P67471

03/01/2008

GROUP POLICY FOR:

PICKERING ASSOCIATES, INC.

ALL MEMBERS
Group Medical Preferred Provider Organization (PPO) Insurance

Print Date: 02/21/2008

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CHANGE NO. --5-- AMENDMENT TO BE ATTACHED TO AND MADE A PART OF PRINCIPAL LIFE INSURANCE COMPANY GROUP POLICY NO. GME P67471 ISSUED TO

PICKERING ASSOCIATES, INC.

It is agreed that the above Group Policy be amended effective as of March 1, 2008, by striking all pages and replacing such pages with the following updated Group Policy.

The effect of this change is to completely replace the documentation of the contract between the above-named Policyholder and The Principal. Therefore, as of the effective date of this change, all prior versions of that documentation are null and void. This change is not intended to renew the contract between the Policyholder and The Principal in any way which affects the time limits of the coverages or limitations as stated in the original documentation.

The provisions and conditions set forth on any attached page are part of this Amendment the same as if set forth above.

This Amendment will become effective as a Written agreement between The Principal and the Policyholder on the first premium due date following the effective date shown above for which premium due under this Group Policy is received by The Principal.

Executed by The Principal as of February 20, 2008.

Joyce N. Hoffman
Senior Vice President and Corporate Secretary

Larry Zimpleman
President and Chief Operating Officer

Countersigned:

Director, Group Compliance

Executed by the Policyholder as of _____.

PICKERING ASSOCIATES, INC.

By: _____

Title: _____

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POLICY RIDER AMENDMENT

GROUP INSURANCE

POLICY NO: P67471

COVERAGE: Medical Expense

EMPLOYER: PICKERING ASSOCIATES, INC.

FIRST:

a. It is agreed that the above Group Policy be amended, effective as of March 1, 2008, by striking Article 5 (a) and replacing such Article 5 (a) with the following updated Group Policy form, GC 5022, PART IV - Benefits, Section B1 (2) - Prescription Drugs Expense Insurance:

Prescription Drugs Covered Charges will include charges for:

a. the following diabetic supplies:

(1) insulin and other antihyperglycemic medications for the treatment of diabetes; and
(2) disposable insulin needles/syringes; and
(3) disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, and Clinitest tablets); and
(4) lancets; and
(5) glucometers (limited to no more than one each calendar year); and
(6) alcohol swabs; and

b. It is agreed that the above Group Policy be amended, effective as of March 1, 2008, by striking Article 6 Definition of "Maintenance Drugs and Medicines" and replacing such Article 6 Definition of "Maintenance Drugs and Medicines" with the following updated Group Policy form, GC 5022, PART IV - Benefits, Section B1 (2) - Prescription Drugs Expense Insurance:

"Maintenance Drugs and Medicines" mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina), diabetes (including, diabetic supplies, e.g., insulin and other antihyperglycemic medications for the treatment of diabetes, disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets, glucometers (limited to one each calendar year) and alcohol swabs), hypertension; glaucoma; thyroid disease; seizure disorders; hyperlipidemia; congestive heart failure; clotting disorders; chronic obstructive pulmonary disease; and hormonal deficiencies (hormone replacement); Attention-Deficit/Hyperactivity Disorder (ADHD); narcolepsy; arthritis; gout; Parkinson’s disease; asthma; antineoplastics;

immunosuppressives; Human Immunodeficiency Virus (HIV); potassium supplements and pancreatic enzymes. Maintenance Drugs and Medicines will also include legend oral contraceptives.

c. It is agreed that the above Group Policy be amended, effective as of March 1, 2008, by striking the following limitation from Article 7 - Limitations which states:

> infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or

and replacing such Article 7 - Limitation with the following updated Group Policy form, GC 5022, PART IV - Benefits, Section B1 (2) - Prescription Drugs Expense Insurance:

> infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin and other antihyperglycemic medications for the treatment of diabetes, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or

SECOND:

a. It is agreed that the above Group Policy be amended, effective as of March 1, 2008, by striking Article 4 Definition of "Maintenance Drugs and Medicines" and replacing such Article 4 Definition of "Maintenance Drugs and Medicines" with the following updated Group Policy form, GC 5023, PART IV - Benefits, Section B1 (3) - Mail Service Prescription Drugs Expense Insurance:

> "Maintenance Drugs and Medicines" mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina), diabetes (including, diabetic supplies, e.g., insulin and other antihyperglycemic medications for the treatment of diabetes, disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets, glucometers (limited to one each calendar year) and alcohol swabs), hypertension; glaucoma; thyroid disease; seizure disorders; hyperlipidemia; congestive heart failure; clotting disorders; chronic obstructive pulmonary disease; and hormonal deficiencies (hormone replacement); Attention-Deficit/Hyperactivity Disorder (ADHD); narcolepsy; arthritis; gout; Parkinson's disease; asthma; antineoplastics; immunosuppressives; Human Immunodeficiency Virus (HIV); potassium supplements and pancreatic enzymes. Maintenance Drugs and Medicines will also include legend oral contraceptives.

b. It is agreed that the above Group Policy be amended, effective as of March 1, 2008, by striking the following limitation from Article 5 - Limitations which states:

> infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or

and replacing such Article 5 - Limitation with the following updated Group Policy form, GC 5023, PART IV - Benefits, Section B1 (3) - Mail Service Prescription Drugs Expense Insurance:

> infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin and other antihyperglycemic medications for the treatment of diabetes, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or

EXCEPT AS SPECIFICALLY DESCRIBED IN THIS POLICY RIDER AMENDMENT, ALL OTHER BENEFITS AND PROVISIONS WILL BE AS DESCRIBED IN THE GROUP POLICY.

This policy Rider Amendment will become effective as a Written agreement between The Principal and the Policyholder on the first premium due date following the effective date shown above for which premium due under this Group Policy is received by The Principal.

Executed by The Principal as of February 20, 2008.

Senior Vice President and Corporate Secretary

President and Chief Operating Officer

PRINCIPAL LIFE INSURANCE COMPANY
DES MOINES, IOWA 50392-0001

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NOTICE TO POLICYHOLDER

OF 10-DAY RIGHT TO EXAMINE THE GROUP POLICY

Within 10 days after its delivery to the Policyholder, this Group Policy may be surrendered by delivering or mailing it to the home office of The Principal or to the group representative or agent through whom application was made, if, for any reason after examining the Group Policy, the Policyholder is not satisfied. In such event, any premium paid will be refunded and this notice will be deemed never effective.

NOTHING HEREIN CONTAINED SHALL VARY, ALTER, OR EXTEND ANY PROVISION OR CONDITION OF THE GROUP POLICY OTHER THAN AS STATED IN THIS NOTICE.

PRINCIPAL LIFE
INSURANCE COMPANY

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PRINCIPAL LIFE INSURANCE COMPANY
(called The Principal in this Group Policy)
Des Moines, Iowa 50392-0001

This group insurance policy is issued to:

PICKERING ASSOCIATES, INC.
(called the Policyholder in this Group Policy)

The Date of Issue is March 1, 2002.

In return for the Policyholder's application and payment of all premiums when due, The Principal agrees to provide:

MEMBER AND DEPENDENT
MEDICAL EXPENSE INSURANCE

Comprehensive Medical

Prescription Drugs

Mail Service Prescription Drugs

subject to the terms and conditions described in this Group Policy.

Senior Vice President and Corporate Secretary

President and Chief Operating Officer

GROUP POLICY NO. GME P67471
NON-PARTICIPATING
CONTRACT STATE OF ISSUE: WEST VIRGINIA

This Policy has been updated effective March 1, 2008

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This Policy has been updated effective March 1, 2008

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This Policy has been updated effective March 1, 2008

This Policy has been updated effective March 1, 2008

PART I - DEFINITIONS

When used in this Group Policy, the terms listed below will mean:

Ambulatory Surgery Center

A facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

a. is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and

b. provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and

c. does not provide the services or other accommodations for Hospital Inpatient Confinement; and

d. is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

Average Wholesale Price (AWP)

The published cost of a drug product to the wholesaler.

Birthing Center

A freestanding facility that is licensed by the proper authority of the state in which it is located and that:

a. provides prenatal care, delivery, and immediate postpartum care; and

b. operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and

c. has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and

d. provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and

e. has a Written agreement with a Hospital in the area for emergency transfer of a patient

or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

Community Mental Health Center

A community or county mental health facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

Copayment; Copay

A specified dollar amount that must be paid by a Member or Dependent each time certain or specified services are rendered. In no event will the Copay amount exceed:

a. for services provided by PPO Providers, the negotiated fee; and

b. for services provided by Non-PPO Providers, the actual cost charged to the Member or Dependent.

Cosmetic Treatment and Services

Treatment or Services to change:

a. the texture or appearance of the skin; or

b. the relative size or position of any part of the body;

when such Treatment or Service is performed primarily for psychological purposes or is not needed to correct or improve a bodily function. Cosmetic Treatment and Services include, but are not limited to, surgery, pharmacological regimens, and all related charges.

Covered Charges

A Treatment or Service is considered to be a Covered Charge if the Treatment or Service is:

a. prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;

b. consistent with the diagnosis or symptoms;

c. not excessive in scope, duration, intensity or quantity;

d. the most appropriate level of services or supplies that can safely be provided; and

e. determined by The Principal to be Generally Accepted.

Creditable Coverage

This Policy has been updated effective March 1, 2008

With respect to an individual, coverage of the individual under any of the following:

a. a Group Health Plan, as defined in this PART I;

b. Health Insurance Coverage, as defined in this PART I;

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

d. Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);

e. TRICARE (Chapter 55 of Title 10, United States Code);

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

g. a state health benefits risk pool;

h. a health benefit plan for government employees (Chapter 89 of Title 5, United States Code);

i. a public health plan established or maintained by a State, the United States, a foreign country, or any political subdivision thereof;

j. a health benefit plan provided under the Peace Corp Act;

k. any other similar coverage permitted under state or federal law or regulations;

l. a health benefit plan provided under a State Children's Health Insurance Program (Title XXI of the Social Security Act).

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits. For this purpose, "Excepted Benefits" mean benefits or coverage under one or more (or any combination) of the following:

a. coverage only for accident (including accidental death and dismemberment);

b. disability income insurance;

c. liability insurance, including general liability insurance and automobile liability insurance;

d. coverage issued as a supplement to liability insurance;

e. Workers' Compensation or similar insurance;

f. automobile medical payment insurance;

g. credit-only insurance (for example, mortgage insurance);

h. coverage for on-site medical clinics;

i. other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;

j. the following benefits, if offered separately from medical expense benefits (provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the plan):

- limited scope dental or vision benefits;
- benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
- other similar limited benefits;

k. the following benefits, if offered as independent, noncoordinated benefits:

- coverage only for a specified disease or illness;
- hospital indemnity or other fixed indemnity insurance;

l. the following benefits, if offered as a separate insurance policy:

- Medicare Supplement insurance;
- coverage supplemental to TRICARE;
- similar supplemental coverage provided to coverage under a Group Health Plan;

m. health flexible spending arrangement, if the following are satisfied:

- the maximum benefit from employee and employer contributions for the year does not exceed two times the employee's annual salary reduction;
- the employee has other group health coverage available that is not limited to Excepted Benefits.

Custodial Care

Assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), chiropractor, physical therapist, occupational therapist, speech therapist, or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.

Date of Issue

The date this Group Policy is placed in force: March 1, 2002.

This Policy has been updated effective March 1, 2008

Deductible; Deductible Amount

A specified dollar amount of Covered Charges that must be incurred by the Member or Dependent before benefits will be payable under this Group Policy for all or part of the remaining Covered Charges during the calendar year.

Dental Services

Any Treatment or Service provided to diagnose, prevent, or correct:

a. periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or

b. malocclusion (abnormal positioning or relationship of the teeth); or

c. ailments or defects of the teeth and supporting tissue and bone (excluding appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

Dependent

a. A Member's spouse, if that spouse:

   (1) is not in the Armed Forces of any country; and
   (2) is not insured under this Group Policy as a Member.

b. A Member's Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children

a. A Member's natural or legally adopted child, if that child:

   (1) is not married; and
   (2) is not in the Armed Forces of any country; and
   (3) is not insured under this Group Policy as a Member; and
   (4) is less than 19 years of age.

   A newly adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

b. A Member's stepchild, if that child:

   (1) meets the requirements in a. (1), (2), (3), and (4) above; and
   (2) receives principal support from the Member.

This Policy has been updated effective March 1, 2008

c. A Member's foster child, if that child:

(1) meets the requirements in a. (1), (2), (3), and (4) above; and
(2) lives with the Member; and
(3) receives principal support from the Member; and
(4) is approved in Writing by The Principal as a Dependent Child.

d. A Member's child 19 years but less than 25 years of age who otherwise qualifies under a., b. or c. above, if that child receives principal support from the Member and is a Full-Time Student, as defined in this PART I.

e. A Member's child 19 years but less than 25 years of age, if that child is a Mormon missionary for a period of two years or less; and

(1) otherwise qualifies under a., b. or c. above; and
(2) receives principal support from the Member.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this Group Policy, provided the child meets this Group Policy's definition of a Dependent Child.

Developmental Disability

A Dependent Child's substantial handicap which:

a. results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

b. is diagnosed by a Physician as a permanent or long-term continuing condition.

Experimental or Investigational Measures

Any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

Full-Time Employee

Any PERSON who is regularly scheduled to work for the Policyholder for at least 25 hours a week. The employee must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of this Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 25 hours a week and otherwise meets the

definition of Full-Time Employee.

Full-Time Student

A Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

a. attends school on a full-time basis, as determined by the school's criteria; and

b. is dependent on the Member for principal support.

Generally Accepted

Treatment or Service for the particular sickness or injury which is the subject of the claim that:

a. has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and

b. is in general use in the relevant medical community; and

c. is not under scientific testing or research.

Group Health Plan

An employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Group Policy

The policy of group insurance issued to the Policyholder by The Principal which describes benefits and provisions for Members and Dependents.

Health Care Extender

A health care provider who assists in the delivery of covered medical services under the direction and supervision of a Physician.

"Direction and supervision" means the Physician co-signs any progress notes Written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

Health Insurance Coverage

Benefits consisting of medical care under any hospital or medical service policy or certificate,

hospital or medical service plan contract, or Health Maintenance Organization (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO) licensed to engage in the business of insurance and subject to state law which regulates insurance.

Health Maintenance Organization (HMO)

An entity that is:

a. A federally qualified Health Maintenance Organization as defined by federal law; or

b. An organization recognized under state law as a Health Maintenance Organization; or

c. A similar organization regulated under state law for solvency in the same manner and to the same extent as such a Health Maintenance Organization.

HMO Affiliation Period

A period of time which, under the terms of the Health Insurance Coverage offered by a Health Maintenance Organization (HMO), must expire before an individual's coverage becomes effective.

Home Health Aide

A person, other than a licensed registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency

A Hospital, agency, or other service that is:

a. certified by Medicare as a home health care agency; or

b. certified by the proper authority of the state in which it is located to provide home health care.

Home Health Care Plan

A program of home care that:

a. is required as the result of a sickness or injury; and

b. prevents, delays or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and

c. is documented in a Written plan of care; and

This Policy has been updated effective March 1, 2008

d. is prescribed by the attending Physician; and

e. is preapproved by The Principal.

Home Infusion Therapy Services

Treatment or Service required for the administration of intravenous drugs or solutions, which:

a. is required as a result of a sickness or injury; and

b. prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and

c. is documented in a Written plan of care; and

d. is prescribed by the attending Physician; and

e. is preapproved by The Principal.

Hospice

A facility, agency, or service that:

a. is licensed by the proper authority of the state in which it is located to establish and manage Hospice Care Programs; and

b. arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and

c. maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Program

A program that furnishes palliative or supportive care focused on comfort and not cure and that is:

a. managed by a Hospice; and

b. established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

Hospice Care Team

A group that provides coordinated Hospice Care Services and normally includes:

a. a Physician;

b. a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);

c. a nurse;

d. a mental health specialist;

e. a social worker;

f. a chaplain; and

g. lay volunteers.

Hospital

An institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

For the purpose of Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

a. a Psychiatric Hospital; and

b. an Inpatient Alcohol or Drug Abuse Treatment Facility; and

c. any other facility required by state law to be recognized as a treatment facility under this Group Policy.

Hospital Inpatient Confined; Hospital Inpatient Confinement

Any period of Treatment or Service in a Hospital in excess of twenty-three consecutive hours for any cause. A Hospital Admission Review as defined in PART IV, Section B1 (1A), is required for Hospital Inpatient Confinements.

Hospital Inpatient Confinement Charges

Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia provided while a person is Hospital Inpatient Confined.

Hospital Room Maximum

This Policy has been updated effective March 1, 2008

Covered Charges by a Hospital for room and board while confined in a private room up to:

a. the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or

b. the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Immediate Family

A Member's or a Dependent's spouse, natural or adoptive parent, natural or adopted child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of a grandparent or grandchild.

Inpatient Alcohol or Drug Abuse Treatment Facility

An institution that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services; and

a. is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and

b. provides 24-hour a day on-site nursing care by licensed registered nurses (R.N.s).

Insurance Month

Calendar month.

Medical Detoxification

Treatment in a Hospital when a patient's life or vital bodily functions are threatened by complications associated with withdrawal from alcohol or drug use, requiring 24-hour nursing care and medical therapy supervised by a Physician in order to stabilize the patient's physical condition.

Medical Emergency

A condition that manifests itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of immediate medical attention could result in:

a. placing the health of the Member or Dependent, or with respect to a pregnant Member or Dependent, the health of the mother and her unborn child, in serious jeopardy; or

b. serious impairment of a bodily function; or

This Policy has been updated effective March 1, 2008

c. serious dysfunction of any bodily organ or part.

Member

Any person who is a Full-Time Employee of the Policyholder.

Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services

Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including but not limited to: individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric, alcohol or drug abuse medication management; biofeedback; alcohol or drug abuse rehabilitation or counseling services; hypnotherapy; narcosynthesis; milieu or other therapies (physical, occupational, or speech therapy) used to diagnose or treat mental health, behavioral, alcohol or drug abuse problems.

Non-Preferred Provider/Non-PPO Provider

A Hospital, Physician, or other provider not contracted with the preferred provider organization (PPO) network identified by The Principal to this Group Policy.

Outpatient Alcohol or Drug Abuse Treatment Facility

A facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.

Period of Confinement

A period of Hospital Inpatient Confinement. For the purposes of applying the Hospital charges Copay amount for each admission, two or more periods of Hospital Inpatient Confinement will be considered one period of confinement unless caused by an unrelated sickness or injury, or unless separated by 30 consecutive days or more.

Physical Handicap

A Dependent Child's substantial physical or mental impairment which:

a. results from injury, accident, congenital defect, or sickness; and

b. is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician

a. A licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or

b. any other licensed health care practitioner that state law requires be recognized as a

Physician under this Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: audiologist, chiropractor, dentist, nurse midwife, midwife, occupational therapist, optometrist, physician's assistant, physical therapist, podiatrist, psychologist, social worker, and speech pathologist.

Physician Visit

A face-to-face meeting between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service.

Placement for Adoption; Placement

The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policy Anniversary

March 1, 2008, and the same day of each following year.

Policyholder

The entity to whom this Group Policy is issued (see Title Page).

Preferred Provider/PPO Provider

A Hospital, Physician, or other provider contracted with a preferred provider organization (PPO) network identified by The Principal to this Group Policy.

The Policyholder's participation in the PPO network does not mean that an insured person's choice of provider will be restricted. The insured person may seek needed medical care from any Hospital, Physician, or other provider of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

The Principal has the right to terminate the preferred provider organization (PPO) portion of this Group Policy if The Principal or the preferred provider organization (PPO) terminates the arrangement.

The Principal also has the right to identify different preferred provider organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

Preferred Provider Organization (PPO) Service Area

The geographic area within which Preferred Provider services are available to persons insured under this Group Policy.

Prevailing Charges

a. For medical care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.

b. For medical care received from Non-Preferred Providers, the amount as determined by The Principal that is derived from a cost-based methodology used by Medicare or a methodology similar to one used by Medicare.

c. For Home Infusion Therapy Services, the amount will be established by The Principal at the time services are preapproved, not to exceed the Average Wholesale Price.

d. For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.

e. For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.

f. For purposes of Treatment or Service for a Medical Emergency provided outside the United States, the Prevailing Charge will be calculated based on the Policyholder's United States Address.

Prior Plan

The group medical expense coverage of the Policyholder for which this Group Policy is a replacement.

Primary Care Physician

A Physician who is a family or general practitioner, internist, obstetrician/gynecologist or pediatrician.

Primary Health Care Nursing Services

Nursing care services provided by a person who is:

a. a nonsalaried licensed registered nurse (R.N.) engaged in private practice or partnership with other health care providers; or

b. a licensed nurse midwife or midwife;

provided such services are within the scope of the person's license.

Psychiatric Hospital

This Policy has been updated effective March 1, 2008

An institution that is licensed as a Hospital by the proper authority of the state in which it is located, and is primarily engaged in providing diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

For the purpose of this definition, a Psychiatric Hospital will also include any inpatient bed in a licensed general Hospital used to provide diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in the absence of a specialized or designated psychiatric or drug treatment unit.

Signed or Signature

Any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by The Principal.

Skilled Nursing Facility

An institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

a. is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.) ; and

b. has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and

c. has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and

d. provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places which furnish Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

Social Detoxification

A Treatment or Service designed to achieve detoxification without the use of drugs or other medical interventions.

Specialty Provider

Any Physician other than a Primary Care Physician who is classified as a specialist by the American Boards of Medical Specialties; or who is designated by this Group Policy as a Specialty Provider.

This Policy has been updated effective March 1, 2008

Total Disability; Totally Disabled

a. For a Member, a Member's inability, as determined by The Principal, due to sickness or injury, to perform the material and substantial duties of his or her regular occupation; and

b. For a Dependent, a substantial impairment, due to sickness or injury, that prevents the individual from performing the material and substantial duties of his or her regular occupation.

Transplant Network

Any network of providers that The Principal determines to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule as provided in PART IV, Section A (5). The Transplant Network is United Resource Networks.

Treatment or Service

When used in this Group Policy, the term "Treatment or Service" will be considered to mean: "confinement, treatment, service, substance, material, or device".

Waiting Period

With respect to a Group Health Plan and an individual who is a potential enrollee in the plan, the period of time that must pass with respect to the individual before he or she is eligible to be covered for benefits under the terms of the plan.

The Waiting Period for coverage of a Member and his or her eligible Dependents under this Group Policy is three consecutive months of continuous employment as a Member, as described in PART III, Section A.

Written or Writing

A record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

PART II - POLICY ADMINISTRATION

Section A - Contract

Article 1 - Entire Contract

This Group Policy, the current Certificate, the attached Policyholder application, and any Member applications make up the entire contract. The Principal is obligated only as provided in this Group Policy and is not bound by any trust or plan to which it is not a signatory party.

Article 2 - Policy Changes

Insurance under this Group Policy runs annually to the Policy Anniversary, unless sooner terminated. No agent, employee, or person other than an officer of The Principal has authority to change this Group Policy, and, to be effective, all such changes must be in Writing and Signed by an officer of The Principal.

The Principal reserves the right to change this Group Policy as follows:

a. Any or all provisions of this Group Policy may be amended or changed at any time, including retroactive changes, to the extent necessary to meet the requirements of any law or any regulation issued by any governmental agency to which this Group Policy is subject.

b. Any or all provisions of this Group Policy may be amended or changed at any time when The Principal determines that such amendment is required for consistent application of policy provisions.

c. By Written agreement between The Principal and the Policyholder this Group Policy may be amended or changed at any time as to any of its provisions.

Any change to this Group Policy, including, but not limited to, those in regard to coverage, benefits, and participation privileges, may be made without the consent of any Member or Dependent.

Payment of premium beyond the effective date of the change constitutes the Policyholder’s consent to the change.

This Policy has been updated effective March 1, 2008

Article 3 - Policyholder Eligibility Requirements

To be an eligible group and to remain an eligible group, the Policyholder must:

a. Be actively engaged in business for profit within the meaning of the Internal Revenue Code, or be established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and

b. Make at least the level of premium contributions required for insurance on its eligible Members. The Policyholder must contribute at least 50% of the required premium for all Members (including disabled Members, if any); and

c. If the Member is to contribute part of the premium, maintain the following participation percentages with respect to Eligible Employees and Dependents:

(1) Eligible Employees:

- if there are 5 or fewer Eligible Employees, 100% of all Eligible Employees must enroll; or
- if there are 6 or more Eligible Employees, at least 75% of all Eligible Employees must enroll.

(2) Dependents:

- if there are 24 or fewer Eligible Employees, maintain a Dependent participation of at least 75% of eligible Dependents; or
- if there are 25 or more Eligible Employees, maintain a Dependent participation of at least 50% of eligible Dependents.

d. If the Member is to contribute no part of the premium, 100% of Eligible Employees and Dependents must enroll, excluding those who reject coverage in Writing.

For the purpose of determining the applicable percentage shown in c. above, Members and Dependents who have existing coverage under another Group Health Plan will be removed from the calculation.

However, if the Policyholder has medical expense coverage for its employees with more than one carrier:

a. If there are 10 or fewer Eligible Employees, employees and Dependents participating in the Policyholder's other medical expense coverage will not be removed from the calculation when determining the applicable percentage.

b. If there are 11 or more Eligible Employees, at least 50% of eligible employees and Dependents participating in medical expense coverage sponsored by the Policyholder

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must enroll under this Group Policy. This requirement does not apply if the Policyholder's other medical expense coverage is issued by an affiliate of The Principal.

If the Policyholder had prior coverage with The Principal which coverage terminated due to nonpayment of premium, fraud or misrepresentation of material fact, or failure to comply with minimum participation or employer-contribution requirements, The Principal will not accept application from that Policyholder within 12 months after the date of such termination.

Article 4 - Policy Incontestability

In the absence of fraud, after this Group Policy has been in force two years, The Principal may not contest its validity except for nonpayment of premium.

Article 5 - Individual Incontestability and Eligibility

All statements made by any individual insured under this Group Policy will be representations and not warranties. In the absence of fraud, these statements may not be used to contest an insured person's insurance unless:

a. the insured person's insurance has been in force for less than two years during the insured's lifetime; and

b. the statement is in Written form Signed by the insured person; and

c. a copy of the form which contains the statement is given to the insured or the insured's beneficiary at the time insurance is contested.

However, these provisions will not preclude the assertion at any time of defenses based upon the person's ineligibility for insurance under this Group Policy or upon the provisions of this Group Policy. In addition, if an individual's age is misstated, The Principal may at any time adjust premium and benefits to reflect the correct age.

The Principal may at any time terminate a Member's or Dependent's eligibility under this Group Policy:

a. in Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;

b. in Writing and with 31-day notice, upon finding in a civil or criminal case that a Member or Dependent has submitted claims that contain false or fraudulent elements under state or federal law;

c. in Writing and with 31-day notice, when a Member or Dependent has submitted a claim

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which, in good faith judgment and investigation, a Member or Dependent knew or should have known contains false or fraudulent elements under state or federal law.

Article 6 - Information to be Furnished

The Policyholder must, upon request, give The Principal all information needed to administer this Group Policy. If a clerical error is found in this information, The Principal may at any time adjust premium to reflect the facts. An error will not invalidate insurance that would otherwise be in force. Neither will an error continue insurance that would otherwise be terminated.

The Principal may inspect, at any reasonable time, all Policyholder and Participating Unit records which relate to this Group Policy.

Article 7 - Certificates

The Principal will give the Policyholder Certificates for delivery to insured Members. The delivery of such Certificates will be in either paper or electronic format. The Certificates will be evidence of insurance and will describe the basic features of the benefit plan. They will not be considered a part of this Group Policy.

Article 8 - Experience Premium Refunds

The Principal will determine the Experience Premium Refund, if any, as of each Policy Anniversary in accordance with the formula to be applied to all such policies receiving an Experience Premium Refund. The Policyholder has no rights to any Experience Premium Refund unless and until determined by The Principal. If premiums due before the Policy Anniversary and for the next following Insurance Month have been paid, any such Experience Premium Refund will be:

a. paid in cash to the Policyholder; or

b. used to pay future premiums due, if the Policyholder directs in Writing.

If at any time total Experience Premium Refund for all years to date exceed the Policyholder’s premium contributions and expense for those years, the excess must be used for the sole benefit of the insured Members.

"Experience Premium Refund" means any portion of the remainder of premium plus any reserves being released by The Principal after all claims, charges, expenses, taxes, amounts to fund deficits, and any other amounts deducted by The Principal have been funded fully, which is determined by The Principal to be distributable for the benefit of the participants in

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this group insurance or of the employee welfare benefit plan for which this Group Policy was purchased. Any Experience Premium Refund will be determined by The Principal according to a formula developed by The Principal for all policies of a class.

Article 9 - Workers' Compensation Not Affected

This Group Policy is not in place of and does not affect nor fulfill the requirements for Workers' Compensation Insurance.

Article 10 - Dependent Rights

A Dependent will have no rights under this Group Policy except as set forth in PART III, Section D, Article 2 and Section F, Article 2.

Article 11 - Policy Interpretation

The Principal has complete discretion to construe or interpret the provisions of this group insurance policy, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. The decisions of The Principal in such matters shall be controlling, binding, and final as between The Principal and persons covered by this Group Policy, subject to the Claims Procedures in PART IV, Section C.

Article 12 - Electronic Transactions

Any transaction relating to this Group Policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law.

Any notice required by the provisions of this Group Policy given by electronic means will have the same force and effect as notice given in writing.

Article 13 - Value Added Service

The Principal reserves the right to offer or provide to a Policyholder a vision discount plan or any other value added service for the employees of the Policyholder. In addition, The Principal may arrange for third party service providers (i.e. optometrists, health clubs), to provide discounted goods and services to those Policyholders of The Principal. While The Principal has arranged these goods, services and third party provider discounts, the third party service providers are liable to the Members for the provisions of such goods and services. The Principal is not responsible for the provision of such goods or services nor is it liable for the failure of the provision of the same. Further, The Principal is not liable to the Members

for the negligent provisions of such goods and/or services by the third party service providers.

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PART II - POLICY ADMINISTRATION

Section B - Premiums

Article 1 - Payment Responsibility; Due Dates; Grace Period

The Policyholder is responsible for collection and payment of all premium due while this Group Policy is in force. Payments must be sent to the home office of The Principal in Des Moines, Iowa.

The first premium is due on the Date of Issue of this Group Policy. Each premium thereafter will be due on the first of each Insurance Month. Except for the first premium, a Grace Period of 31 days will be allowed for payment of premium. "Grace Period" means the first 31-day period following a premium due date. This Group Policy will remain in force until the end of the Grace Period, unless the Group Policy has been terminated by notice as described in this PART II, Section C. The Policyholder will be liable for payment of the premium for the time this Group Policy remains in force during the Grace Period.

Article 2 - Premium Rates

The premium rate(s) for each Member insured for Medical Expense Insurance will be:

Member Without Dependents	$246.41
Member and Spouse	$671.13
Member and Children	$557.67
Member and All Dependents	$982.39

Article 3 - Premium Rate Changes

The Principal may change a premium rate on any of the following dates:

a. on any premium due date, if the rate has then been in force 12 months or more and if Written notice is given to the Policyholder at least 31 days before the date of change; or

b. on any premium due date, after the initial premium rate has been in force 12 months or more and if Written notice is given to the Policyholder at least 31 days before the date of change; or

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c. on any date the definition of Member or Dependent is changed; or

d. on any date that a schedule of insurance or class of insured Members is changed.

If the Policyholder agrees to participate in the electronic services program of The Principal and, at a later date elects to withdraw from participation, such withdrawal may result a fee being charged to the Policyholder.

Article 4 - Premium Amount

The amount of premium to be paid on each due date will be the sum of the premium rates then in effect for all Members then insured. The Principal may change a premium rate for a Member on any premium due date if the age of the Member has changed since the last premium due date.

If a Member is added or a present Member's insurance is increased or terminated on other than the first day of an Insurance Month, premium for that Member will be adjusted and applied as if the change were to take place on the first of the next following Insurance Month.

If a Member's coverage is terminated, notice of the termination should be provided to The Principal within 31 days of the termination date. Failure to notify The Principal of the termination of coverage within 31 days will result in the Policyholder being liable for the difference between the premium paid and all benefits provided or claims verified and/or paid after the date of termination.

Refund of premium for late reported terminations are not available unless otherwise specifically required by law.

Article 5 - Contributions from Members

Members are required to contribute a part of the premium for their insurance under this Group Policy.

Members are required to contribute a part of the premium for their Dependent's insurance under this Group Policy.

This Policy has been updated effective March 1, 2008

Section C - Policy Termination

Article 1 - Failure to Pay Premium

This Group Policy will terminate at the end of a Grace Period if total premium due has not been received by The Principal before the end of the Grace Period. Failure by the Policyholder to pay the premium within the Grace Period will be deemed notice by the Policyholder to The Principal to discontinue this Group Policy at the end of the Grace Period.

Article 2 - Termination By Notice

The Policyholder may terminate this Group Policy effective on the day before a premium due date by giving Written notice to The Principal prior to that premium due date.

The Principal may nonrenew or terminate this Group Policy for the reasons described in Article 3 below. The effective date of any such nonrenewal or termination and the applicable notice provisions will be as described in Article 4 below.

Article 3 - Renewability Provisions

This Group Policy is renewable, with respect to all Members and Dependents, at the option of the Policyholder. However, The Principal has the right to nonrenew or terminate this Group Policy for any of the following reasons:

a. Nonpayment of Premium. The Policyholder has failed to pay premium in accordance with the requirements of this Group Policy.

b. Fraud or Misrepresentation. The Policyholder has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the Group Policy.

c. Violation of Participation or Contribution Rules. The Policyholder has failed to comply with a material provision of this Group Policy relating to group participation or employer contribution rules.

d. Movement Outside the Service Area. There is no longer any insured person who lives,

resides or works in the provider network's service area.

e. Cessation of Small-Employer Status. The employer has ceased to be a Small Employer. "Small Employer" means an employer that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year.

f. Relocation of the Group. The Policyholder relocates to a state where The Principal has ceased to offer Health Insurance Coverage in the Small Group Market.

g. Termination of Coverage in The Small Group Market. The Principal ceases to offer Health Insurance Coverage in the Small Group Market in the State of WEST VIRGINIA.

h. No Longer Actively Engaged in Business. The Policyholder ceases to be actively engaged in business for profit within the meaning of the Internal Revenue Code, or be established as a legitimate non-profit corporation within the meaning of the Internal Revenue Code.

For the purpose of these provisions, "Small Group Market" means the health insurance market under which individuals obtain Health Insurance Coverage (directly or through any arrangement) on behalf of themselves and their dependents through a Group Health Plan maintained by a Small Employer, as defined above.

Article 4 - Nonrenewal or Termination: Effective Date and Notice Provisions

Termination of this Group Policy due to the Policyholder's nonpayment of premium will be as described in Article 1 above.

Nonrenewal or termination by the Principal of this Group Policy for any other reason, as described in Article 3 above, will be subject to the effective date and notice provisions set forth in this Article.

a. Fraud or Misrepresentation, Movement Outside the Service Area, Relocation of the Group or No Longer Actively Engaged in Business: The termination date will be the day immediately preceding the premium due date specified by The Principal in its Written notice to the Policyholder. The Principal will give such notice at least 60 days prior to the termination date.

b. Violation of Participation or Contribution Rules, or Cessation of Small Employer Status: The termination date will be on any premium due date. The Principal will give Written notice of termination to the Policyholder at least 60 days prior to the termination date.

c. Termination of Coverage in The Small Group Market: The termination date will be the day immediately preceding the premium due date specified by The Principal in its

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Written termination notice. Such notice will be provided to the state's insurance regulator, each Policyholder and all insured persons at least 180 days prior to the termination date.

Article 5 - Policyholder Responsibility to Members

If this Group Policy terminates for any reason, the Policyholder must:

a. notify each Member of the effective date of the termination; and

b. refund or otherwise account to each Member all contributions received or withheld from Members for premiums not actually paid to The Principal.

Article 6 - Policy Changes

a. Changes by The Principal

The Principal has the right to make certain modifications to the Group Policy as of any Policy Anniversary as provided in PART II, Section A. Any such modification will be effective on a uniform basis among all Group Health Plans in the Small Group Market with that same product.

In addition, The Principal may discontinue offering a particular type of health insurance coverage as of any premium due date. In this event, The Principal will:

(1) Provide notice of such discontinuance to each Policyholder, and to all persons covered under such coverage, at least 90 days prior to the date of discontinuance; and

(2) Offer to each Policyholder the option to purchase any other health insurance coverage currently being offered by The Principal in the Small Group Market, as defined in Article 3. Such offer will be uniformly applied to all Policyholders in the Small Group Market, without regard to claims experience or any other health-related factors.

b. Changes Requested by the Policyholder

The Policyholder may request modification of policy provisions. If The Principal agrees to such modification, it will be effective on the premium due date mutually agreed to by the Policyholder and The Principal.

This Policy has been updated effective March 1, 2008

Section A - Eligibility

Article 1 - Member Medical Expense Insurance

A person will be eligible for Member Medical Expense Insurance on the date the person completes the Waiting Period.

The Waiting Period is a period of three consecutive months during which the person is continuously employed as a Member.

Article 2 - Dependent Medical Expense Insurance

A person will be eligible for Dependent Medical Expense Insurance on the later of:

a. the date the person is eligible for Member Medical Expense Insurance; or

b. the date the person first acquires a Dependent.

Section B - Effective Dates

Article 1 - Member Medical Expense Insurance

a. Effective Date for Noncontributory Insurance

Unless a Member waives coverage in writing and is covered under another group medical policy, insurance for which the Member contributes no part of premium will become effective on the date the Member is eligible. Insurance must be requested on a form provided by The Principal.

If request for noncontributory insurance is made more than 31 days after the date an individual is eligible and other than during an Annual Open Enrollment Period described in d. (3) below or Special Enrollment Period described in d. (4) below, insurance for such individual will become effective as described for Late Enrollees in d. (1) and d. (2) below.

If request for noncontributory insurance is made more than 31 days after the date an individual is eligible but during an Annual Open Enrollment Period described in d. (3) below, insurance for such individual will become effective as described in d. (3) below.

If request for noncontributory insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period described in d. (4) below, insurance for such individual will become effective as described in d. (4) below.

b. Effective Date for Contributory Insurance

If a Member is to contribute a part of premium, insurance must be requested in a form provided by The Principal. The requested insurance will become effective on:

(1) the date the Member is eligible, if the request is made on or before that date; or
(2) the date of the Member's request, if the request is made within 31 days after the date the Member is eligible.

If request for contributory insurance is made more than 31 days after the date an individual is eligible and other than during an Annual Open Enrollment Period described in d. (3) below or Special Enrollment Period described in d. (4) below, insurance for such individual will become effective as described for Late Enrollees in d. (1) and d. (2) below.

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If request for contributory insurance is made more than 31 days after the date an individual is eligible but during an Annual Open Enrollment Period as described in d. (3) below, insurance for such individual will become effective as described in d. (3) below.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but during a Special Enrollment Period described in d. (4) below, insurance for such individual will become effective as described in d. (4) below.

c. Statement of Health Requirements

A statement of health, in a form provided by The Principal, may be required from each Member when he or she first requests insurance under this Group Policy. The statement of health will be used for rating the group, case management or reinsurance purposes. In no event will a person be declined for insurance, or charged an additional premium, due to his or her health status.

d. Late Enrollment Provisions

(1) Definition

Late Enrollee. Late Enrollee means, with respect to coverage under an employer's Group Health Plan, a Member or Dependent who enrolls under such plan other than during:

(a) the first period in which the individual is eligible to enroll under the Group Health Plan; or

(b) a Special Enrollment Period described in d. (4) below.

For the purpose of (a) above, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if:

(a) the individual loses eligibility under the Group Health Plan or due to a general suspension of the Group Health Plan; and

(b) the individual later becomes eligible again under the Group Health Plan or due to resumption of the Group Health Plan's coverage.

The term "Late Enrollee" also means a Member or Dependent who:

(a) was previously insured under this Group Policy, but elected to terminate the insurance; and

(b) reapplies for insurance more than 31 days after the termination date; and

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(c) does not qualify for one of the Special Enrollment Periods described in d. (4) below.

(2) Effective Date for Late Enrollees

If a Late Enrollee requests insurance other than during an Annual Open Enrollment Period or Special Enrollment Period, the effective date of insurance for such Late Enrollee will be the next Policy Anniversary date, provided on such date:

(a) the Member continues to meet the Group Policy's definition of a Member; and

(b) for Dependent coverage, the Dependents continue to meet the Group Policy's definition of Dependent.

The individual will be subject to the Group Policy's Preexisting Condition Exclusion provisions, as described in PART IV, Section E, when his or her insurance becomes effective.

(3) Annual Open Enrollment Period

An Annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

(a) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period, as described in d. (4) below; or

(b) during any previous Annual Open Enrollment Period; or

(c) within 31 days after the termination date, if the individual was previously insured under this Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Open Enrollment period, the Member or Dependent:

(a) must meet the eligibility requirements described in this Group Policy, including satisfaction of any applicable Waiting Period; and

(b) may not be covered under an alternate medical expense coverage offered by the Policyholder unless the Annual Open Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Open Enrollment Period is the one-month period immediately prior to

the Policy Anniversary date.

The effective date for any such individual requesting insurance during the Annual Open Enrollment Period will be the day immediately following completion of the Annual Open Enrollment Period.

The individual will be subject to the Group Policy's Preexisting Condition Exclusion provisions, as described in PART IV, Section E, when his or her insurance becomes effective.

(4) Special Enrollment Periods

If request for a Member's or Dependent's enrollment is made after the first period in which the individual was eligible to enroll but during a Special Enrollment Period as described below, that Member or Dependent will be a Special Enrollee and will not be considered a Late Enrollee.

The Special Enrollment Periods are:

(a) Loss of Other Coverage: A Special Enrollment Period will apply to a Member or Dependent if all the following conditions are met:

(i) the individual (Member or Dependent) was covered under another Group Health Plan or had other Health Insurance Coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and

(ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, cessation of dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage lifetime limit on all benefits, when the individual no longer resides, lives, or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and

(iii) request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the lifetime limit of all benefits under the other health coverage.

The effective date of insurance will be the date after the other coverage terminates.

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NOTE: For the purpose of (a)(ii) above:

(i) "loss of eligibility" does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage); and

(ii) "employer contributions" include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

(b) Newly Acquired Dependents: A Special Enrollment Period will apply to a Member or Dependent if:

(i) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and

(ii) a person becomes a Dependent of the Member through marriage, birth, adoption or Placement for Adoption; and

(iii) request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or Placement for Adoption.

The effective date of the Member's or Dependent's insurance will be:

(i) in the event of marriage, the date of marriage; or

(ii) in the event of a Dependent Child's birth, the date of such birth; or

(iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

(c) Court-Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): A Special Enrollment Period will apply to a Member's Dependent Child if:

(i) the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and

(ii) the Member has failed to enroll the Dependent Child during a previous enrollment period; and

(iii) the Member is required by a QMCSO or NMSN as defined by federal

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law and state insurance laws to provide health coverage for the Dependent Child.

The request for enrollment:

(i) may be made at any time after the issue date of the QMCSO or NMSN; and

(ii) will apply only to the Member and/or Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date of the Member's or Dependent Child's insurance will be the date of issue of the QMCSO or NMSN.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of this Group Policy.

(d) All Other Court-Ordered Coverage: A Special Enrollment Period will apply to a Member's Dependent Child if:

(i) the Member is enrolled but has failed to enroll the Dependent Child during a previous enrollment period; and

(ii) the Member is required by a court or administrative order to provide health coverage for the Dependent Child; and

(iii) request for enrollment is made within 31 days after the issue date of the court or administrative order.

The effective date of the Dependent Child's insurance will be the date of the request for enrollment.

(e) Election to Transfer Coverage: A Special Enrollment Period will apply to a Member and his or her Dependents if:

(i) the Policyholder offers employees a choice among health benefit coverages; and

(ii) the Member elects to transfer from another of the offered coverages to coverage under this Group Policy; and

(iii) request for enrollment is made during an open enrollment period designated by the Policyholder for such transfer.

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The effective date of the Member's and Dependent's insurance under this Group Policy will be the day immediately following the last day of the designated open enrollment period described in (d) (iii) above.

e. Effective Date for Benefit Changes - Change in Member Status

A change in a Member's Scheduled Benefits because of a change in the Member's status (insurance class) will be effective on the date of change in status.

Any termination of Scheduled Benefits due to a change in a Member's status (insurance class) will be effective on the date of the change in status.

f. Effective Date for Benefit Changes - Change by Policy Amendment

A change in the amount of a Member's Scheduled Benefits because of a change in the Schedule of Insurance (as described in PART IV, Section A) by amendment to this Group Policy will be effective on the date of change.

Article 2 - Dependent Medical Expense Insurance

Dependent Medical Expense Insurance is available only with respect to Dependents of Members currently insured for Member Medical Expense Insurance. If a Member is eligible for Dependent Medical Expense Insurance, such insurance will become effective under the same terms as set forth for Member Medical Expense Insurance in this Section B, Article 1, except as described below:

a. Any required statement of health will be with respect to the health of the Member's Dependents.

b. If Dependent Medical Expense Insurance is then in effect for any other Dependent of the Member, a Member will be insured with respect to a new Dependent on the date the new Dependent is acquired. Request for insurance is not required provided The Principal has been notified of the new Dependent within 31 days after the date the Dependent is acquired.

c. A newly born or newly adopted child will be covered under this Group Policy from the moment of birth, or on the date of adoption or Placement for Adoption (whichever is earlier), provided the child meets the Group Policy's definition of a Dependent Child. Any applicable prior-application provisions will be waived with respect to such child.

However, if payment of a specific premium is required to provide coverage for a Dependent Child, the Member must notify The Principal of the birth, adoption or Placement within 31 days after the date it occurs in order to have the child's coverage continue beyond the 31-day period. If such notice is not given to The Principal within

the 31-day period, the child will be subject to the Late Enrollment provisions described in this section. If the request for enrollment is a result of a QMCSO or NMSN, the child will not be a Late Enrollee and is eligible for a Special Enrollment Period as described in Article 1 of this section.

If the child's insurance terminates because the Member fails to request coverage for the child (or make the required premium payment) within the 31-day period following the child's date of birth, adoption or Placement, benefits will be payable only for covered expenses incurred by the child during the 31-day period in which insurance was in force. The Individual Purchase Rights described in this PART III, Section F will not apply to the child.

Section C - Individual Terminations

Article 1 - Member Medical Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under this Group Policy will terminate on the earliest of:

a. the date this Group Policy is terminated; or

b. the date the last premium is paid for the Member's Insurance; or

c. for contributory insurance, any date desired, if requested by the Member before that date; or

d. the date the Member ceases to be a Member as defined in PART I; or

e. the date the Member ceases to be in a class for which Member Medical Expense Insurance is provided; or

f. the date the Member ceases to be actively employed; or

g. for Comprehensive Medical Expense Insurance, Prescription Drugs Expense Insurance, and Mail Service Prescription Drugs Expense Insurance, the date the total amount of benefits paid under this Group Policy for the Member reaches the Overall Lifetime Maximum Payment Limit shown in PART IV, Section A.

Article 2 - Dependent Medical Expense Insurance

Unless continued as provided in Section D - Continuation, a Member's coverage under the Group Policy for a Dependent will terminate on the earliest of:

a. the date his or her Member Medical Expense Insurance ceases; or

b. the date Dependent Medical Expense Insurance is removed from this Group Policy; or

c. the date the last premium is paid for the Member's Dependent Medical Expense Insurance; or

This Policy has been updated effective March 1, 2008

d. for contributory insurance, any date desired, if requested by the Member before that date; or

e. the date the Member ceases to be in a class for which Dependent Medical Expense Insurance is provided; or

f. for each spouse or Dependent Child, on the date that spouse or Dependent Child ceases to be a Dependent as defined in PART I. However, a spouse who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent as defined in PART I; or

g. for each spouse or Dependent Child, for Comprehensive Medical Expense Insurance, Prescription Drugs Expense Insurance, and Mail Service Prescription Drugs Expense Insurance, the date the total amount of benefits paid under this Group Policy for that spouse or Dependent Child reaches the Overall Lifetime Maximum Payment Limit shown in PART IV, Section A.

The custodial parent will be notified if his or her Dependent Child's coverage is modified or terminated.

This Policy has been updated effective March 1, 2008

Section D - Continuation

Article 1 - Member Medical Expense Insurance

a. Sickness or Injury

Insurance for a Member who has ceased to be actively employed due to sickness or injury may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in this PART III, Section C; or
(2) the date the Member recovers; or
(3) the date the Member is covered under the USERRA continuation provision.
(4) the date coverage has been continued under this Section for twelve (12) consecutive months.

b. Layoff or Approved Leave of Absence

Insurance for a Member who has ceased to be actively employed due to layoff or approved leave of absence may be continued until the earliest of:

(1) the date insurance would otherwise cease as provided in this PART III, Section C; or
(2) the date the layoff or approved leave of absence ends; or
(3) the date the Member becomes eligible for any other group medical expense coverage; or
(4) the date one month after the date the Member has ceased to be actively employed.

If coverage under this Group Policy is subject to COBRA or a state continuation law, this continuation period will run concurrent with the COBRA or state continuation period.

NOTE: If active employment ends because of involuntary layoff, insurance may be continued for up to 18 months as described in Article 3-State Required-West Virginia.

c. State Required - West Virginia

A Member's Medical Expense Insurance may also be continued as described in Article 3, State Required Continuation.

This Policy has been updated effective March 1, 2008

Article 2 - Dependent Medical Expense Insurance

a. During Continuation of Member Insurance

Except as otherwise provided in this PART III, Section C, Dependent Medical Expense Insurance may remain in force during any period that Member Medical Expense Insurance is continued.

b. Developmentally Disabled or Physically Handicapped Children

(1) Qualification

Medical Expense Insurance for a child may be continued after the child reaches the maximum age for Dependent Children as defined in PART I of this Group Policy, provided that:

- the child is incapable of self-support as the result of a Developmental Disability or Physical Handicap and became so before reaching the maximum age and is dependent on the Member for primary support; and
- except for age, the child continues to be a Dependent Child as defined in PART I; and
- proof of the child's incapacity is sent to The Principal within 31 days after the date the child reaches the maximum age; and
- further proof that the child remains incapable of self-support is provided when The Principal requests; and
- the child undergoes examination by a Physician when The Principal requests. The Principal will pay for these examinations and will choose the Physician to perform them.

(2) Period of Continuation

Insurance for a Dependent Child who qualifies as set forth above may be continued until the earlier of:

- the date insurance would cease for any reason other than the child's attainment of the maximum age; or
- the date the child becomes capable of self-support or otherwise fails to qualify as set forth in (1) above.

c. Comprehensive Medical Overall Lifetime Maximum Payment Limit

If the Member's Comprehensive Medical Expense Insurance terminates because the total amount of benefits paid under this Group Policy on behalf of the Member reaches the Comprehensive Medical Overall Lifetime Maximum Payment Limit, his or her Dependent Medical Expense Insurance (including insurance under Section B1 (2) and

Section B1 (3)) will continue until the earliest of:

(1) the date the Member ceases to be a Member as defined in PART I; or
(2) the date Dependent Medical Expense Insurance would otherwise cease as provided in this PART III, Section C; or
(3) the date the Member's insurance would have otherwise ceased if the Member had not exhausted his or her Comprehensive Medical Expense benefits.

d. State Required - WEST VIRGINIA

A Dependent's Medical Expense Insurance may also be continued as described in Article 3, State Required Continuation.

Article 3 - State Required - West Virginia

a. Qualification for Continuation

A Member may elect to continue insurance including Dependents insurance under this Group Policy if insurance would otherwise terminate due to the member's involuntary layoff. Such insurance may be continued if, on the date insurance would otherwise cease, the Group Policy is in force.

b. Period of Continuation

Insurance for a Member who qualifies as described above may be continued until the earliest of:

(1) the date this Group Policy is terminated; or
(2) the end of the premium period for which premium is paid, if the Member fails to make timely payment of a required premium; or
(3) the date insurance would otherwise cease as provided in this PART III, Section C; or
(4) the date the Member becomes eligible for other group medical expense coverage; or
(5) the date insurance has been continued for 18 months.

Article 4 - Federal Required Continuation

a. Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (excepting the federal government and religious organizations) who:

(1) maintains group health coverage; and
(2) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Federal law requires that certain group plans allow qualified persons who would otherwise lose coverage under the Group Policy as a result of a qualifying event, to elect to continue group coverage under the Group Policy. A full description of the COBRA continuation provisions is included in the administration material provided to the Policyholder and in the booklet-certificate.

b. Family and Medical Leave Act (FMLA)

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects this Group Policy. A full description of the FMLA continuation provisions is included in the administration material provided to the Policyholder.

(1) FMLA and Other Continuation Provisions

These FMLA continuation provisions:

- are in addition to any other continuation provisions described in this Group Policy, if any; and
- will run concurrently with any other continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

(2) Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar work weeks in the current or preceding calendar year.

(3) Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

This Policy has been updated effective March 1, 2008

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

(4) Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child.
- the placement of a child with the Eligible Employee for adoption or foster care.
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition".
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

(5) Reinstatement

An Eligible Employee’s terminated insurance may be reinstated in accordance with the provisions of the FMLA.

c. Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

Federal law requires that if a Member’s insurance would otherwise end because he or she enters into active military duty or inactive military duty for training, the Member may elect to continue insurance (including Dependents insurance) in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Such continued insurance will terminate on the earliest of:

(1) for a Member and his or her Dependents:

- the date this Group Policy is terminated; or
- the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
- the date 24 months after the date the Member enters active military duty; or

- the date after the day in which the Member fails to return to active employment or apply for reemployment with the Policyholder.

(2) for a Member's Dependents:

- the date Dependent Medical Expense Insurance would otherwise cease as provided in this PART III, Section C; or
- any date desired, if requested by the Member before that date.

Continuation provisions described in this Group Policy for sickness, injury, layoff, or approved leave of absence, if any, may apply. These continuation provisions, however, will terminate on the date the Member is covered under the USERRA continuation provision. If the Member qualifies for USERRA, COBRA, or state continuation, the election of one means the rejection of the other.

The reinstatement time period, as provided in this PART III, Section E, may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects this Group Policy. A full description of the USERRA continuation provisions is included in the administration material provided to the Policyholder.

Section E - Reinstatement

Article 1 - Reinstatement

A Member's terminated insurance will be reinstated if:

a. insurance ceased because of layoff or approved leave of absence; and

b. the Member returns to active employment for the Policyholder within six months of the date insurance ceased.

The Member's reinstated insurance will be in force on the date of return to active employment.

Only the period of time during which a Member is actually insured will be included in determining the length of his or her continuous coverage under this Group Policy. For this purpose the period of time during which a reinstated Member's insurance was not in force:

a. will not be considered an interruption of continuous coverage; and

b. will not be used to satisfy any provision of this Group Policy which pertains to a period of continuous coverage.

Section F - Individual Purchase Rights

Article 1 - Member Medical Expense Insurance

a. Individual Purchase

If a Member qualifies and makes timely application, he or she may convert the group coverage by purchasing other medical expense insurance when insurance under this Group Policy terminates. A statement of health will not be required for such purchase. The form, terms, and conditions of the converted coverage will be as then provided by The Principal with respect to insurance for which application is made in accordance with the Individual Purchase provisions described in this section. NOTE: The benefits provided under the conversion policy are not the same as the benefits provided by this Group Policy.

b. Purchase Qualification

A Member will qualify for individual purchase if insurance under this Group Policy terminates and the Member has been continuously covered under this Group Policy (or for similar benefits under any group policy which it replaces) for at least the 3-month period immediately prior to the date insurance terminates. Except that, a Member will not qualify for individual purchase if insurance under this Group Policy terminates because:

(1) the Member failed to pay any required premium; or
(2) the Group Policy terminates and continuous coverage is provided under replacement group medical expense coverage; or
(3) the Member reaches the Comprehensive Medical Overall Lifetime Maximum Payment Limit; or
(4) the Member's continuation of insurance ends as provided in PART III, Section D, and such continuation ends because the Member:

- fails to pay any required premium; or
- becomes covered under other group medical expense coverage.

The persons to be covered under any medical expense insurance purchased will be the Member and all Dependents who are covered under this Group Policy on the date insurance is terminated, except that any Developmentally Disabled or Physically Handicapped child beyond the maximum age for Dependent Children will be covered as

provided below in Article 2.

A Member will not be eligible for individual purchase if the purchased insurance, together with any similar benefits for which the person is covered under another plan or program, will result in overinsurance or duplication of benefits based on standards for overinsurance as established by The Principal.

c. Application/Effective Date

Notice of the individual purchase right must be given to the Member by the Policyholder before insurance under this Group Policy terminates, or as soon as reasonably possible thereafter.

A Member must apply for individual purchase and the first premium for the other medical expense insurance must be paid to The Principal within 31 days after the date insurance terminates under this Group Policy.

The other medical expense insurance will then be in force on the day after such termination date.

Article 2 - Dependent Medical Expense Insurance

a. Spouse

A spouse may purchase other medical expense insurance in the same manner as described for a Member in Article 1 above, if insurance for the spouse under this Group Policy ceases because:

(1) the Member dies; or
(2) the spouse is divorced or legally separated from the Member; or
(3) the spouse reaches the Comprehensive Medical Overall Lifetime Maximum Payment Limit; or
(4) continuation ends as provided in this PART III, Section D, for a Member's spouse, unless the continuation ends because the spouse:

- fails to pay any required premium; or
- becomes covered under other group medical expense coverage.

b. Dependent Children

A Dependent Child may purchase other medical expense insurance in the same manner as described for a Member in Article 1 above, if insurance for the Dependent Child under this Group Policy ceases because:

(1) the child ceases to be a Dependent Child as defined in PART I; or
(2) continuation ends as provided in this PART III, Section D, for a Member's Dependent Child, unless the continuation ends because the Dependent Child:

- fails to pay any required premium; or
- becomes covered under other group medical expense coverage; or

(3) the child reaches the Comprehensive Medical Overall Lifetime Maximum Payment Limit.

c. Developmentally Disabled or Physically Handicapped Children

A Developmentally Disabled or Physically Handicapped child beyond the maximum age for Dependent Children may purchase other medical expense insurance in the same manner as described above, if insurance for the Dependent Child under this Group Policy ceases due to termination of the Member's insurance as described in Article 1 above.

Section A - Medical Expense Insurance (General Provisions)

Article 1 - Schedule of Insurance

a. Insurance Class

Subject to the Effective Date provisions of PART III, Section B, Scheduled Benefits for insured Members and Dependents will be:

Class	Scheduled Benefits
All Members and their Dependents	All benefits as described under PART IV, Section A, B1 (2) and B1 (3)

b. Maximum Benefits

Benefit payment provided under PART IV, Section A, for a Member or Dependent will not exceed:

Comprehensive Medical	
Overall Lifetime Maximum Payment Limit	$5,000,000
Prescription Drugs	See Section B1 (2)
Mail Service Prescription Drugs	See Section B1 (3)

As described in the following Part IV Sections, there are other Lifetime Maximum Payment Limits applicable to certain medical Treatments or Service. Benefits paid toward all such limits will be counted towards the Overall Lifetime Maximum Payment Limit described above, and will reduce the Overall Lifetime Maximum Payment Limit accordingly.

Article 2 - Benefit Qualification

This Policy has been updated effective March 1, 2008

A Member or Dependent will qualify for payment of the benefits provided for an insurance class if:

a. he or she is insured in that class on the date medical Treatment or Service is received; and

b. the claim requirements of this PART IV, Section C, are satisfied.

Article 3 - Benefits Payable

Benefits payable under this Group Policy will be as described under PART IV, Section A, B1 (2) and B1 (3), subject to:

a. the limitations listed in such section(s); and

b. the terms and conditions set forth in:

(1) Utilization Management Program in this PART IV, Section B1 (1A); and
(2) Coordination with Other Benefits in this PART IV, Section F; and
(3) Medicare Carveout in this PART IV, Section G; and
(4) Subrogation and Reimbursement in this PART IV, Section H.

Article 3A - Benefits Payable - Required by Federal Law

Subject to the provisions as described in Article 3 above, benefits under this Group Policy will be payable for:

a. Newborns' and Mothers' Health Protection Act of 1996

Under Federal law, Group Health Plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a Group Health Plan may not, under Federal law, require that a provider obtain authorization from the Group Health Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

See "Maternity Coverage" under Benefits Payable - State Required - WEST VIRGINIA below for description of how benefits will be payable under the Group Policy.

b. Women's Health and Cancer Rights Act of 1998

This Policy has been updated effective March 1, 2008

Under Federal law, group health plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation between the attending Physician and the patient.

See "Mastectomy and Reconstructive Surgery After Mastectomy" under Benefits Payable - State Required - WEST VIRGINIA below for a description of how benefits will be payable under the Group Policy.

Article 3B - Benefits Payable - State Required - West Virginia

Subject to the provisions, as described in Article 3 above, benefits will be payable under this Group Policy for:

a. Child Immunizations

Covered Charges will include the cost of Child Immunizations administered to a Dependent Child from birth through age 16. Benefits are payable for the cost of each immunization (including the cost of the vaccine, if incurred by the health care provider), and all costs of vaccine administration. Benefits for Child Immunizations will be payable at 100% of Prevailing Charges and no Deductible or Copay will be applied.

NOTE: This benefit will be coordinated with the Pediatric Vaccine benefit described on PART IV, Section A (7).

b. Treatment of Diabetes

Covered Charges will include charges incurred for the treatment of diabetes. Benefits will be payable for:

(1) Equipment and supplies as follows: blood glucose monitors; monitor supplies; insulin; injection aids; syringes; insulin infusion devices; pharmacological agents for controlling blood sugar; and orthotics.

(2) Diabetes self-management education, including information on proper diets, prescribed by a Physician. Coverage is limited to:

(a) Visits medically necessary upon the diagnosis of diabetes;

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(b) Visits when a Physician has identified or diagnosed a significant change in the symptoms or conditions that necessitates changes in the patient's self-management; and

(c) Reeducation or refresher education when a new medication or therapeutic process relating to a patient's treatment or management of diabetes has been identified as Medically Necessary Care by a Physician. However, coverage for this reeducation or refresher education is limited to a maximum benefit of $100 each calendar year for each insured person.

The education may be provided by:

(i) the Physician as part of an office visit for diabetes diagnosis or treatment; or
(ii) a certified diabetes educator certified by a national diabetes educator certification program; or
(iii) a registered dietician registered by a nationally recognized professional association of dietitians upon the referral of a Physician.

To qualify for insurance coverage, the national diabetes education certification program or nationally recognized professional association of dietitians described above must be certified to the Commissioner of Insurance by the Commissioner of the Bureau of Public Health.

Benefits will be payable the same as any other covered Treatment or Service.

NOTE: For the purpose of these state-required benefits, the following diabetic supplies will be payable under PART IV Benefits Section B1 (2) - Prescription Drug Expense or PART IV Benefits Section B1 (3) - Mail Service Prescription Drug Expense: insulin; disposable insulin needles/syringes; disposable blood/urine glucose acetone testing agents (e.g. Chemstrips, Acetest tablets, and Clinitest tablets); lancets; glucometer (limited to no more than one each calendar year); and alcohol swabs.

All other diabetic supplies will be payable the same as any other covered Treatment or Service under Benefits Payable - State Required - WEST VIRGINIA.

c. Mammography, Pap Smear, and Human Papilloma Virus Tests

Covered Charges will include charges incurred for mammography, pap smear and Human Papilloma Virus tests.

Benefits will be payable the same as for any other Physician Office or Clinic Service.

d. Temporomandibular Joint Disorders (TMJ) and Craniomandibular Disorders

Covered Charges will include charges incurred for medically necessary treatment of

temporomandibular joint disorders and craniomandibular disorders. Benefits will be payable the same as for treatment of any other joint in the body, provided the treatment is furnished by a Doctor of Medicine (M.D.) or Osteopathy (D.O.), Dentist, or other health care professional acting within the scope of his or her license.

Covered Charges will include:

(1) Clinical examinations, including a medical and/or dental history;
(2) Diagnostic x-rays;
(3) Conventional diagnostic and therapeutic injections;
(4) Temporary orthotics. However, splints or appliances are limited to one every three years, and all adjustments during the first six months after installation are considered part of the total appliance fee. Benefits are not payable for appliances designed for orthodontic purposes;
(5) Physical medicine and physiotherapy, including ultra-sound, diathermy, high-voltage galvanic stimulation, and transcutaneous nerve stimulation; and
(6) Surgery on the temporomandibular joint, including but not limited to arthrotomy and diagnostic arthroscopy.

Covered Charges will not include orthodontic services, or treatment for replacement of the dentition, supporting tissues and bone.

e. Reconstructive or Cosmetic Surgery After an Act of Family Violence

Covered Charges will include charges incurred for reconstructive or Cosmetic Surgery that result from an injury caused by an act of family violence when the person inflicting the injury was convicted of a felony, a lesser included misdemeanor offense, or a charge of domestic battery for inflicting the injury. Benefits will be payable the same as for any other covered Treatment or Service.

f. Mastectomy and Reconstructive Surgery After Mastectomy

Covered Charges will include charges incurred for reconstructive surgery following a mastectomy. This includes:

- All stages of reconstruction on the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined by the attending physician in consultation with the patient.

Covered Charges will include a minimum of 48 hours of inpatient hospital care following a radical or modified mastectomy, and not less than 24 hours of inpatient hospital care following a total mastectomy or partial mastectomy with lymph node

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dissection for the treatment of breast cancer.

The attending physician and patient may determine a shorter length of stay is appropriate.

Benefits will be payable the same as for any other covered Treatment or Service.

g. Hearing Tests for Newborns

Covered Charges will include charges incurred for tests for hearing loss on infants following birth.

Benefits will be payable the same as any other Physician Office or Clinic Service.

h. Maternity Coverage

Covered Charges will include Hospital Confinement Charges incurred by a mother and newborn Dependent Child. Benefits will be payable for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean section, excluding the day of delivery. Benefits will be payable the same as any other covered Treatment or Service, however, the 48-hour and 96-hour minimum will not be subject to the Hospital Admission Review or Medically Necessary Care requirements of this Policy. Any benefits payable in excess of the 48-hour or 96-hour minimum will be subject to all terms and conditions of this Policy that apply to any other covered Treatment or Service.

i. Colorectal Cancer Screening

Covered Charges will include charges incurred for colorectal cancer examinations and laboratory tests that are performed for colorectal cancer screening or diagnostic purposes.

Benefits will be payable the same as for any other Physician Office or Clinic Services up to $3,000 per visit. Additional benefits, if any, beyond the $3,000 will be subject to the calendar year deductible amount and the coinsurance percentage. All other flexible sigmoidoscopies or colonoscopies will be payable the same as for any other covered Treatment or Service.

j. Rehabilitation Services

Covered Charges will include charges for rehabilitation services designed to improve a patient’s condition or restore the patient to his or her optimal physical, medical, psychological, social, emotional, vocational and economic status.

The rehabilitation services will include diagnostic testing, assessment, monitoring or

treatment of the following conditions individually or in combination: stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma; fracture of femur; brain injury; polyarthritis, (including rheumatoid arthritis); neurological disorders, (including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease); cardiac disorders, (including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease); or burns.

Rehabilitation services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

Benefits will be payable the same as for any other covered Treatment or Service.

k. Contraceptive Drugs and Devices

Covered Charges will include charges for prescription drugs or prescription devices approved for contraceptive use by the United States Food and Drug Administration.

Covered Charges will also include charges for outpatient contraceptive services including consultations, examinations, procedures and medical services related to the use of contraceptive methods to prevent pregnancy, as well as contraceptive supplies ordered by an authorized health care provider for non contraceptive purposes, or to preserve the life or health of a Member or Dependent.

Benefits will be payable the same as for any other covered Treatment or Service.

l. Kidney Disease Screening

Covered Charges will include charges for kidney disease screening and laboratory testing services ordered by a licensed physician.

"Kidney disease screening and laboratory testing" includes annual blood pressure testing, urine albumin laboratory test, urine protein laboratory test and serum creatinine testing.

Benefits will be payable the same as for any other Physician Office or Clinic Service.

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Section A (1) - Comprehensive Medical Expense Insurance (PPO), Payment Conditions

Article 1 - Payment Conditions

If a Member or Dependent has a medical condition resulting from a sickness or injury, The Principal will pay the charges for any Treatment or Service that is listed in PART IV, Section A (3) under Covered Charges, but the benefits payable for all listed Treatment or Service received during a calendar year will not be more than the applicable amount shown below.

For medical care received from Preferred Providers and from Non-Preferred Providers, total benefits payable for each Member or Dependent during his or her lifetime will not be more than the Comprehensive Medical Overall Lifetime Maximum Payment Limit.

a. Preferred Providers

If medical care is received from Preferred Providers, Comprehensive Medical benefits payable for medical care received each calendar year will be:

(1) for Treatment or Service listed under Hospital Services, Physician Hospital Services, and All Other Covered Services 80% of each person's Covered Charges in excess of the applicable Deductible or Copay amount until the maximum Out-of-Pocket Expense limits are met; and
(2) for Treatment or Service listed under Physician Office or Clinic Services, 100% of each person's Covered Charges in excess of the applicable Copay amount; and
(3) 100% of Covered Charges in excess of:

- $4,000 of Out-of-Pocket Expenses for a Member or Dependent; or
- $6,000 of Out-of-Pocket Expenses for all persons in the same family (a Member and his or her Dependents).

The following exceptions apply:

(1) For payment conditions applicable to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, see PART IV, Section A (4).

(2) For payment conditions applicable to Transplant Services, see PART IV, Section A (5).

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(3) For payment conditions applicable to Medical Emergency, see PART IV, Section A (6).

(4) For payment conditions applicable to Wellness Services see PART IV, Section A (7).

(5) For payment conditions applicable to Rehabilitative Services, see PART IV, Section A (8).

(6) For payment conditions applicable to Outpatient X-ray Services, see PART IV, Section A (9).

(7) For payment conditions applicable to Outpatient Laboratory Services, see PART IV, Section A (9).

(8) For payment conditions applicable to Emergency Room Services, see PART IV, Section A (10).

If the Member or Dependent is referred to another provider, the Member or Dependent should verify with their Physician that the referral is for a Preferred Provider.

b. Non-Preferred Providers

If medical care is received from Non-Preferred Providers, Comprehensive Medical benefits payable for medical care received each calendar year will be:

(1) for Treatment or Service listed under Hospital Services, Physician Hospital Services, Physician Office or Clinic Services, and All Other Covered Services, 60% of each person's Covered Charges in excess of the applicable Deductible or Copay amount until the maximum Out-of-Pocket Expense limits are met; and

(2) 100% of Covered Charges in excess of:

- $6,000 of Out-of-Pocket Expenses for a Member or Dependent; or
- $12,000 of Out-of-Pocket Expenses for all persons in the same family (a Member and his or her Dependents).

The following exceptions apply:

(1) Benefits payable for Hospital Inpatient Confinement Charges, benefits payable will be reduced by 25% (but not more than $2,000 per individual each calendar year) unless the Utilization Management Requirements described in Section B1 (1A) are satisfied.

(2) For payment conditions applicable to Mental Health, Behavioral, Alcohol or Drug

Abuse Treatment Services, see PART IV, Section A (4).

(3) For payment conditions applicable to Transplant Services, see PART IV, Section A (5).

(4) For payment conditions applicable to Medical Emergency, see PART IV, Section A (6).

(5) For payment conditions applicable to Wellness Services see PART IV, Section A (7).

(6) For payment conditions applicable to Rehabilitative Services, see PART IV, Section A (8).

(7) For payment conditions applicable to Outpatient X-ray Services, see PART IV, Section A (9).

(8) For payment conditions applicable to Outpatient Laboratory Services, see PART IV, Section A (9).

(9) For payment conditions applicable to Emergency Room Services, see PART IV, Section A (10).

c. Services provided by a Non-PPO anesthesiologist, radiologist, and pathologist

For services provided by a Non-PPO anesthesiologist, radiologist, or pathologist, benefits will be payable at the PPO deductible and coinsurance level when such services are provided at a PPO Hospital (inpatient, outpatient, and emergency room) or a licensed freestanding surgical center.

d. Ambulance services

Covered Charges for ambulance services will be paid at the PPO level (including application of the PPO Deductible Amount and coinsurance) regardless of whether such services are provided by a PPO Provider or a Non-PPO Provider.

This Policy has been updated effective March 1, 2008

Section A (2) - Copay and Deductible Amount and Out-of-Pocket Expense

Article 1 - Copay Amount

a. Preferred Providers

If medical care is received from Preferred Providers, the individual Copay amounts for a Member or Dependent will be:

(1) none for outpatient Laboratory Services obtained from Lab Card; and

(2) for each Physician seen for a Physician Office or Clinic Service, a $25 Copay for each Physician Visit provided by a Primary Care Physician. This Copay provision does not apply to charges incurred for MRIs, CATs, PETs, SPECTs and other similar imaging tests. These charges are subject to the calendar year Deductible shown below; and

(3) for each Physician seen for a Physician Office or Clinic Service, a $25 Copay for each Physician visit provided by a Specialty Provider. This Copay provision does not apply to charges incurred for MRIs, CATs, PETs, SPECTs and other similar imaging tests. These charges are subject to the calendar year Deductible shown below; and

The Copay amounts will continue to apply after the calendar year Deductible and the Out-of-Pocket Expense Limits have been satisfied.

b. Non-Preferred Providers

If medical care is received from Non-Preferred Providers, the individual Copay amounts for a Member or Dependent will be:

(1) for Hospital Services Covered Charges for Hospital Inpatient Confinement Charges, a $500 Copay for each period of Hospital Inpatient Confinement. Hospital Services Covered Charges for Birthing Center Services, Ambulatory Surgery Center Services, and freestanding dialysis center services will be subject to the calendar year Deductible shown below. This per-admission Copay is in addition to the calendar year Deductible shown below; and

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(2) a $100 Copay for each Hospital emergency room visit (unless admitted to the Hospital immediately following emergency room treatment). This per-visit Copay is in addition to the calendar year Deductible shown below; and

(3) none for outpatient laboratory services obtained from Lab Card; and

The Copay amounts will continue to apply after the calendar year Deductible and the Out-of-Pocket Expense Limits have been satisfied.

Article 1A - Deductible Amount

a. Preferred Providers

If medical care is received from Preferred Providers, the individual Deductible amount for a Member or Dependent will be:

(1) $1,500 each calendar year for all other Covered Charges (including all charges incurred for MRIs, PETs, CATs, SPECTs and other similar imaging tests).

b. Non-Preferred Providers

If medical care is received from Non-Preferred Providers, the individual Deductible amount for a Member or Dependent will be:

(1) $1,500 each calendar year for all other Covered Charges (including charges incurred for MRIs, PETs, CATs, SPECTs and other similar imaging tests).

c. Family Maximum Deductible

The family maximum combined Deductible amount with respect to "all other Covered Charges" described above for all persons in the same family (a Member and his or her Dependents) each calendar year will be $3,000, but not counting more than $1,500 of such Covered Charges for each person in the family.

When the family maximum Deductible is satisfied, benefits will be payable as if the "all other Covered Charges" individual calendar year Deductible for each person in the family has been satisfied.

Copay amounts cannot be used to satisfy the family Deductible limit.

Article 2 - Out of Pocket Expenses

This Policy has been updated effective March 1, 2008

"Out-of-Pocket Expenses" mean Covered Charges for Treatment or Service for which no benefits are payable because of Deductible, Copayment, and coinsurance features. Out-of-Pocket Expenses does not include charges that are in excess of Prevailing Charges or charges that are not Covered Charges under this Group Policy.

Covered Charges used to satisfy the Out-of-Pocket Expense limits that apply when care is received from Preferred Providers will be used to satisfy the Out-of-Pocket Expense limits that apply when care is received from Non-Preferred Providers and vice versa.

In addition, the following charges will not count toward satisfaction of the Out-of-Pocket Expense limits:

a. Covered Charges for which no benefits are payable because of the Utilization Management Requirements penalty; or

b. the Hospital Services per-admission Copay amount; or

c. the Physician Office or Clinic Services per-visit Copay amount; or

d. the emergency room per-visit Copay amount; or

e. Covered Charges for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

For the Physician Office or Clinic Services per-visit Copay amount: The coinsurance amount that the Member or Dependent must pay after the Copay amount will be counted toward satisfaction of the Out-of-Pocket Expense limits, but will not be counted toward satisfaction of the "all other Covered Charges" calendar year Deductible Amount.

Article 3 - Period of Confinement

For purposes of applying the Hospital charges Copay amount for each admission, two or more periods of Hospital Inpatient Confinement will be considered one period of confinement unless caused by an unrelated sickness or injury, or unless separated by 30 consecutive days or more.

This Policy has been updated effective March 1, 2008

Section A (3) - Covered Charges

Article 1 - Covered Charges

Covered Charges will be the actual cost charged to the Member or Dependent but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Covered Charges for Comprehensive Medical benefits payable will be based on four Categories of medical care services as described below.

Payment of Covered Charges not listed shall be determined by The Principal based on the amount payable for a Covered Charge of a comparable nature.

a. Hospital Services includes:

(1) charges by a Hospital for room and board (but not more than the Hospital Room Maximum if confinement is in a private room); and
(2) Hospital services other than room and board; and
(3) charges by a Physician for pathology, radiology, or the administration of anesthesia while receiving treatment during a Hospital Inpatient Confinement (on an inpatient or outpatient basis); and
(4) the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), including Primary Health Care Nursing Services, but only when such services are provided while receiving treatment during a Hospital Inpatient Confinement or as otherwise required by state law; and
(5) physical, occupational, and speech therapy, but only when such services are provided while receiving treatment during a Hospital Inpatient Confinement; and
(6) charges for blood and blood plasma when provided while the person is receiving treatment during a Hospital Inpatient Confinement; and
(7) Birthing Center services, including the service of a licensed midwife or nurse midwife, when such services are provided while the person is receiving treatment in a Birthing Center; and
(8) Ambulatory Surgery Center services; and
(9) freestanding dialysis center services; and
(10) Inpatient Rehabilitative Services as described in PART IV, Section A(8).

b. **Physician Hospital Services** include charges for the services of a Physician (including surgery and Physician Visit), while receiving treatment at a Hospital (on an inpatient or

outpatient basis).

c. Physician Office or Clinic Services include:

(1) charges for Treatment or Service furnished at the Physician's office or clinic. Such services include charges for a Physician Visit, injections, take-home drugs, blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy. MRIs, CATs, PETs, and SPECTs or other similar imaging tests are paid under All Other Covered Services as listed below; and
(2) the services of a Health Care Extender; and
(3) physical, occupational, and speech therapy as described in PART IV, Section A (8); and
(4) the services of licensed midwives or nurse midwives.

d. All Other Covered Services include:

(1) drugs and medicines requiring a Physician's prescription and approved by the Food and Drug Administration for general marketing, excluding any charges payable under this PART IV, Section B1 (2) and Section B1 (3); and
(2) charges for ambulance services provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) or to and from a Hospital when needed to transition to a more cost effective level of care as determined by The Principal; and
(3) surgical dressings, supplies, covered orthotics, casts, splints, braces and crutches and equipment not considered to be Durable Medical Equipment as described in PART IV, Section A (12); and
(4) oxygen, nebulizers and related charges; and
(5) Skilled Nursing Facility Care as described below in PART IV, Section A (15); and
(6) Hospice Care as described in PART IV, Section A (14); and
(7) Home Health Care as described in PART IV, Section A (11); and
(8) Home Infusion Therapy Services as described in PART IV, Section A (11); and
(9) Durable Medical Equipment as described in PART IV, Section A (12); and
(10) Prosthetics as described in PART IV, Section A (13); and
(11) the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), including Primary Health Care Nursing Services, but only when such services are provided as part of Home Health Care, Home Infusion Therapy Services or Hospice Care as required by state law; and
(12) anesthesia; and
(13) cornea or skin transplants; and
(14) magnetic resonance imaging (MRIs), computerized axial tomography (CATs), positron emission tomography (PETs), and single photon emission computerized tomography (SPECTs), or other similar imaging tests and all related services (other than evaluation and management services) including but not limited to drugs

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and supplies; and

(15) Dental Services to repair damages to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within twelve months after the accident. Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results.

(16) Outpatient non-surgical back, neck, and spine as described in PART IV, Section A (8).

Article 2 - Covered Charges for Multiple Surgical Procedures

If a Member or Dependent undergoes two or more procedures during the same anesthesia period, Covered Charges for the services of a Physician, facility or other covered provider for each procedure that is clearly identified and defined as a separate procedure will be based on:

a. 100% of Prevailing Charges for the first or primary procedure; and

b. 50% of Prevailing Charges for the second procedure; and

c. 25% of Prevailing Charges for each of the other procedures.

Article 3 - Covered Charges for an Assistant during Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if the skill level of a Medical Doctor or Doctor of Osteopathy would be required to assist the primary surgeon. Covered Charges for such services will be paid at up to 20% of Prevailing Charges of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

In addition, the multiple surgical procedure percentiles, as described in Article 2 will be applied.

This Policy has been updated effective March 1, 2008

Section A (4) - Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services and Serious Mental Illness

Article 1 - Payment Conditions - Mental Health, Behavioral, Alcohol or Drug Abuse and Serious Mental Illness

The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services and Serious Mental Illness. These benefits will be payable instead of any other benefits described in this Group Policy, except as otherwise indicated in this Article 1. In the event the Member or Dependent receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service, as determined by The Principal.

a. Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services (for other than Serious Mental Illness)

(1) Inpatient Hospital Services

If a Member or Dependent is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, or a psychiatric or alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described in (5) below for not more than 10 days of inpatient services each calendar year for each insured person. Each day of Partial Hospitalization or Day Treatment Services, as described in (2) below, will reduce this 10-day benefit by one day.

For Alcohol or Drug Abuse Treatment Services: Inpatient Hospital benefits will be payable only for Medical Detoxification confinements (except when the Member or Dependent receives Partial Hospitalization or Day Treatment Services). Such benefits are subject to the 10-day calendar year Inpatient Hospital Services limit described above.

Benefits are limited to three inpatient Hospital confinements for each insured

person during his or her lifetime.

(2) Partial Hospitalization or Day Treatment Services

If a Member or Dependent receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in (5) below.

Partial Hospitalization or Day Treatment Services are subject to the Inpatient Hospital Services 10-day calendar year limit. Each day of Partial Hospitalization or Day Treatment Services will reduce the Inpatient Hospital Services 10-day calendar year benefit by one day.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

"Partial Hospitalization or Day Treatment Services" means a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol, or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

(3) Outpatient Services

If a Member or Dependent receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Community Mental Health Center, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described in (5) below for up to 12 visits for each insured person each calendar year, not to exceed an overall maximum of 25 visits for each insured person during his or her lifetime.

"Outpatient Services" means Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

(i) crisis intervention or stabilization;
(ii) psychological testing;
(iii) individual psychotherapy;
(iv) family therapy;

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(v) group therapy;
(vi) electroconvulsive therapy;
(vii) psychiatric, alcohol or drug abuse medication management;
(viii) biofeedback;
(ix) behavior modification treatment;
(x) alcohol or drug abuse rehabilitation or counseling services;
(xi) hypnotherapy;
(xii) narcosynthesis.

(4) Physician Visits

If a Member or Dependent receives any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

(i) While Hospital Inpatient Confined: Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under (5) below.

(ii) While receiving Partial Hospitalization or Day Treatment Services: Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under (5) below.

(iii) All Other Physician Visits: Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be payable as described in (5) below. Covered Services will be those listed under Outpatient Services in (3) above.

(5) Benefits Payable

(i) Inpatient Hospital Services: Benefits will be payable as follows:

- 60% of Covered Charges if medical care is received from Preferred Providers; and
- 50% of Covered Charges if medical care is received from Non-Preferred Providers.

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Benefits payable will be subject to the same Deductible or Copay that applies to any other Hospital Inpatient Confinement, as well as the calendar year and lifetime maximum benefits described in (1) above.

Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.

(ii) Partial Hospitalization or Day Treatment Services: Benefits will be payable on the same basis as described above for Inpatient Hospital Services and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described in (2) above.

(iii) Outpatient Services: Benefits will be payable as follows:

- 60% of Covered Charges if medical care is received from Preferred Providers; and
- 50% of Covered Charges if medical care is received from Non-Preferred Providers.

Benefits payable will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the calendar year and lifetime maximum benefits described in (3) above.

(iv) Physician Visits: Benefits will be payable as follows:

- 60% of Covered Charges if medical care is received from Preferred Providers; and
- 50% of Covered Charges if medical care is received from Non-Preferred Providers.

Benefits payable will be subject to the calendar year Deductible as well as the limits described in (4) above.

Charges for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not apply toward the Out-of-Pocket Expense limits and will never be paid at 100%.

b. Serious Mental Illness

If a Member or Dependent receives Treatment or Service for a Serious Mental Illness (on an inpatient or outpatient basis), benefits will be payable the same as for any other covered Treatment or Service.

This Policy has been updated effective March 1, 2008

For this purpose, "Serious Mental Illness" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of:

(1) schizophrenia and other psychotic disorders;
(2) bipolar disorders;
(3) depressive disorders
(4) substance-related disorder with the exception of caffeine-related disorders and nicotine-related disorders;
(5) anxiety disorders; and
(6) anorexia and bulimia.

Charges for Serious Mental Illness will apply toward the Out-of-Pocket Expense limits.

c. Provisions Applicable to Mental Health, Behavioral, Alcohol or Drug Treatment Services (including Serious Mental Illnesses)

For the purpose of the benefits described in this Article 1:

(1) Benefits payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will be applied toward the Comprehensive Medical Overall Lifetime Maximum Payment Limit, and this maximum will be reduced by the benefits paid.

(2) No benefits will be payable for any charges incurred in excess of the limits and maximums described in Section A (4). The general Comprehensive Medical limitations in Section A (18) will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In addition, Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:

- residential or inpatient Hospital alcohol or drug abuse rehabilitation or counseling Treatment or Service; or
- residential mental health or behavioral Treatment or Service; or
- recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or
- psychoanalysis and aversion therapy; or
- Social Detoxification; or
- after-care treatment programs for alcohol or drug abuse.

(3) Covered Charges incurred for outpatient laboratory services and for outpatient drug and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service, and are not subject to the limits described in

This Policy has been updated effective March 1, 2008

this Article 1.

This Policy has been updated effective March 1, 2008

PART IV - BENEFITS

Section A (5) - Transplant Services

Article 1 - Payment Conditions - Transplant Services

"Transplant Services" mean Covered Charges incurred in connection with the Covered Transplants listed below that are a Covered Charge and not considered to be an Experimental or Investigational Measure. The following benefits will be payable for Treatment or Service for Transplant Services. These benefits will be payable instead of any other benefits described in this Group Policy, except as otherwise provided in this Section.

a. Covered Transplants

The following human-to-human organ or bone marrow transplant procedures will be considered Covered Charges, subject to all limitations and maximums described in this Section A (5), for a patient who is covered under this Group Policy.

(1) Heart;
(2) Heart/lung (simultaneous);
(3) Lung;
(4) Liver;
(5) Kidney;
(6) Kidney-pancreas;
(7) Pancreas;
(8) Small bowel
(9) Bone marrow transplant or peripheral stem cell infusion for the following conditions when a positive response to standard medical treatment or chemotherapy has been documented. Unless otherwise indicated, coverage is for one transplant or infusion only within a 12 month period.

- Acute Lymphoblastic Leukemia - Autologous bone marrow transplant or peripheral stem cell infusion;
- Acute Lymphoblastic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Acute Myelogenous Leukemia - Autologous bone marrow transplant or peripheral stem cell infusion;
- Acute Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Chronic Lymphocytic Leukemia - Allogeneic bone marrow transplant or

peripheral stem cell infusion;

- Chronic Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion; donor leukocytes are covered following relapse post marrow transplant;
- Aplastic Anemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Hodgkin's Disease - Autologous bone marrow transplant or peripheral stem cell infusion;
- Hodgkin's Disease - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Multiple Myeloma - Autologous bone marrow transplant or peripheral stem cell infusion; single or tandem (two transplants or perfusions within 12 months of each other);
- Multiple Myeloma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Pediatric Neuroblastoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Pediatric Neuroblastoma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Primary Amyloidosis - Autologous bone marrow transplant or peripheral stem cell infusion;
- Myleodysplasia with refractory anemia - Allogeneic bone marrow transplant or peripheral stem infusion;
- Pediatric Monosomy 7 - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- SCID (Severe Combined Immunodeficiency Disease) - Allogeneic bone marrow transplant or stem cell infusion;
- Thalassemia - Allogeneic bone marrow transplant or stem cell infusion.

The following non-myeloablative regimens are considered Covered Charges, subject to all limitations and maximums described in this Section A (5), for a patient who is covered under this Group Policy:

- Multiple Myeloma - Allogeneic bone marrow transplant or stem cell infusion;
- Non-Hodgkin's Lymphoma - Allogeneic bone marrow transplant or stem cell infusion;
- Chronic B-Cell Lymphocytic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion; donor leukocytes are covered following relapse post marrow transplant.

This Policy has been updated effective March 1, 2008

Cornea and skin transplants are not Covered Transplants for the purpose of this Article 1. Instead, cornea and skin transplants are covered under the normal provisions of this Comprehensive Medical section, and are not subject to any conditions set forth in this Section.

b. Covered Charges

For the purpose of this Article, Transplant Services Covered Charges will include all services listed in the general Comprehensive Medical Covered Charges section, including, but not limited to, services by a Home Health Care Agency, Skilled Nursing Facility, Hospice, and services for Home Infusion Therapy Services and Durable Medical Equipment.

Covered Charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage.

c. Benefits Payable: Within the Transplant Network

For Transplant Services provided by a provider in the Transplant Network, benefits payable for Treatment or Service received each calendar year will be paid at the PPO level of benefits, subject to the calendar year Deductible.

If transplant related services are provided by a provider in the Transplant Network, travel and lodging expenses for the patient and the patient's Immediate Family will be covered if the treating facility is greater than 100 miles one way from the patient's home (excluding travel or lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Comprehensive Medical ambulance benefit, if such expenses are incurred solely to meet timing requirements imposed by the transplant. Benefits payable cannot be used to satisfy any Deductible or coinsurance amount under the ambulance benefit in the normal provisions of the Comprehensive Medical section.

Travel and lodging benefits will be payable at 100% without application of any Deductible Amount, up to a lifetime maximum benefit of $5,000 for each transplant recipient.

All travel and lodging benefits must be approved in advance by The Principal.

As used in this Section, "Transplant Network" means United Resource Networks.

d. Benefits Payable: Outside the Transplant Network

For Transplant Services provided by any covered provider other than a Transplant Network Provider, benefits will be payable the same as any other covered Treatment or

Service, subject to the calendar year Deductible and the applicable coinsurance rate, up to the following maximum benefits for each transplant episode for each surgery listed below, and up to a lifetime maximum benefit of $500,000 for each insured Member or Dependent:

Liver	$250,000
Kidney	$250,000
Heart	$250,000
Lung	$250,000
Heart/Lung (simultaneous)	$250,000
Bone Marrow	
- Autologous	$250,000
- Allogeneic	$250,000
Kidney/Pancreas (simultaneous)	$250,000
Kidney	$250,000
Pancreas	$250,000
Small Bowel	$250,000

Services subject to the transplant episode and lifetime maximums will include Covered Charges as specified in this section, including, but not limited to: evaluation; pre-transplant, transplant, and post-transplant care (not including outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Services by a Home Health Care Agency, Hospice, or Skilled Nursing Facility and services for Home Infusion Therapy Service and Durable Medical Equipment will reduce those provisions maximums as described in Section A (11), (12), (14) and (15).

No benefits will be payable for travel and lodging expenses if services are provided outside the Transplant Network.

e. Limitations: Applicable Within and Outside the Transplant Network

The general Comprehensive Medical limitations listed in Section A (18) will apply to Transplant Services. In addition, limitations specific to Home Health Care, Home Infusion Therapy Services, Durable Medical Equipment, Hospice, and Skilled Nursing Facility provisions will apply to Transplant Services if those benefits are used in connection with a Covered Transplant.

For each transplant episode Covered Charges will include:

(1) Transplant evaluations from no more than two transplant providers; and

(2) No more than one listing with the United Network of Organ Sharing (UNOS).

If the transplant is not a Covered Transplant under this Group Policy, all charges related to the transplant and all related complications will be excluded from payment under this Group Policy, including, but not limited to, dose-intensive chemotherapy.

Benefits paid for Transplant Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

This Policy has been updated effective March 1, 2008

Section A (6) - Medical Emergency

Article 1 - Payment Conditions - Medical Emergency

If a Member or Dependent requires treatment, either within the PPO Service Area or outside the PPO Service Area, for a Medical Emergency and cannot reasonably reach a Preferred Provider, benefits for such treatment received for that Medical Emergency will be paid as if the treatment had been provided by a Preferred Provider. Treatment or Service for conditions other than that which created the Medical Emergency will be paid at the Non-PPO level.

This Policy has been updated effective March 1, 2008

Section A (7) - Wellness Services

Article 1 - Payment Conditions - Wellness Services

a. Routine Physical Exams

(1) Adult Wellness

If medical care is received from Preferred Providers, charges incurred for Routine Physical Exams will be payable as described below:

For a Member or Dependent 19 years of age or older: Benefits will be payable at the PPO level the same as for any other Physician Office or Clinic Service, but will be limited to a calendar year maximum benefit of $300 for each insured person.

No benefits will be payable if services are provided by a Non-PPO Provider.

(2) Well Child Visits

Dependents under age 19: If services are provided by a PPO Provider, benefits will be payable at the PPO level the same as for any other Physician Office or Clinic Service.

If services are provided by a Non-PPO provider, benefits will be payable at the Non-PPO level the same as for any other Physician Office or Clinic Service.

"Routine Physical Exam" means a medical examination given by a Physician for a reason other than to diagnose or treat a suspected or identified sickness or injury. Included as part of the examination are x-rays, laboratory tests, immunizations and other tests given in connection with the examination. Not included are charges for magnetic resonance imaging (MRIs); computerized axial tomography (CATs); and positron emission tomography (PETs), and single photon emission computerized tomography (SPECTs) or other similar imaging tests.

Also not included are charges for Child Immunizations, Mammography, Pap Smear and Human Papilloma Virus Tests, and Colorectal Cancer Screening. Such charges are payable as described in PART IV, Section A.

This Policy has been updated effective March 1, 2008

b. Pediatric Vaccines

Covered Charges will include the cost of Pediatric Vaccines administered to a Dependent Child from birth through 18 years of age.

"Pediatric Vaccines" mean those vaccines shown on the list established and periodically reviewed by the Advisory Committee on Immunization Practices as referenced by Section 1928 of Title 19 of the Social Security Act or such other list of vaccines as mandated by other Federal or State laws that are applicable to this Group Policy.

Benefits for Pediatric Vaccines will be paid the same as any other Physician Office or Clinic Service.

Note: The benefit will be coordinated with the Child Immunizations provision in PART IV, Section (A).

c. Screening Colonoscopies

Refer to PART IV, Section A - Benefits Payable - State Required - WEST VIRGINIA.

d. Mammograms

Refer to PART IV, Section A - Benefits Payable - State Required - WEST VIRGINIA.

This Policy has been updated effective March 1, 2008

Section A (8) - Rehabilitative Services

Article 1 - Payment Conditions - Rehabilitative Services

a. Outpatient, Office or Clinic Services

(1) Back, Neck and Spine

Covered Charges will include charges for all services incurred for diagnosis and non-surgical treatment (including post-surgical therapy) of the vertebrae, disc, spine, back, neck and adjacent tissues in an outpatient, office or clinic setting. Benefits will be payable the same as any other covered Treatment or Service as described under All Other Covered Services, PART IV, Section A (3) up to a maximum benefit of $1,000 each calendar year for each insured person.

(2) Occupational Therapy, Physical Therapy and Speech Therapy, excluding Back, Neck and Spine as described above

Covered Charges will include charges incurred for occupational therapy, physical therapy and speech therapy, excluding services described above for back, neck and spine, up to a combined maximum benefit of $2,500 each calendar year for each insured person. Benefits will be payable the same as any other Specialist Physician Office or Clinic Service regardless of location of service.

b. Inpatient Services

Covered Charges will include charges incurred for inpatient rehabilitative services in an Inpatient Rehabilitation Facility for each insured person during the Member’s or Dependent’s lifetime. Benefits will be payable the same as any other covered Treatment or Service up to a maximum of 30 days per calendar year.

"Inpatient Rehabilitation Facility" is a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation bed) that provides rehabilitation health services (including but not limited to physical therapy, occupational therapy or speech therapy) on an inpatient basis, as authorized by law.

Note: Rehabilitative Services will be payable as shown above, except as provided for under Rehabilitation Services in PART IV, Section A.

This Policy has been updated effective March 1, 2008

Section A (9) - Outpatient X-Ray Services; Outpatient Laboratory Services

Article 1 - Payment Conditions - Outpatient X-Ray Services

Payment of outpatient x-ray services will be made as follows:

a. The PPO level of benefits will be paid only to Preferred Providers.

b. If the Member or Dependent goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the x-ray(s) to a PPO facility for interpretation, the PPO level of benefits will be paid. If the Member or Dependent is not seen within that facility, the Physician Office or Clinic Service Copay, if any, will not apply, but the PPO level of benefits will be paid.

c. If the Member or Dependent goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the x-ray(s) to a non-PPO facility, the level of benefits for Non-Preferred Providers will apply.

d. If the Member or Dependent goes to a PPO freestanding x-ray facility, the Physician Office or Clinic Service Copay, if any, will apply and the PPO level of benefits will be paid. If the x-ray facility is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

Article 2 - Payment Conditions - Outpatient Laboratory Services

Quest Diagnostics is a laboratory provider that conducts outpatient testing. Quest Diagnostics, under Lab Card has entered into an agreement with The Principal to provide outpatient Laboratory Services for which benefits are payable under this Group Policy.

"Laboratory Services" mean Covered Charges for testing of materials, fluids or tissues obtained from patients for the purpose of screening, diagnosing or monitoring a condition and for determining appropriate treatment.

If the Member or Dependent goes to a Physician's office or clinic and the Physician sends the laboratory work to a Lab Card facility for processing, The Principal will pay 100% of Covered Charges for the Laboratory Services.

This Policy has been updated effective March 1, 2008

If the Member or Dependent goes to a Physician's office or clinic and the Physician sends the laboratory work to a non-Lab Card facility, regular benefits will apply, including any applicable Deductibles, Copays, and coinsurance.

If the Member or Dependent goes to a Lab Card facility with a Physician's directive, The Principal will pay 100% of Covered Charges for the Laboratory Services. If the laboratory facility is not a Lab Card facility, regular benefits will apply, including any applicable Deductibles, Copays, and coinsurance.

This Policy has been updated effective March 1, 2008

PART IV - BENEFITS

Section A (10) - Emergency Room Services

Article 1 - Payment Conditions - Emergency Room Services

Covered Charges will include charges for Treatment or Service received in an emergency room. Benefits payable for emergency room treatment will be subject to Copays, Deductibles, and coinsurance in the following order:

a. First, the emergency room Copay will be applied; and

b. Then, the calendar year Deductible; and

c. Last, the Member's or Dependent's coinsurance percentage will be applied.

The emergency room Copay amount, if any:

a. will be waived if the insured is admitted to the Hospital immediately following emergency room treatment; and

b. will not count toward satisfaction of the calendar year Deductible.

This Policy has been updated effective March 1, 2008

Section A (11) - Home Health Care and Home Infusion Therapy Services

Article 1 - Payment Conditions - Home Health Care

a. Covered Charges

Covered Charges will include charges by a Home Health Care Agency for:

(1) part-time or intermittent home nursing care by or under the supervision of a licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) ; and
(2) part-time or intermittent home care by a Home Health Aide; and
(3) physical, occupational, speech, or respiratory therapy; and
(4) services of a licensed midwife or nurse midwife; and
(5) intermittent services of a registered dietician or social worker; and
(6) drugs and medicines which require a Physician's prescription, (except as specified under Home Infusion Therapy Services), as well as other supplies prescribed by the attending Physician; and
(7) laboratory services (except as specified under Home Infusion Therapy Services).

The Home Health Care Services must be:

(1) rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:

- prescribed by the attending Physician at least once every 60 days; and
- established prior to the initiation of the Home Health Care Services; and

(2) preapproved by The Principal prior to the initiation of the Home Health Care Plan, or in the event that services are required on a weekend, The Principal is notified the next following business day. If Home Health Care Services are not preapproved by The Principal, no benefits will be payable.

In addition, the attending Physician must certify that Home Health Care services are necessary to prevent, delay or shorten Hospital Inpatient Confinement or Skilled Nursing Facility Confinement.

b. Benefits Payable

This Policy has been updated effective March 1, 2008

Benefits will be payable the same as for any other covered Treatment or Service up to a maximum of 100 Home Health Care visits per calendar year for each insured person. For this purpose, one visit will be counted for up to four hours of service (in a 24-hour period) by a Home Health Aide and one visit will be counted for each visit by any other covered provider. Covered providers include a: Home Health Aide, licensed registered nurse (R.N.), licensed practical nurse (L.P.N.), registered dietician, licensed midwife or nurse midwife, social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, or any other member of the Home Health Care team.

Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

c. Limitations

The general Comprehensive Medical limitations listed in PART IV, Section A (18) will apply to Home Health Care. In addition, Home Health Care Covered Charges will not include charges for:

(1) more than 100 Home Health Care visits in a calendar year for each insured person; or
(2) nursing, laboratory or therapy services rendered as part of Home Infusion Therapy Services; or
(3) services provided by a Member or Dependent's Immediate Family or any other person residing in the home; or
(4) Custodial Care.

Article 2 - Payment Conditions - Home Infusion Therapy Services

a. Covered Charges

Covered Charges will include charges by a Home Health Care Agency, home infusion company or infusion suite for the following services:

(1) intravenous chemotherapy;
(2) intravenous antibiotic therapy;
(3) intravenous steroidal therapy;
(4) intravenous pain management;
(5) intravenous hydration therapy;
(6) intravenous antiretroviral and antifungal therapy;
(7) intravenous inotropic therapy;
(8) total parenteral nutrition;
(9) intravenous gamma globulin;

This Policy has been updated effective March 1, 2008

(10) intrathecal and epidural;
(11) blood and blood products;
(12) injectable antiemetics;
(13) injectable diuretics; and
(14) injectable anticoagulants.

The Home Infusion Therapy Services must be:

(1) rendered in accordance with a prescribed treatment plan. The treatment plan must be:

- set up prior to the initiation of the Home Infusion Therapy Service; and
- prescribed by the attending Physician; and

(2) preapproved by The Principal prior to the initiation of the Home Infusion Therapy Services, or in the event that services are required on a weekend, The Principal is notified the next following business day. If Home Infusion Therapy Services are not preapproved by The Principal, no benefits will be payable.

In addition, the attending Physician must certify that Home Infusion Therapy services are necessary to prevent, delay or shorten Hospital Inpatient Confinement or Skilled Nursing Facility confinement.

Covered Charges will be limited to: drugs; intravenous solutions; Durable Medical Equipment; pharmacy compounding and dispensing services; fees associated with drawing blood for the purpose of monitoring response to therapy; ancillary medical supplies; and nursing services for intravenous restarts and dressing changes; and nursing services required due to a Medical Emergency.

b. Benefits Payable

Benefits will be payable the same as for any other covered Treatment or Service. Benefits payable will be based on the allowable charge of The Principal, which is the amount established by The Principal at the time services are preapproved. The maximum allowable charge for drugs and medicines for Home Infusion Therapy Services will be established by The Principal at the time services are preapproved and will not exceed the Average Wholesale Price.

Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

c. Limitations

The general Comprehensive Medical limitations listed in PART IV, Section A (18) will

apply to Home Infusion Therapy Services. In addition, Home Infusion Therapy Covered Charges will not include charges for:

(1) services or supplies which are provided under any other section of this Group Policy for services, drugs, equipment, or supplies used in Home Infusion Therapy Services, except as specifically provided for in this section; or
(2) services or supplies for any Home Infusion Therapy Services not specifically provided for in this section; or
(3) services or supplies for any nursing visits, care or services associated with Home Infusion Therapy Services other than those identified in this section; or
(4) services or supplies for other services required to administer therapy in the home setting, but which do not involve direct patient contact, including, but not limited to, delivery charges and record keeping; or
(5) services provided by a Member's or a Dependent's Immediate Family or any other person residing in the home.

This Policy has been updated effective March 1, 2008

Section A (12) - Durable Medical Equipment

Article 1 - Payment Condition - Durable Medical Equipment

a. Covered Charges

Covered Charges will include charges for rental or purchase of Durable Medical Equipment. Durable Medical Equipment means equipment that:

(1) can withstand repeated use; and
(2) is primarily and customarily used to serve a medical purpose; and
(3) is generally not useful to a person who is not sick or injured, or used by other family members; and
(4) is appropriate for home use; and
(5) improves bodily function caused by sickness or injury, or further prevents deterioration of the medical condition.

Covered Charges will include repair, adjustment or replacement of purchased Durable Medical Equipment, unless damage results from the Member's or Dependent's negligence or abuse of such equipment.

b. Benefits Payable

Benefits will be payable the same as for any other covered Treatment or Service up to a maximum benefit of $2,500 each calendar year. However, the Covered Charge for rental of Durable Medical Equipment will be limited to the purchase price of the said piece of equipment. If no purchase price is available, the purchase price will be limited to 1.5 times the manufacturer's invoice price. The determination as to whether to purchase or rent the equipment is at the sole discretion of The Principal.

Claims submitted for Durable Medical Equipment must be accompanied by the Physician's Written prescription of necessity. However, this prescription does not by itself entitle the Member or Dependent to benefits.

Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

c. Limitations

This Policy has been updated effective March 1, 2008

The general Comprehensive Medical limitations listed in PART IV, Section A (18) will apply to Durable Medical Equipment charges. In addition, Durable Medical Equipment Covered Charges will not include Durable Medical Equipment charges which:

(1) are in excess of the purchase price of the equipment; or
(2) are for Durable Medical Equipment used in Home Infusion Therapy Services, except as provided under Section A (11); or
(3) are provided during rental for repair, adjustment, or replacement of components and accessories necessary for the functioning and maintenance of covered equipment, as this is the responsibility of the Durable Medical Equipment supplier; or
(4) are motorized carts or scooters, except for wheelchairs: or
(5) are non-hospital type beds: or
(6) are lift chairs.

This Policy has been updated effective March 1, 2008

Section A (13) - Prosthetics

Article 1 - Payment Condition - Prosthetics

a. Covered Charges

Covered Charges will include charges for prosthetic devices (including external electronic voice boxes and similar hand held communication devices after laryngectomy) and supplies which replace all or part of:

(1) an absent body part (including contiguous tissue) resulting from sickness, injury, or congenital anomalies); or
(2) the function of a permanently inoperative or malfunctioning body part.

Covered Charges will include the purchase, fitting, and necessary adjustment or replacement of the prosthetic device. In addition, Covered Charges will include cleaning and repairs, unless damage results from a Member's or Dependent's negligence or abuse of the prosthetic device.

b. Benefits Payable

Benefits will be payable the same as for any other covered Treatment or Service, up to a lifetime maximum benefit of $50,000 for each insured person. Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

c. Limitations

The general Comprehensive Medical limitations listed in PART IV, Section A (18) will apply to prosthetic charges. In addition, Prosthetic Covered Charges will not include prosthetic charges which are:

(1) in excess of the limits and maximums described in this Article; or
(2) for prosthetic charges that are not prescribed by the attending Physician; or
(3) for dental implants.

This Policy has been updated effective March 1, 2008

Section A (14) - Hospice Care

Article 1 - Payment Condition - Hospice Care

a. Covered Charges

Covered Charges will include charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility for:

(1) any terminally ill Member or Dependent who chooses to participate in a Hospice Care Program rather than receive medical treatment to promote cure, and who, in the opinion of the attending Physician, is not expected to live longer than 6 months; and
(2) the family of such Member or Dependent;

but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program.

Hospice Care Services consist of:

(1) inpatient and outpatient hospice care, home care, nursing care, homemaking services, dietary services, social counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual; and
(2) medical equipment, drugs and medicines (requiring a Physician's prescription) prescribed for the dying individual by any Physician who is a part of the Hospice Care Team; and
(3) instructions for care of the patient, social counseling, and other supportive services for the family of the dying individual.

b. Benefits Payable

Benefits will be payable the same as for any other covered Treatment or Service. However, the maximum benefit payable for any combination of Covered Charges described under Hospice Care Services will be limited to a lifetime maximum benefit of $25,000 (excluding charges for Hospital Inpatient Confinement) for each insured person. Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum

Payment Limit and this maximum will be reduced by the benefits paid.

c. Limitations

The general Comprehensive Medical limitations listed in PART IV, Section A (18) will apply to Hospice Care. In addition, Hospice Care Covered Charges will not include Hospice Care charges that:

(1) are in excess of the limits and maximums described in this Article; or
(2) are for Hospice Care Services not approved by the attending Physician and The Principal; or
(3) are for transportation services; or
(4) are for Hospice Care Services provided at a time other than while participating in a Hospice Care Program.

This Policy has been updated effective March 1, 2008

Section A (15) - Skilled Nursing Facility Confinement

Article 1 - Payment Condition - Skilled Nursing Facility

a. Covered Charges

If a Member or Dependent is confined in a Skilled Nursing Facility, Covered Charges will include any charges incurred for room, board, and other services required for treatment, provided:

(1) the Member or Dependent requires daily skilled nursing or skilled rehabilitation care on an inpatient basis as determined by The Principal; and
(2) the Skilled Nursing Facility confinement immediately follows a Hospital Inpatient Confinement for which benefits were payable under this Group Policy; and
(3) the Skilled Nursing Facility confinement results from the sickness or injury that was the cause of the Hospital Inpatient Confinement; and
(4) the Skilled Nursing Facility confinement begins not later than 14 days after the end of Hospital Inpatient Confinement or begins not later than 14 days after the end of a prior Skilled Nursing Facility confinement for which benefits were payable under this Group Policy; and
(5) inpatient Skilled Nursing Facility confinement is certified by a Physician as necessary to treat a sickness or injury.

The requirements for prior Hospital Inpatient Confinement will be waived if pre-approved by The Principal. If not pre-approved, and the Skilled Nursing Facility care does not follow Hospital Inpatient Confinement as described, no benefits will be payable.

b. Benefits Payable

Benefits will be payable the same as for any other covered Treatment or Service, not to exceed a maximum benefit of:

(1) $800 for any one day of Skilled Nursing Facility confinement; and
(2) 60 days for all Skilled Nursing Facility confinements that result from the same or related sickness or injury.

The following services will not be subject to the Skilled Nursing Facility confinement

This Policy has been updated effective March 1, 2008

maximums as stated above: drugs and medicines (requiring a Physician's prescription) that are not billed by the Skilled Nursing Facility, visits by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), durable medical equipment, and x-ray or laboratory services.

Benefits paid will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.

c. Limitations

The general Comprehensive Medical limitations in PART IV, Section A (18) will apply to Skilled Nursing Facility confinements. In addition, Skilled Nursing Facility Covered Charges will not include Skilled Nursing Facility confinement charges billed by the Skilled Nursing Facility that:

(1) are in excess of the limits and maximums described in this Article; or
(2) are incurred on or after the date the attending Physician stops treatment or ceases to prescribe skilled nursing care.

This Policy has been updated effective March 1, 2008

Section A (18) - Limitations

Article 1 - Limitations

Covered Charges will not include and no benefits will be paid for:

a. Treatment or Service that is not a Covered Charge; or

b. Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure prescribed in the notice of that claim decision); or

c. any part of a charge for Treatment or Service that exceeds Prevailing Charges; or

d. the services of any person who is in the Member's or Dependent's Immediate Family; or

e. Dental Services or materials, including dental implants, except as described under Covered Charges; or

f. eye examinations for the correction of vision or the fitting of glasses; vision materials including but not limited to frames or lenses; or

g. hearing aids; or

h. acupressure treatment; acupuncture treatment ; or

i. drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing; or

j. vitamins, minerals (except prescription potassium supplements), whether or not they require a Physician's prescription; or

k. nutritional supplements (even if the only source of nutrition), or special diets (whether or not they require a Physician's prescription); or

l. wigs or hair prostheses; or

This Policy has been updated effective March 1, 2008

m. Treatment or Service for Cosmetic Treatment and Services, or complications arising therefrom, unless the Cosmetic Treatment or Service results from a sickness or an accidental injury; and unless the Cosmetic Treatment or Service is completed within 18 months after the date of that sickness or injury, (except as provided for under Reconstructive or Cosmetic Surgery After an Act of Family Violence); or

n. personal hygiene, comfort, or convenience items, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, hoyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators or lift; adaptive equipment for the purpose of aiding in the performance of Activities of Daily Living including, but not limited to dressing, bathing, preparation or feeding of meals; or

o. "barrier free" home modifications, whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, railings or standing frames; or

p. non-implantable communication-assist devices, including, but not limited to, communication boards, and computers; or

q. Treatment or Service for work-hardening programs or vocational rehabilitation services; or

r. Treatment or Service leading to, in connection with, or resulting from sexual transformation or intersex surgery; or

s. cryopreservation or storage; or

t. Treatment or Service for education or training (except as provided under Treatment of Diabetes in PART IV, Section A), developmental delay, or learning disorders; or

u. social counseling (except as provided under Hospice Care), marital counseling, or sexual disorder therapy; or

v. Treatment or Service for which the Member or Dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or

w. Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

x. Treatment or Service that results from war or act of war; or

y. Treatment or Service that results from participation in criminal activities; or

This Policy has been updated effective March 1, 2008

z. Treatment or Service for and complications related to:

(1) human-to-human organ or bone marrow transplants, except as described under Transplant Services or Covered Charges; or
(2) animal-to-human organ or tissue transplants; or
(3) implantation within the human body of artificial or mechanical devices designed to replace human organs; or

aa. behavior modification or group therapy, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; or

ab. Treatment or Service for smoking cessation or nicotine addiction, gambling addiction, or stress management; or

ac. Treatment, or Service for insertion, removal, or revision of breast implants, unless provided post-mastectomy; or

ad. Treatment or Service for any sickness or condition for which the insertion of breast implants, or the fact of having breast implants within the body, was a contributing factor, unless the sickness or condition occurs post-mastectomy; or

ae. Treatment or Service for Kerato-Refractive Eye Surgery for myopia (nearsightedness), hyperopia (farsightedness) or astigmatism; or

af. charges for telephone calls or telephone consultations or missed appointments; or

ag. Treatment or Service covered by medical expense insurance issued under the Individual Purchase Rights described in PART III of this Group Policy; or

ah. Treatment or Service that results from:

(1) an injury arising out of or in the course of any employment for wage or profit if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Worker's Compensation Act or other similar law; or

(2) a sickness covered by a Workers' Compensation Act or other similar law; or

ai. any nursing services (except as described under Covered Charges and as required by state law); or

aj. Treatment or Service related to the restoration of fertility or the promotion of conception (including reversal of voluntary sterilization); or

This Policy has been updated effective March 1, 2008

ak. Treatment or Service for foot care with respect to: corns, calluses, trimming of toenails, flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet, casting for orthotics, or any appliance (including orthotics), except as provided under Treatment of Diabetes; or

al. Treatment or Service provided by a licensed practical nurse (L.P.N.), licensed registered nurse (R.N.), nurse midwife, or midwife if charges for that Treatment or Service are also made by a Physician; or

am. dietetic counseling, unless provided while the Member or Dependent is Hospital Inpatient Confined, or as provided under Home Health Care or Hospice Care, or Treatment of Diabetes; or

an. Treatment or Service by any type of health care practitioner not otherwise provided for in this Group Policy, unless recognition is state mandated; or

ao. Treatment or Service that is subject to the Preexisting Condition Exclusion described in this PART IV; or

ap. Treatment or Service provided outside the United States, unless such Treatment or Service is for a Medical Emergency; or

aq. Treatment or Service provided for weight loss or reduction of obesity, even if the Member or Dependent has other health conditions which might be helped by weight loss or reduction of obesity; or

ar. Treatment or Service for Custodial Care; or

as. Treatment or Service for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained; or

at. Treatment or Service for vision therapy or orthoptic therapy; or

au. Treatment or Service that is paid for by a Medicare Supplement Insurance Plan; or

av. charges for e-mail communication or e-mail consultation; or

aw. charges that are billed incorrectly or separately for Treatment or Services that are an integral part of another billed Treatment or Service as determined by The Principal; or

ax. charges for Physician overhead, including but not limited to surgical suites or rooms, or equipment used to perform the particular Treatment or Service (i.e. laser equipment); or

ay. Treatment or Services for non-synostotic plagiocephaly; or

This Policy has been updated effective March 1, 2008

az. Additional charges incurred because care was provided after hours, on a Sunday, holidays or week-end; or

ba. charges for heating pads, heating and cooling units, ice bags or cold therapy units; or

bb. Treatment or Service for unattended home sleep studies; or

bc. Treatment or Service for DESI (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or

bd. Charges for devices used specifically as safety items or to affect performance in sports-related activities; or

be. Treatment or Service for gynecomastia (abnormal breast enlargement in males); or

bf. Charges for sports, employment or immigration physicals; or

bg. Treatment or Service for hyperhidrosis (excessive sweating); or

bh. Treatment or Service for complications of a non-covered Treatment or Service; or

bi. Treatment or Service incurred after termination of coverage under this Group Policy; or

bj. Charges for travel and lodging except as indicated under PART IV, Section A (5); or

bk. Charges for transportation services except as described for ambulance services under PART IV, Section A (3), All Other Covered Services; or

bl. Treatment or Services for standby services.

This Policy has been updated effective March 1, 2008

Section B1 (1A) - Utilization Management Program

Article 1 - Applicability

The provisions of this section will apply to all Members and Dependents who are covered under the Comprehensive Medical Expense Insurance benefits as described in PART IV, Section A.

Article 2 - Definitions Applicable to the Utilization Management Program

Concurrent Review

Utilization Review conducted during a patient's Hospital stay or course of treatment.

Continued Stay Review

A review by The Principal of a Physician's report of the need for continued Hospital Inpatient Confinement to determine if the continued stay is for a Covered Charge.

Health Professional

An individual who:

a. has undergone formal training in a health care field;

b. holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and

c. has professional experience in providing direct patient care.

Hospital Admission Review

A review by The Principal of a Physician's report of the need for Hospital Inpatient Confinement (scheduled or emergency) to determine if the admission is for a Covered Charge.

Initial Clinical Review(er)

Clinical review conducted by appropriate licensed or certified Health Professionals. Initial

Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification.

Noncertification

A decision by The Principal that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the requirements of The Principal for a Covered Charge, appropriateness, health care setting, level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

Notification of Utilization Review Services

Receipt of necessary information to initiate review of a request for Utilization Review services to include the patient's name and Member's name (if different from patient's name), attending Physician's name, treatment facility's name, diagnosis and date of service.

Ordering Provider

The Physician or other provider who specifically prescribes the health care service being reviewed.

Peer Clinical Review(er)

Clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the Peer Clinical Reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

Prospective Review

Utilization Review conducted prior to a patient's stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or precertification.

Retrospective Review

Utilization Review conducted after the patient is discharged from a Hospital or other health care facility or has completed a course of treatment.

Urgent Review

This Policy has been updated effective March 1, 2008

Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to the Member or the patient's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Member or patient's medical condition, would subject the Member or patient to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the decision of The Principal using the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Utilization Review

A set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

Article 3 - Payment Conditions - Utilization Management Requirements - Applicable to medical care received from a Non-Preferred Provider

Comprehensive Medical benefits payable for Hospital Inpatient Confinement Charges will be reduced by 25% unless:

a. For Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested from The Principal by a Member, a Dependent, or a designated patient representative as soon as a Hospital Inpatient Confinement is scheduled, but no later than two business days before a Hospital Inpatient Confinement for other than a Medical Emergency, and for a Medical Emergency, within two business days of a Hospital Inpatient Confinement.

   If a Hospital Admission Review is not requested in a timely manner as specified above, the 25% reduction in benefits payable will be applied to all Hospital Inpatient Confinement Charges.

   Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges The Principal determines to be a Covered Charge.

   Certain exceptions apply to Hospital Inpatient Confinement for childbirth as described in Article 4 below.

The 25% reduction in benefits payable is a penalty for failure to comply with any of the Utilization Management Requirements listed. The reduction:

a. will not count toward satisfaction of the Out-of-Pocket Expense limits amount shown in PART IV, Section A (2); and

b. will not exceed $2,000 per individual each calendar year.

This Policy has been updated effective March 1, 2008

Article 4 - Hospital Admission Review - Applicable to medical care received from a Non-Preferred Provider

A Hospital Admission Review by The Principal is required for all Hospital Inpatient Confinements (scheduled or emergency).

The following exception applies to Hospital Inpatient Confinement for childbirth:

Covered Charge requirements are waived and a Hospital Admission Review is not required for mother and baby, for:

(1) A 48-hour Hospital Inpatient Confinement following vaginal delivery, not counting the day of delivery; or
(2) A 96-hour Hospital Inpatient Confinement following cesarean section, not counting the day of delivery.

A request for review by The Principal of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by the Member, a Dependent or a designated patient representative before the end of that time period.

If the Member, or Dependent, or a designated patient representative fails to request a Hospital Admission Review as specified in this Article, benefits will be reduced as described in Article 3 above. Exception: For all Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth, the penalty will be applied beginning the day after the automatically approved time period ends. **Except as waived above, no benefits will be payable for any Treatment or Service that is not for a Covered Charge.**

For the purpose of these requirements, "Hospital Admission Review" means review by The Principal of a Physician’s report of the need for a Hospital Inpatient Confinement, scheduled or emergency, (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).

The report (verbal or Written) must include the:

a. reason(s) for the Hospital Inpatient Confinement; and

b. significant symptoms, physical findings, and treatment plan; and

c. procedures performed or to be performed during the Hospital Inpatient Confinement; and

d. estimated length of the Hospital Inpatient Confinement.

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If a Hospital Inpatient Confinement will exceed the approved number of days, The Principal will initiate a Continued Stay Review. For the purpose of these requirements, "Continued Stay Review" means a review by The Principal of a Physician's report of the need for continued Hospital Inpatient Confinement.

The report (verbal or Written) must include the:

a. reason(s) for requesting continued Hospital Inpatient Confinement; and

b. significant symptoms, physical findings, and treatment plan; and

c. procedures performed or to be performed during the Hospital Inpatient Confinement; and

d. estimated length of the continued Hospital Inpatient Confinement.

Article 5 - Utilization Review Program

Notice of Utilization Review

For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when The Principal receives Notification of Utilization Review Services.

If the Member, Dependent, or designated patient representative fails to follow the procedures of The Principal for filing a claim for a Hospital Admission Review, a Prospective Review, or an Urgent Review, The Principal will notify the Member, Dependent or designated patient representative of the failure and the proper procedures to be followed.

a. Prospective Review

For an initial Prospective Review, a decision and notification of the decision will be made within 15 calendar days of the date The Principal receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, The Principal will either issue a Noncertification or send an explanation of the information needed to complete the review prior to expiration of the 15 calendar days. If The Principal does not issue a Noncertification and requests additional information to complete the review, the Member, the patient, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Principal will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, The Principal will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient. Upon request, The Principal

will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient.

b. Urgent Prospective Review

For Urgent Review of a Prospective Review, a decision and notification of the decision will be made within 72 hours of the date The Principal receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, The Principal will either issue a Noncertification or send an explanation of the information needed to complete the review within 24 hours of receipt of Notification of Utilization Review Services. If The Principal does not issue a Noncertification and requests additional information to complete the review, the Member, the patient, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 48 hours to provide the necessary information. The Principal will render a decision within 48 hours of either receiving the necessary information or if no additional information is received, the expiration of the 48 hours to provide the specified additional information. For certifications, The Principal will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient. Upon request, The Principal will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient.

c. Concurrent Review

For a Concurrent Review that does not involve an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by The Principal will be decided within the timeframes and according to the requirements for Prospective Review.

For an Urgent Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by The Principal will be decided and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. If a request is made less than 24 hours prior to the expiration of the previously approved period or number of treatments, a decision and notification of the decision will be made within 72 hours of receipt of the Notification of Utilization Review Services.

d. Retrospective Review

For a Retrospective Review, a decision and notification of the decision will be made within 30 calendar days after The Principal receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, The Principal

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will either issue a Noncertification or send an explanation of the information needed to complete the review prior to the expiration of the 30 calendar days. If The Principal does not issue a Noncertification and requests additional information to complete the review, the Member, the patient, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Principal will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, The Principal will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient. Upon request, The Principal will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient.

e. Request for Reconsideration

When an initial decision is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one (1) business day to discuss the Noncertification decision with the attending Physician or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician or other Ordering Provider will be informed of their right to initiate an appeal and the procedure to do so. For certifications, The Principal will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient. Upon request, The Principal will provide Written notification of the certification. For Noncertifications, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Member or patient.

f. Appeal of Noncertifications

The Member, Dependent, a designated patient representative, Physician, or other health care provider has the right to request two appeal reviews of any utilization management decision by telephone, fax, or in Writing. The Principal will make a full and fair review of the Noncertification. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

g. Expedited Appeal Review and Voluntary Appeal Review

An Expedited Appeal Review is a request, usually by telephone but can be Written, for a review of a decision not to certify an Urgent Review. An Expedited Appeal Review

must be requested within 180 calendar days of the receipt of a Noncertification.

A decision and notification of the decision on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review. Written or electronic notification of the appeal review outcome will be made to the attending Physician or other Ordering Provider and Member or patient.

If the Noncertification is affirmed on the appeal review, the Member, the patient, attending Physician, or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax or in Writing. The Member, the patient, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for appeal. The Principal will make a decision within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, The Principal will send a Written explanation of the additional information that is required or an authorization for the Member or the patient's Signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to The Principal within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the Member or patient's right to bring civil action following notification of the decision rendered during the expedited appeal, nor does it have any effect on the Member or patient's rights to any other benefit under this Group Policy. The Principal offers the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, the Member or the patient may file a civil action or pursue any other legal remedies.

Note: The expedited appeal process does not apply to Retrospective Reviews.

h. Standard Appeal Review and Voluntary Appeal Review

A standard appeal may be requested either in Writing or verbally. It must be requested within 180 calendar days of the receipt of a Noncertification. A decision and notification of the decision will be made in Writing to the Member or patient, the attending Physician or other Ordering Provider within 30 calendar days of receiving the request for an appeal.

If the Noncertification is affirmed on the appeal review, the Member, the patient, attending Physician, or other Ordering Provider can request a voluntary appeal. The appeal may be requested by telephone, fax or in Writing. The Member, the patient,

attending Physician or other Ordering Provider may submit Written comments, documents, records, and other information relating to the request for appeal. The Principal will make a decision within 30 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, The Principal will send a Written explanation of the additional information that is required or an authorization for the Member or the patient's Signature so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to The Principal within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the Member or patient's right to bring civil action following notification of the decision rendered during the standard appeal, nor does it have any effect on the Member or patient's rights to any other benefit under this Group Policy. The Principal offers the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the second appeal process, the Member or the patient may file a civil action or pursue any other legal remedies.

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Section B1 (2) - Prescription Drugs Expense Insurance

Article 1 - Payment Conditions

If drugs and medicines are prescribed to treat a Member's or Dependent's sickness or injury, The Principal will pay 100% of the charges, in excess of the Copay amount described in this section.

Benefit payment will be limited to:

a. Covered Charges as described in this section; and

b. for certain qualified Maintenance Drugs and Medicines, a 90-day supply for each prescription and each refill; and

c. for all other drugs and medicines, not more than a 30-day supply for each prescription and each refill; and

d. prescriptions filled by a Member Pharmacy.

If the Member or Dependent uses a Nonmember Pharmacy, Prescription Drugs Covered Charges less the Copay may only be reimbursed up to the amount determined by the Payment Schedule established by The Principal for each prescription or refill.

Article 2 - Prescription Drugs Utilization Review

a. For Maintenance Drugs and Medicines

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same Member or Dependent) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

b. For all other Drugs and Medicines

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription or refill (for the same Member or Dependent) and the previously

dispensed quantity of the drug or medicine was for:

(1) Less than a 15-day supply and the dispensing date for the current prescription is more than four days before a previously dispensed supply would be exhausted; or
(2) More than a 14-day supply and the dispensing date for the current prescription is more than ten days before the previously dispensed supply would be exhausted; or
(3) More than a 14-day supply and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

Exhaustion of the previously dispensed supply is determined based on when the last dose of the medicine or drug would have been consumed if the previously dispensed supply was consumed by the prescription date. Prescriptions may be refilled prior to exhaustion of a previously dispensed quantity for the same prescription or refill for up to a 30 day quantity once per calendar year.

For certain drugs and classes of drugs designated by The Principal, The Principal reserves the right to:

(1) require prior authorization for dispensing; and
(2) limit payment of benefits for specified quantities; and
(3) require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by The Principal.

Article 3 - Copay Amount for Maintenance Drugs and Medicines

The amount equal to 3-times the applicable Copay amount shown in Article 4 below for all other drugs.

Article 4 - Copay Amount for all other drugs

The Copay amount for each prescription and each refill will be:

a. for Tier 1 Prescription Drugs: $10.00; and

b. for Tier 2 Prescription Drugs: $25.00; and

c. for Tier 3 Prescription Drugs and all other drugs: $40.00.

Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member or Dependent must pay the difference between the

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Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the Physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.

Article 5 - Prescription Drugs Covered Charges

Prescription Drugs Covered Charges will be the actual cost charged to a Member or Dependent but only to the extent that the actual cost charges does not exceed the maximum amount allowed under the Payment Schedule as established by The Principal.

Prescription Drugs Covered Charges will include charges for:

a. the following diabetic supplies:

   (1) insulin; and
   (2) disposable insulin needles/syringes; and
   (3) disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, and Clinitest tablets); and
   (4) lancets; and
   (5) glucometers (limited to no more than one each calendar year); and
   (6) alcohol swabs; and

b. compounded medications (except for compound medications that use an injectable drug) in which at least one ingredient is a Prescription Legend Drug. Reimbursement for compounded medications will be up to 135% of Average Wholesale Price of the most expensive active ingredient; and

c. the following injectable medications: epinephrine, glucagons and triptans; and

d. legend contraceptives, except injectables or devices; and

e. any other drug or medicine that can be legally dispensed only upon the Written prescription of a Physician.

In no event will the maximum amount allowed under the Payment Schedule for each prescription or refill exceed the Average Wholesale Price less 14%.

Article 6 - Definitions

"Average Wholesale Price" in this section means the published cost of a drug product that is

paid by the pharmacist to the wholesaler.

"Brand Name Prescription Drug/Brand Name Drug" means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

"Formulary" means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers.

"Generic Prescription Drugs" mean pharmaceutical products manufactured and sold under their chemical, common, or official name or a drug that The Principal identifies as a Generic Drug. Classification of a Prescription Drug as a Generic is determined by The Principal and not by the manufacturer or pharmacy. The Principal classifies a Prescription Drug as a Generic based on available data resources, therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified a Generic by The Principal.

"Maintenance Drugs and Medicines" mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions which shall include only the following: coronary artery disease (angina), diabetes (including, diabetic supplies, e.g., insulin, disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets, glucometers (limited to one each calendar year) and alcohol swabs), hypertension, glaucoma, thyroid disease, seizure disorders, hyperlipidemia, congestive heart failure, clotting disorders, chronic obstructive pulmonary disease, and hormonal deficiencies (hormone replacement); Attention-Deficit/Hyperactivity Disorder (ADHD); narcolepsy; arthritis; gout; Parkinson’s disease; asthma; antineoplastics; immunosuppressives; Human Immunodeficiency Virus (HIV); potassium supplements and pancreatic enzymes. Maintenance Drugs and Medicines will also include legend oral contraceptives.

"Member Pharmacy" means any pharmacy which has contracted with Pharmacy Benefit Manager to provide prescription drugs for which benefits are provided under this Group Policy.

"Nonmember Pharmacy" means any pharmacy which has not contracted with the designated prescription drugs claims administrator to become a Member Pharmacy.

"Payment Schedule" means the maximum reimbursement amount allowed under the program as established by The Principal.

"Pharmacy Benefit Manager" means CaremarkPCS.

"Prescription Drug Copay" means a specified dollar amount that must be paid by a Member or Dependent for each prescription and each refill. The Prescription Drug Copay amount will not be applied to the Comprehensive Medical Deductible Amount or Out-of-Pocket Expense

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limits.

"Prescription Legend Drugs" mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

"Tier 1 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 2 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 3 Prescription Drugs" mean a list of prescription drugs established by The Principal.

Article 7 - Limitations

Prescription Drugs Covered Charges will not include and no benefits will be paid for:

a. drugs or medicines that are not Covered Charges; or

b. drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or

c. drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or

d. drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which the Member or Dependent is confined; or

e. drugs or medicines delivered or administered by the prescriber; or

f. drugs or medicines prescribed or dispensed by a person in the Member's or Dependent's Immediate Family; or

g. vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or

h. dietary supplements; or

i. contraceptives, non-oral dosage forms, excluding patches and vaginal rings; or

j. therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as specifically provided above under Prescription Drugs Covered Charges; or

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k. infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or

l. administration of any drug or medicine; or

m. any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or

n. drugs or medicines for which the Member or Dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or

o. drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

p. drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or

q. drugs or medicines provided as a result of a sickness or injury that is due to participation in criminal activities; or

r. drugs or medicines covered by medical expense insurance issued under the Individual Purchase Rights described in PART III of this Group Policy; or

s. drugs or medicines provided as the result of:

(1) an injury arising out of or in the course of any employment for wage or profit, if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
(2) a sickness covered by a Workers' Compensation Act or other similar law; or

t. growth hormones; or

u. cosmetic, and health and beauty aids; or

v. Levonorgestrel (Norplant); or

w. dermatologicals used as hair growth stimulants; or any other drug or medicine used for cosmetic purposes; or

x. drugs labeled "Caution--limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or

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y. topical dental fluorides; or

z. DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or

aa. drugs or medicines that are lost, stolen, or spilled; or

ab. smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms; or

ac. anorectics (any drug used for the purpose of weight control); or

ad. minerals. Exception: Potassium supplements are covered; or

ae. drugs or medicines provided or dispensed outside the United States, except those provided or dispensed in connection with a Medical Emergency; or

af. hematinics; or

ag. drugs or medicines for the treatment of onychomycosis (nail fungus); or

ah. drugs or medicines that are paid for by a Medicare Supplement Insurance Plan; or

ai. drugs or medicines prescribed for treatment leading to, in connection with or resulting from sexual transformation or intersex surgery.

Article 8 - Payment, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on the Member or Dependent's identification card or contact The Principal. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or The Principal within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or The Principal receives proof of loss. Proof of loss includes the patient's name, Member's name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or The Principal may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the request of Pharmacy

Benefit Manger or The Principal could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or The Principal will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manger or The Principal will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or The Principal receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or The Principal will submit a detailed explanation of the basis for its denial.

A Claimant may request an appeal of a claim denial by Written request to The Principal within 180 calendar days of receipt of notice of the denial. The Principal will make a full and fair review of the claim. The Principal may require additional information to make the review. The Principal will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in Writing. The claimant may submit Written comments, documents, records and other information relating to the claim for benefits. The Principal will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, The Principal will send a Written explanation of the additional information that is required or an authorization for the claimant’s Signature so information can be obtained from the provider. This information must be sent to The Principal within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the claimant’s right to bring civil action following the first appeal, nor does it have any effect on the claimant’s right to any other benefits under this Group Policy. The Principal offers the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "claimant" means Member or Dependent.

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Section B1 (3) - Mail Service Prescription Drugs Expense Insurance

Article 1 - Payment Conditions

If Maintenance Drugs and Medicines are prescribed to treat a Member's or Dependent's sickness or injury, The Principal will pay 100% of the charges, in excess of the Copay amount described in this section.

Benefit payment will be limited to:

a. prescribed maintenance medications which are necessary to treat a chronic or long-term sickness or injury and that can be legally dispensed only upon the Written prescription of a Physician; and

b. a 90-day supply for each prescription and each refill; and

c. prescriptions which are filled through the pharmacies designated by The Principal to administer its mail order prescription drugs program.

Article 2 - Prescription Drugs Utilization Review

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same Member or Dependent) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

For certain drugs and classes of drugs designated by The Principal, The Principal reserves the right to:

a. require prior authorization for dispensing; and

b. limit quantities whose cost will be deemed to be covered Maintenance Drugs and Medicines; and

c. require the dispensing of certain drugs before paying benefits for another drug within a

given class, as established by The Principal.

Article 3 - Copay Amount

The Copay amount for each prescription and each refill will be:

a. for Tier 1 Prescription Drugs: $25.00; and

b. for Tier 2 Prescription Drugs: $62.50; and

c. for Tier 3 Prescription Drugs and all other drugs: $100.00.

Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member or Dependent must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the Physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.

Article 4 - Definitions

"Brand Name Prescription Drug/Brand Name Drug" means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

"Formulary" means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers.

"Generic Prescription Drugs" mean pharmaceutical products manufactured and sold under their chemical, common, or official name or a drug that The Principal identifies as a Generic Drug. Classification of a Prescription Drug as a Generic is determined by The Principal and not by the manufacturer or pharmacy. The Principal classifies a Prescription Drug as a Generic based on available data resources, therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified a Generic by The Principal.

"Maintenance Drugs and Medicines" mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina), diabetes (including diabetic

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supplies, e.g., insulin, disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets; glucometers (limited to one each calendar year) and alcohol swabs), hypertension, glaucoma, thyroid disease; seizure disorders; hyperlipidemia; congestive heart failure; clotting disorders; chronic obstructive pulmonary disease; and hormonal deficiencies (hormone replacement); Attention-Deficit/Hyperactivity Disorder (ADHD); narcolepsy; arthritis; gout; Parkinson's disease; asthma; antineoplastics; immunosuppressives; Human Immunodeficiency Virus (HIV); potassium supplements and pancreatic enzymes. Maintenance Drugs and Medicines will also include legend oral contraceptives.

"Payment Schedule" means the maximum reimbursement amount allowed under the program as established by The Principal.

"Pharmacy Benefit Manager" means CaremarkPCS.

"Prescription Drug Copay" means a specified dollar amount that must be paid by a Member or Dependent for each prescription and each refill. The Prescription Drug Copay amount will not be applied to the Comprehensive Medical Deductible Amount or Out-of-Pocket Expense limits.

"Prescription Legend Drugs" mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

"Tier 1 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 2 Prescription Drugs" mean a list of prescription drugs established by The Principal.

"Tier 3 Prescription Drugs" mean a list of prescription drugs established by The Principal.

Article 5 - Limitations

Prescription Drugs Covered Charges will not include and no benefits will be paid for:

a. drugs or medicines that are not Covered Charges; or

b. drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or

c. drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or

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d. drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which the Member or Dependent is confined; or

e. drugs or medicines delivered or administered by the prescriber; or

f. drugs or medicines prescribed or dispensed by a person in the Member's or Dependent's Immediate Family; or

g. vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or

h. dietary supplements; or

i. contraceptives, non-oral dosage forms, excluding patches and vaginal rings; or

j. therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use; or

k. infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin, epinephrine, glugacon and triptans) or any prescription directing parenteral administration or use; or

l. administration of any drug or medicine; or

m. any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or

n. drugs or medicines for which the Member or Dependent has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or

o. drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or

p. drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or

q. drugs or medicines provided as a result of a sickness or injury that is due to participation in criminal activities; or

r. drugs or medicines covered by medical expense insurance issued under the Individual Purchase Rights described in PART III of this Group Policy; or

s. drugs or medicines provided as the result of:

This Policy has been updated effective March 1, 2008

(1) an injury arising out of or in the course of any employment for wage or profit, if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
(2) a sickness covered by a Workers' Compensation Act or other similar law; or

t. growth hormones; or

u. cosmetic, and health and beauty aids; or

v. Levonorgestrel (Norplant); or

w. dermatologicals used as hair growth stimulants; or any other drug or medicine used for cosmetic purposes; or

x. drugs labeled "Caution--limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or

y. topical dental fluorides; or

z. DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or

aa. drugs or medicines that are lost, stolen, or spilled; or

ab. smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms; or

ac. anorectics (any drug used for the purpose of weight control); or

ad. minerals. Exception: Potassium supplements are covered; or

ae. drugs or medicines provided or dispensed outside the United States, except those provided or dispensed in connection with a Medical Emergency; or

af. hematinics; or

ag. drugs or medicines for the treatment of onychomycosis (nail fungus); or

ah. drugs or medicines that are paid for by a Medicare Supplement Insurance Plan; or

ai. drugs or medicines prescribed for treatment leading to, in connection with or resulting from sexual transformation or intersex surgery.

This Policy has been updated effective March 1, 2008

Article 6 - Payment, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on the Member or Dependent's identification card or contact The Principal. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or The Principal within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or The Principal receives proof of loss. Proof of loss includes the patient's name, Member's name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or The Principal may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the request of Pharmacy Benefit Manger or The Principal could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or The Principal will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manger or The Principal will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or The Principal receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or The Principal will submit a detailed explanation of the basis for its denial.

A Claimant may request an appeal of a claim denial by Written request to The Principal within 180 calendar days of receipt of notice of the denial. The Principal will make a full and fair review of the claim. The Principal may require additional information to make the review. The Principal will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in Writing. The claimant may submit Written comments, documents, records and other information relating to the claim for benefits. The Principal will

This Policy has been updated effective March 1, 2008

make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, The Principal will send a Written explanation of the additional information that is required or an authorization for the claimant's Signature so information can be obtained from the provider. This information must be sent to The Principal within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefits under this Group Policy. The Principal offers the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

For purposes of this section, "claimant" means Member or Dependent.

This Policy has been updated effective March 1, 2008

Section C - Claim Procedures

Article 1 - Notice of Claim

Written notice must be sent to The Principal by or for a Member or Dependent who wishes to file claim for benefits under this Group Policy. This notice must be sent within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Article 2 - Claim Forms

The Principal, when it receives notice of claim, will provide appropriate claim forms for filing proof of loss. If the forms are not provided within 15 calendar days after The Principal receives notice of claim, the person will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

Article 3 - Proof of Loss

Written proof of loss must be sent to The Principal within 36 months after the date of the loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when The Principal receives proof of loss. Proof of loss includes the patient’s name, Member’s name (if different from the patient’s name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and the extent of the loss. The Principal may request additional information to substantiate loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the request of The Principal could result in declination of the claim.

Article 4 - Payment, Denial and Review

The Employment Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If the claim cannot be processed due to incomplete information, The Principal will either deny the claim or send a Written explanation requesting information prior to the expiration of the 30 calendar days. If The Principal does not deny the claim and requests additional information to complete the review,

the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Principal will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under this Group Policy may be payable sooner, provided The Principal receives complete and proper proof of loss. If a claim is not payable or cannot be processed, The Principal will submit a detailed explanation of the basis for its denial.

A claimant may request an appeal of a claim denial by Written request to The Principal within 180 calendar days of receipt of the notice of denial. The Principal will make a full and fair review of the claim. The Principal may require additional information to make the review. The Principal will notify the claimant in Writing of the appeal decision within 60 calendar days of receiving the appeal request. The first level of appeal review must be completed before filing a civil action or pursing any other legal remedies.

After exhaustion of the formal appeal process, a claimant may request a voluntary appeal. The appeal must be requested in Writing. The claimant may submit Written comments, documents, records, and other information relating to the claim for benefits. The Principal will make a determination within 60 calendar days of request for a voluntary appeal. However, if the appeal cannot be processed due to incomplete information, The Principal will send a Written explanation of the additional information that is required or an authorization for the claimant's Signature so information can be obtained from the provider. This information must be sent to The Principal within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request or as required by state law.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefit under this Group Policy. The Principal offers the voluntary appeal process in an effort that the claim may be resolved in good faith without legal intervention. At anytime during the voluntary appeal process, the claimant may file a civil action or pursue any other legal remedies.

For purpose of this section, "claimant" means Member or Dependent.

Article 5 - Facility of Payment

The Principal will normally pay all benefits to the Member. However, if the claim benefits result from a Dependent's sickness or injury, The Principal may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge The Principal to the full extent of those payments.

This Policy has been updated effective March 1, 2008

a. If payment amounts remain due upon a Member's death, those amounts may, at The Principal's option, be paid to the Member's estate, spouse, child, parent, or provider of medical services.

b. If The Principal believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, The Principal may pay whoever has assumed the care and support of the person.

c. Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Member or Dependent.

d. Benefits payable to a Lab Card facility will be paid directly to the facility.

e. Benefits payable to Transplant Network Providers will be paid directly to the Transplant Network Provider.

Article 6 - Medical Examinations

The Principal may have the person whose loss is the basis for claim examined by a Physician. The Principal will pay for these examinations and will choose the Physician to perform them.

Article 7 - Legal Action

Legal action to recover benefits under this Group Policy may not be started earlier than 90 calendar days after required proof of loss has been filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after that proof is required to be filed.

Article 8 - Time Limits

Any time limit listed in this section will be adjusted as required by law.

Article 9 - Recoding of Procedures

When a claim contains one or more procedure codes with the same date of service, The Principal may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. The Principal will base such review on generally recognized and authoritative coding resources, including but not limited to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding Systems (HCPCS).

This Policy has been updated effective March 1, 2008

If The Principal determines, in its own discretion, that the claim may be more appropriately coded using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

This Policy has been updated effective March 1, 2008

Section D - Replacement of a Prior Plan

Article 1 - Applicability

When insurance under this Group Policy replaces coverage under a Prior Plan, this section will apply to those Members and Dependents who:

a. are eligible and enrolled under this Group Policy on its Date of Issue; and

b. were covered under the Prior Plan on the date of its termination.

Article 2 - Benefits Payable

Benefits will not be paid under this section for any Treatment or Service:

a. received before the Date of Issue of this Group Policy; or

b. for which benefits are paid under the Prior Plan; or

c. for which benefits would have been paid under the Prior Plan (including that plan's extended benefit provision) in the absence of this section.

Article 3 - Deductible Credit

Charges for Treatment or Service received by a Member or Dependent while covered under a Prior Plan may be applied to satisfy the Comprehensive Medical Deductible Amount for the calendar year in which this Group Policy became effective, provided the charges are limited to those that:

a. would be Comprehensive Medical Covered Charges under this Group Policy; and

b. were not paid under the Prior Plan; and

c. were for Treatment or Service received during the calendar year in which this Group Policy became effective; and

d. would have counted toward satisfaction of the Prior Plan's deductible amount.

This Policy has been updated effective March 1, 2008

Deductible amounts carried over from a Prior Plan will not count towards satisfaction of the Out-of-Pocket Limit.

This Policy has been updated effective March 1, 2008

Section E - Preexisting Condition Exclusion

Article 1 - Applicability

The Preexisting Condition Exclusion provisions described in this section will apply only to Members and Dependents who are Late Enrollees as defined in PART III, Section B.

Article 2 - Definition

A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of an individual's coverage under this Group Policy.

However, pregnancy will not be considered a Preexisting Condition.

Genetic information will not be considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information.

Article 3 - Exclusion Period

Benefits for Treatment or Service of an individual's Preexisting Condition will be excluded for a period of 12 consecutive months after the effective date of the individual's coverage under this Group Policy; and then benefits will be payable only with respect to Treatment or Service received after the exclusion period.

Exemption for Certain Dependent Children: The Preexisting Condition Exclusion described above will not apply to any Dependent Child:

a. who is the Member's newborn child, or a child newly adopted by the Member (or Placed for Adoption with the Member) prior to the child's attainment of age 18; and

b. whose insurance becomes effective under this Group Policy within the 31-day period immediately following the child's date of birth, adoption or Placement for Adoption.

If a Dependent Child becomes insured under this Group Policy other than as described above, that child will also be exempt from the Preexisting Condition Exclusion if:

This Policy has been updated effective March 1, 2008

a. the child was covered under another Creditable Coverage as of the last day of the 31-day period beginning with the child's date of birth, adoption, or Placement for Adoption (provided the adoption or Placement occurred prior to the child's attainment of age 18); and

b. the child has subsequently maintained continuous Creditable Coverage, with no gap in coverage exceeding 63 days.

If any such child's coverage under this Group Policy terminates and the child later becomes insured again under this Group Policy, the exemption will continue to apply to the child unless there has been a period of at least 63 days during all of which the child was not covered under any Creditable Coverage.

For the purpose of these provisions, a Waiting Period or HMO Affiliation Period will not be considered a break in Creditable Coverage.

Article 4 - Credit for Previous Creditable Coverage

The Preexisting Condition exclusion period described in Article 3 above will be reduced by days of continuous Creditable Coverage, if any, applicable to the individual as of the effective date of his or her coverage under this Group Policy.

In determining days of continuous Creditable Coverage, any period of Creditable Coverage which occurs before a significant break in coverage will not be counted. For this purpose, "significant break in coverage" means a period of 63 days during all of which a person is not covered under any Creditable Coverage. However, a Waiting Period or HMO Affiliation Period will not be considered a break in coverage.

With respect to a Member or Dependent becoming insured under this Group Policy, a period of Creditable Coverage will not be considered continuous if, after such period and before the effective date of the individual's insurance, there was a 63-day period during all of which the individual was not covered under any Creditable Coverage.

This Policy has been updated effective March 1, 2008

Section F - Coordination with Other Benefits

Article 1 - Purpose

The intent of this section is to provide that the sum of benefits paid under this Group Policy, plus benefits paid under all other Plans will not exceed the lesser of the financial liability of the Member or Dependent or the Prevailing Charge of The Principal for a Treatment or Service.

Article 2 - Definitions

As used in this section, the terms listed below will mean:

a. Plan

Any medical expense benefits provided under:

(1) any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
(2) *any program required or established by state or Federal law (including Medicare Parts A, B and C); and
(3) any program sponsored by or arranged through a school or other educational agency; and
(4) the first-party medical expense provisions of any automobile policy issued under a no-fault insurance statute and traditional fault-type contracts.

The term Plan will not include benefits provided under:

(1) individual or family insurance contracts;
(2) individual or family subscriber contracts;
(3) individual or family coverage through Health Maintenance Organizations (HMOs);
(4) individual or family coverage under other prepayment, group practice, and individual practice plans;
(5) group or group-type hospital indemnity benefits of $100 per day or less;
(6) student accident policy. These contracts cover grammar, high school and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis; and
(7) a state plan under Medicaid, and will not include a law or plan when, by law, its

benefits are in excess of those of any private insurance plan or other non-governmental plan.

Also, the term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

*Not applicable to persons subject to the Medicare Carveout provisions as described in this PART IV, Section G.

b. Primary Plan/Secondary Plan

The order of benefit determination rules determine whether This Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

c. Allowable Expense

A health care service or expense, including Deductibles, coinsurance, and Copayments, if any, that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expense:

(1) If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of Generally Accepted medical practice, or one of the Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

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

d. Claim Determination Period

The part of a calendar year during which a Member or Dependent would receive benefit payments under this Group Policy if this section were not in force.

This Policy has been updated effective March 1, 2008

Article 3 - Effect on Benefits

Benefits otherwise payable under this Group Policy for Allowable Expenses during a Claim Determination Period may be reduced if:

a. benefits are payable under any other Plan for the same Allowable Expenses; and

b. the rules listed in Article 4 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Group Policy.

The reduction will be the amount needed to provide that the sum of payments under this Group Policy plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of this Plan.

For this purpose:

a. benefits payable under other Plans will include the benefits that would have been paid had claim been made for them; and

b. *for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B and C whether or not the person is covered under that Part B.

*Not applicable to persons subject to the Medicare Carveout provisions as described in this PART IV, Section G.

Article 4 - Order of Benefit Determination

Except as described in Articles 5 and 6 below, the benefits payable of a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

a. Non-Dependent/Dependent. The benefits of a Plan which covers the person for whom benefits are claimed as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) Secondary to the Plan covering the person as a Dependent; and
(2) Primary to the Plan covering the person as other than a Dependent (e.g. a retired

employee);

then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent. This provision is not applicable to persons subject to the Medicare Carveout provisions described in this PART IV, Section G.

b. Dependent Child--Parents Not Separated or Divorced. Except as stated in paragraph c. below, when this Group Policy and another Plan cover the same child as a Dependent of different persons called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent Child--Separated or Divorced Parents. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;
(2) then, the Plan of the spouse of the parent with custody of the child; and
(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

e. Active/Inactive Employee. The benefits of a Plan which covers the person for whom benefits are claimed as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid-off or retired employee or as that employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of

benefits, this rule will not apply.

f. Continuation of Coverage. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

(1) first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
(2) second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

g. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan which covered the person for whom benefits are claimed longer are determined before those of the Plan which covered that person for the shorter time.

Article 5 - Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under this Group Policy.

For persons subject to Medicare Carveout provisions, the benefits payable under this Group Policy will be directly reduced by Medicare benefits, as described in this PART IV, Section G.

Article 6 - Exception for Plans Issued Under the West Virginia Public Employees Insurance Act

The benefits payable under this Group Policy will be determined before the benefits payable under a plan issued pursuant to the West Virginia Public Employees Insurance Act.

Article 7 - Exchange of Information

Any person who claims benefits under this Group Policy must, upon request, provide all information The Principal believes is needed to coordinate benefits as described in this section.

In addition, all information The Principal believes is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

This Policy has been updated effective March 1, 2008

Article 8 - Facility of Payment

The Principal may reimburse any other Plan if:

a. benefits were paid by that other Plan; but

b. should have been paid under this Group Policy in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under this Group Policy and, to the extent of those amounts, will discharge The Principal from liability.

Article 9 - Right of Recovery

If, in accordance with this section, it is determined that benefits paid under this Group Policy should have been paid by any other Plan, The Principal will have the right to recover those payments from:

a. the person to or for whom the benefits were paid; or

b. the other companies or organizations liable for the benefit payments.

This Policy has been updated effective March 1, 2008

Section G - Medicare Carveout

Article 1 - Applicability

This section will apply to Members and their Dependents, where permitted by Federal law who:

a. are age 65 and older; and

b. are covered by Medicare Parts A, B and C (or would have been covered had complete and timely application been made).

Article 2 - Effect on Benefits

For Members and Dependents to whom this section applies, the Comprehensive Medical benefits payable under this Group Policy for Treatment or Service received will be reduced by:

a. the benefits payable for such Treatment or Service by Medicare Parts A, B and C; or

b. the benefits that would have been payable for such Treatment or Service by Medicare Parts A and B had the Member or Dependent been covered by Medicare Parts A and B.

Article 3 - Benefits Payable

For the purpose of the provisions described in this section:

a. If the provider has agreed to accept Medicare assignments with respect to a Treatment or Service, benefits payable under this Group Policy for the corresponding Covered Charges will be based on the amount of charges allowed by Medicare.

b. If the provider has not agreed to accept Medicare assignments with respect to a Treatment or Service, benefits payable under this Group Policy for the corresponding Covered Charges will be based on the lesser of:

   (1) the Prevailing Charges; or
   (2) the amount of the Limiting Charge as defined by Medicare.

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PART IV - BENEFITS

Section H - Subrogation and Reimbursement

Article 1 - Applicability

Subject to applicable law, this section will apply to Members and Dependents who:

a. receive benefit payment under this Group Policy as the result of a sickness or injury; and

b. have a lawful claim against another party, parties, or insurer (including uninsured, underinsured, and no-fault automobile insurers) for compensation, damages, or other payment because of that same sickness or injury.

The Principal will have the right of first reimbursement from any recovery a Member or Dependent receives even if the Member or Dependent has not been made whole.

Article 2 - Transfer of Rights

In those instances where this section applies, the rights of the Member or Dependent to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to The Principal, but only to the extent of benefit payments made under this Group Policy.

Article 3 - Member and Dependent Obligations

To secure the rights of The Principal under this section, a Member or Dependent must:

a. Complete any applications or other instruments and provide any documents The Principal might require, and cooperate with The Principal and its agents in order to protect the subrogation rights of The Principal.

b. If payment from the other party or parties has been received, reimburse The Principal for benefit payment made under this Group Policy (but not more than the amount paid by the other party or parties).

c. The Member and Dependent will not take any action that prejudices the rights of The Principal. If the Member or Dependent enters into litigation or settlement negotiations

regarding the obligations of other parties, the Member or Dependent must not prejudice, in any way, the subrogation rights of The Principal under this Section.

The costs of legal representation retained by The Principal in matters related to subrogation will be borne solely by The Principal. The costs of legal representation retained by the Member or Dependent will be borne solely by the Member or Dependent.

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