information and complete documents needed by Us in order to enforce the right to subrogation. Further, the Insured cannot take any action that would prevent Us from pursuing this right of subrogation.

Third-Party Liability Provision

If You intend to institute an action for damages against a third party, You must give Us reasonable notice of Your intention to institute the action.

You may request that We pay a proportionate share of the reasonable costs of the third-party action, including attorney fees. However, We may elect not to participate in the cost of the action. If We make an election to participate, We will waive 50% of any subrogation rights granted to Us in accordance with Idaho state law.

Our right of subrogation may not be enforced until the Injured Insured has been fully compensated for the Insured's injuries.

SECTION 10—COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS AND GRIEVANCES

We, Mountain Health CO-OP, have established a Complaint and Grievance process. We contract with U of U Health Plans Health Plans, Inc., whose contact information appears on page 5, *Important Information*, to process claims, handle complaints, grievances and appeals on Our behalf through U of U Health Plans Customer Service and the U of U Health Plans Appeals and Grievances Department, respectively. A complaint involves a communication from the Insured expressing discontent or dissatisfaction with services. A grievance is the same as an appeal.

If the Insured has a complaint, the Insured may call the U of U Customer Service at the telephone number which appears on page 5, *Important Information*. The U of U Health Plans Customer Service representative will make every effort to resolve the issue within one (1) business day. If more time is needed, to resolve the matter, the U of U Customer Service representative will notify the Insured of the extended time needed to respond.

The Insured may also file a written complaint. The mailing address of U of U Health Plans Customer Service appears on page 4, *Important Information*. The Insured will be notified of the response to or resolution of this matter within thirty (30) days of the Insured's written complaint.

CLAIMS PROCEDURES

A "Claim" is any request for a Group Policy benefit or benefits made for an Insured in accordance with this Group Policy's claims procedure. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these procedures.

The initial benefit claim determination notice will be included in the Insured's explanation of benefits (EOB) or in a letter from Us. Written notification will be provided whether or not the decision is adverse.

The Insured becomes a "Claimant" when the Insured makes a request for a benefit or benefits in accordance with this Group Policy's claims procedures.

An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these claims procedures only if an Appointment of Authorized Representative form, which appoints an authorized representative, is completed by the member.

An Appointment of Authorized Representative form may be obtained from, and completed forms must be submitted to the U of U Customer Service Department at the address listed on page 4, *Important Information*. An assignment for purposes of payment does not constitute appointment of an authorized representative under these claims procedures. Once an Authorized Representative is appointed, then We will direct all information, notification, etc., regarding the claim to the authorized representative. The Claimant will be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise.

Any reference in these claims procedures to Claimant is intended to include the authorized representative of such Claimant appointed in compliance with the above procedures.

NOTIFICATION OF ADVERSE CLAIM DETERMINATION

1. Adverse benefit determination on a claim is "adverse" if it is: (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Policy benefit.
2. Notification of adverse benefit determination, in writing, will be provided to the Claimant of the adverse benefit determination on a claim and will include the following, in a manner calculated to be understood by the Claimant:
    a. A statement of the specific reason(s) for the decision. If the adverse benefit determination is fraud, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;
    b. Reference(s) to the specific Policy provision(s) on which the decision is based;
    c. If applicable, a description of any additional material or information necessary to perfect the claim and why such information is necessary;
    d. A description of this Group Policy's procedures and time limits for appeal of the decision, and the right to obtain information about those procedures, contact information for a consumer appeal assistance program, and if applicable, a statement of the right to sue in federal court;
    e. If applicable, a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
    f. If the decision involves scientific or clinical judgment, either: (a) an explanation of the scientific or clinical judgment applying the terms of the Group Policy to the Claimant's medical circumstances; or (b) a statement that such explanation will be provided at no charge upon request;

g. In the case of an urgent care claim, an explanation of the expedited review methods available for such claims, and

h. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

Notification of the adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

YOUR RIGHT TO APPEAL

An Insured has a right to appeal an adverse benefit determination under these claims procedures.

1. **How to File an Appeal.** If a Claimant disagrees with an adverse benefit determination, the Claimant (or authorized representative) may appeal the decision within 180 days from receipt of the adverse benefit determination. The appeal may be made in writing or over the telephone, and should list the reasons the Claimant does not agree with the adverse benefit determination, may include additional medical documentation, and must be sent to the address given for the U of U Health Plans Appeals and Grievances Department. If the Claimant (or authorized representative) is appealing over the telephone, the Claimant should call the telephone number listed on the inside cover of this Policy.

   The Claimant may ask for Request for Review forms which may be obtained by contacting the U of U Health Plans Appeals and Grievances Department. A Request for Review form or a written appeal will be treated as received by the U of U Health Plans Appeals and Grievances Department (a) on the date it is hand-delivered to the above address and room; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on any such envelope will be proof the date of mailing. Written appeals must be sent to the U of U Health Plans Appeals and Grievances Department address shown on page 5.

2. **Access to Documents.** The Claimant will, on request and free of charge, be given reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit determination, the names of each such expert will be provided on request by the Claimant, regardless of whether the advice was relied on by Us.

3. **Submission of Comments.** A Claimant has the right to submit documents, written comments, or other information in support of an appeal.

4. **Important Appeal Deadline.** The appeal of an adverse benefit determination must be filed within 180 days following the Claimant's receipt of the notification of adverse benefit determination. Failure to comply with this important deadline may cause a Claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

5. **Urgent Treatment Care Appeals.** In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to the U of U Health Plans Appeals and Grievances Department by mail or telephone; refer to page 5, *Important Information*, for contact information. The claim should include at least the following information:

a. The identity of the Claimant;

b. A specific medical condition or symptom;

c. A specific treatment, service, or product for which approval or payment is requested; and

d. Any reasons why the appeal should be processed on a more expedited basis.

6. **Evidence Consideration.** The review of the claim on appeal will take into account all evidence, testimony, new and additional records, documents or other information the Claimant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

   If the U of U Health Plans Grievances and Appeals Department considers, relies on or generates new or additional evidence in connection with its review of the claim, it will provide the Claimant with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the U of U Health Plans Grievances and Appeals Department. If the U of U Health Plans Grievances and Appeals Department relies on new or additional reasons in denying the Claimant's claim on review, the U of U Health Plans Appeals and Grievances Department will provide the Claimant with the new or additional reasons as soon as possible and with sufficient time to respond before a final determination is required to be provided by the U of U Health Plans Appeals and Grievances Department.

7. **Scope of Review.** The person who reviews and decides the Claimant's appeal will be a different individual than the person who decided the initial adverse benefit determination and will not be a subordinate of the person who made the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The U of U Health Plans Appeals and Grievances Department will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

8. **Medical Professionals.** In the event that a claim is denied on the grounds of medical judgment, the U of U Health Plans Appeals and Grievances Department will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same person who was consulted, if any, regarding the initial benefit determination or a subordinate of that person.

TIME PERIOD FOR NOTIFICATION OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATIONS

1. **Urgent Treatment Care Claims.** Urgent Care Claims Appeals will be completed as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt by the U of U Health Plans Appeals and Grievances Department of the written appeal or completed Request for Review form. The U of U Health Plans Appeals and Grievances Department will notify the Claimant and/or the Insured's Authorized Representative verbally and provide a follow-up written notice no later than seventy-two (72) hours after receipt of the appeal request.

   "Urgent Care Claim" is a claim for medical care to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that

cannot be adequately managed without the care that is the subject of the claim. If the treating Physician determines the claim is "urgent," the Plan must treat the claim as urgent.

2. **Post-Service Claims.** The appeal of a post-service claim will be decided within a reasonable period but no later than sixty (60) days after receipt by the U of U Health Plans Appeals and Grievance Department of the written appeal or completed Request for Review form.

   "Post-Service Claim" is a claim that involves consideration of payment or reimbursement of costs for medical care that has already been provided).

3. **Concurrent Care Claims.** The appeal of a decision to reduce or terminate an initially approved course of treatment will be decided before the proposed reduction or termination takes place. The U of U Health Plans Appeals and Grievances Department will decide the appeal of a denied request to extend any concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

"Concurrent Care" is when the Claimant has more than one medical condition existing and more than one Physician actively treats the condition related to their expertise, each physician can demonstrate medical necessity, and the treatments are provided on the same date(s). For example, an orthopedic surgeon cares for the patient's fracture while the hospitalist oversees diabetes and hypertension management.

NOTIFICATION OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

1. If the decision on appeal upholds, in whole or in part, the initial adverse benefit determination, the final internal adverse benefit determination notice will be provided, in writing, to the Claimant and will include the following, written in a manner calculated to be understood by the Claimant:

   a. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds,the notice will include: (1) the basis for the fraud; or (2) intentional misrepresentation of a material fact;

   b. A reference to the specific Policy provision(s) on which the decision is based, including identification of any standard relied upon in this Group Policy to deny the claim (such as a medical necessity standard), on which the final internal adverse benefit determination is based;

   c. If applicable, a statement describing the Claimant's right to request an external review and the time limits for requesting an external review;

   d. If applicable, a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the final internal adverse benefit determination (or a statement that such information will be provided free of charge upon request);

   e. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a medical necessity or an experimental treatment or similar exclusion or limitation as applied to the claimant's medical circumstances; or a statement that such explanation will be provided at no charge on request;

   f. Contact information for a consumer appeal assistance program and a statement of the claimant's right to file a civil action under Section 502(a) of ERISA; and

g. A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination.

Notification of an adverse decision on appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

EXTERNAL REVIEW PROCEDURES

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with us. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on us. You will have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity only if your claim is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final Adverse Benefit Determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- Our determination that your health care service or supply was Investigational.

For purposes of the External Review the following definitions will be used:

Medically Necessary or **Medical Necessity** means treatment, services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of an Insured's Illness, Injury, or medical condition according to accepted standards of medical practice.

(a) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Insured's illness, injury or disease;
(b) Not primarily for the convenience of the Insured, physician or other health care provider; and
(c) Not more costly than an alternative service or sequence of services or supply, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Insured's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible medical or scientific evidence.

Investigational/Experimental Service

Any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by Us, it fails to meet any one of the following criteria:

(a) The service/technology has final approval from the appropriate government regulatory bodies;
(b) Medical or scientific evidence regarding the service/technology is sufficiently comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the service/technology;
(c) The service/technology's overall beneficial effects on health outweigh the overall harmful effects on health;
(d) The service/technology is as beneficial as any established alternative.

When used under the usual conditions of medical practice, the service/technology should be

reasonably expected to satisfy the criteria of paragraphs (c) and (d) of this subsection; and

(e) The service/technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

If a service/technology is determined to be investigational, all services associated with the service/technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

You must first exhaust our internal grievance and appeals process. Exhaustion of that process includes completing all levels of appeal or, unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed the appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the time if your request qualifies as an "urgent treatment request" defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St. 3rd Floor
Boise, ID 83720-0043

For more information and for an external review request form:

- See the Idaho Department of Insurance web site, www.doi.idaho.gov, or
- Call the Department of Insurance at (208) 334-4250, or toll-free in Idaho at 1-800-721-3272

You may represent yourself in the request or name another person, including your treatment health care Provider, to act as your authorized representative. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The Department of Insurance will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final Adverse Benefit Determination will be reviewed by an independent review organization selected by the Department of Insurance. We will pay the costs of the review.

STANDARD EXTERNAL REVIEW

You must file a written external review request with the Department of Insurance within four months after the date we issue a final notice of denial.

1. Within seven days after the Department of Insurance receives your request, the Department of Insurance will send a copy to us.

2. Within 14 days after we receive your request from the Department of Insurance, we will

determine if the request is eligible. Within five business days after we complete that review, we will notify you and the Department of Insurance in writing if the request is eligible or what additional information is needed. If we deny your request for review, you may appeal that determination to the Department of Insurance.

3. If your request is eligible for review, the Department of Insurance will assign an independent review organization to your review within seven days of receipt of our notice. The Department of Insurance will also notify you in writing.

4. Within seven days of the date you receive the Department of Insurance notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization for consideration.

5. The independent review organization must provide written notice of its decision to you, us, and the Department of Insurance within 42 days after receipt of an external review request.

EXPEDITED EXTERNAL REVIEW REQUEST

You may file a written "urgent treatment request" with the Department of Insurance for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent treatment request" means a claim relating to an admission, availability of care, continued stay or health care service for which the Insured received emergency service but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize your life or health or your ability to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The Department of Insurance will send your request to us. We will determine, within two full business days, if your request is eligible for review. We will notify you and the Department of Insurance no later than one business day if your request is eligible. If we deny your request for review, you may appeal that determination to the Department of Insurance.

If your request is eligible for review, the Department of Insurance will assign an independent review organization to your review upon receipt of our notice. The Department of Insurance will also notify you. The independent review organization must provide notice of its decision to you, us, and the Department of Insurance within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will, not later than one business day after receiving notice of the decision, notify you and the Department of Insurance of our intent to pay the covered benefit.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on

us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration, or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

SECTION 11—GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Group Policy, including the application, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Group Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this Group Policy or to waive any of its provisions.

MISSTATEMENT OF AGE

If the age of the Insured has been misstated, all amounts payable under this Group Policy will be such as the premium paid would have purchased at the correct age.

REPRESENTATIONS

In the absence of fraud, any statement made by the Insured will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed application.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the date of issue of this Group Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this Group Policy will be used to void this Group Policy or to deny a claim for loss incurred or disability (as defined in this Group Policy) commencing after the expiration of such two-year period.

No claim for loss incurred or disability (as defined in this Group Policy) commencing after two (2) years from the date of issue of this Group Policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Group Policy.

CHANGE OF BENEFICIARY

Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the Insured. The consent of the beneficiary or beneficiaries will not be requisite to surrender or assignment of this Group Policy, or to any change of beneficiary or beneficiaries, or to any other changes in this Group Policy.

ASSIGNMENT

Covered Person may not assign any rights they may have under this Policy. No person, other than a Covered Person, is entitled to Covered Benefits under this Contract. This Contract is not assignable or transferable to any other person.

LEGAL ACTIONS

No action of law or equity will be brought to recover on this Group Policy prior to the expiration

of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Group Policy. No such action will be brought after the expiration of 3 years after the written proof of loss is required to be furnished.

NONPARTICIPATING

This Group Policy does not share in any distribution of surplus. No dividends are payable.

CHOICE OF LAW

This Contract will be administered under the laws of the State of Idaho. Any provision of this Contract that is not in conformity with applicable law or regulation in the State of Idaho shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of the State of Idaho.

Rescission

This Policy is subject to rescission if a Covered Person commits an act or omission that constitutes fraud or intentional misrepresentation of a material fact.

Validity of Contract

This Policy shall not be rendered invalid if any provision is held by a court to be illegal or in conflict with applicable law but this Policy shall be construed without the invalid provision.

Benefit Discretion

We may agree, at our sole discretion, to make payments for services, supplies, drugs , devices or medical expenses which are not listed as Covered Benefits in order to provide quality care at a lesser cost.

In-Network Providers

In-Network Providers are independent contractors and We are not responsible for any of In-Network Providers' actions or omissions.

Notices

We will send notices required by this Policy using the United States mail, postage prepaid. Notices will be mailed to the address appearing on our records. Covered Person must send notices to Us at the address listed on our website, https://www.mhc.coop/what-is-mhc/contact/. Any required time periods will be measured from the date the notice was mailed.

Term

The term of this Policy is set in the schedule of benefits.