CONCERT HEALTH PLAN INSURANCE COMPANY
OAKBROOK, ILLINOIS

CERTIFICATE OF INSURANCE

This certificate is not an insurance policy. It is an outline of the insurance provided by the group Policy and it does not extend or change the coverage afforded by such group Policy. The insurance described by this certificate is subject to all the provisions, terms, exclusions and conditions of the group Policy. The group Policy is available at the offices of your group.

No change in the Policy or the terms of this certificate may be made without the express written consent of one of Our officers which is noted on or attached to the Policy.

This certificate supersedes and replaces any certificate previously issued under the provisions of the group Policy.

Kianoosh Jafari, M.D.
President

GROUP INSURANCE CERTIFICATE

CONCERT HEALTH PLAN INSURANCE COMPANY
Oak Brook, Illinois

POLICYHOLDER

EMPLOYER: DOWD/WESCOTT GROUP, LLC.

EMPLOYEE:

CERTIFICATE NUMBER:

GROUP NUMBER:

PLAN CODE: PH24

BENEFITS	EFFECTIVE DATE
MEDICAL COVERAGE FOR EMPLOYEE & COVERED DEPENDENTS	
VISION BENEFITS FOR EMPLOYEE & COVERED DEPENDENTS	
DRUG COVERAGE FOR EMPLOYEE & COVERED DEPENDENTS	
MENTAL HEALTH COVERED SERVICES RIDER	

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IMPORTANT NOTICES

HOW TO GET THE MOST FROM YOUR HEALTH INSURANCE

Preferred provider organizations are networks of Hospitals, Qualified Treatment Facilities, Qualified Practitioners, and other providers that are contracted to furnish, at negotiated fees, medical Services for the Employees (and their covered Dependents) of participating Employers. These are known as Participating or In-Network Providers.

REASONS TO USE AN IN-NETWORK PROVIDER

1. We negotiate fees for medical Services provided by In-Network Providers. The negotiated fees lower costs for You when You use Hospitals, Qualified Treatment Facilities, Qualified Practitioners, and other providers in the Network.
2. In addition, You may receive a better benefit and Your Out-of-Pocket expenses will be minimized.
3. You will have a wide variety of Hospitals, Qualified Treatment Facilities, Qualified Practitioners, and other providers in the network to help You with Your medical care needs.

In order to avoid reduced benefit payments, obtain Your medical care from In-Network Providers whenever possible. However, the choice of provider is Yours.

HOW TO CHOOSE A PROVIDER

A list of the participating Hospitals, Qualified Treatment Facilities, Qualified Practitioners and other providers in the network will be given to You at the time Your coverage becomes effective. The list is also available at our Web site www.concerthealth.com. This list is subject to change. To confirm that Your Hospital, Qualified Treatment Facility, Qualified Practitioner or other provider is a CURRENT participant in Your provider network, You must call the number listed on the back of Your medical identification card.

LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED.

Notice: You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE

Medicare means Title XVIII, Parts A and B of the Social Security Act. If You are eligible for Medicare benefits, but not enrolled, benefits under this plan will be paid as if You had enrolled for Medicare.

IF YOUR EMPLOYER EMPLOYS 20 OR MORE EMPLOYEES, and You are age 65 or over and are eligible for Medicare, You have the option of either:

1. Continuing coverage under this plan, in which case Medicare benefits would be secondary to this plan; or
2. Electing Medicare as Your primary coverage, in which case benefits under this plan will be coordinated with Medicare.

IF YOUR EMPLOYER EMPLOYS FEWER THAN 20 EMPLOYEES, and You are age 65 or over and are eligible for Medicare, the benefits of this plan are secondary to Medicare.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, 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 symmetrical appearance; and
3. Prostheses and treatment of physical complications of the mastectomy, including lymphedema,

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and Coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

If Your plan covers normal pregnancy benefits, the following notice applies to You. Under federal law, group health plans and health insurance issuers offering group health insurance coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your plan administrator or see the Precertification requirements in the Utilization Management section of this certificate.

NOTICE OF PRIVACY POLICY AND PRACTICES

This Notice tells how and why We collect personal information about Our customers, how We handle it and with whom We share it. We respect the privacy of personal information and handle it securely. Our practices apply to current and former customers. We collect personal information:

- To determine eligibility for health care coverage
- To provide benefits and pay claims or to conduct utilization management programs
- To provide other information and services valuable to Our customers.

We may also be required to collect and keep certain information so that We meet legal and regulatory requirements. We keep this information after a customer's health care coverage ends.

Personal Information We Collect from Customers

We ask people seeking benefits to provide certain information when they complete an enrollment form. This information may include, for example:

- Name, address and phone number
- Social Security Number, Marital Status and Birth Date
- Information about other coverage

Customers may also give personal information when they fill out surveys or contact Us.

Personal Information We Collect From Others

We may also receive personal information about Our customers from others, such as:

- Employers, insurance agents or brokers and insurance companies that provide coverage to Our customers
- Health care providers (doctors, clinics, hospitals)
- Business partners (companies with whom We have arrangements to assist Us in providing customer products and services)

The information We collect from others may also include eligibility, claims and payment information.

How We Protect Personal Information

We use strict safeguards to protect the personal information of Our customers. These safeguards include how We store personal information in workspaces and computers, and how We transfer that information within Our company and to Our business partners. We only allow people who work for Us or Our business partners to see personal information when it is part of their job to provide products or services to Our customers. These people are informed about the safeguards We have in place, Our privacy policies, and the law that protects privacy.

When We Disclose Personal Information

We may share personal information We collect within Our family of companies ("affiliates") as permitted by law. We do not share personal customer information outside of Our affiliates except when the law allows or requires Us to do so. For any other types of disclosures to third parties, We require a customer request or authorization. Some examples of persons to whom We disclose personal information include the following:

- Business partners who help to administer customer benefits and services
- Our attorneys, accountants and auditors who need the information to provide their services to Us
- Authorized representatives such as parents and guardians, or people given permission by the customer
- Health care providers, insurance agents and brokers, other insurers, consumer reporting agencies
- Law enforcement and regulatory authorities
- Companies that market Our products and services, or companies with whom We have joint marketing or disease management agreements

Individual Rights

Our customers can access the personal information We collect upon request. We may not share information that We collect for a lawsuit or legal claim. We try to keep customer information correct and current. We have procedures for customers to make corrections to incorrect information. If You believe that any personal information We have is not correct, please call the Customer Service telephone number on Your ID card or write to Chief Privacy Officer, Concert Health Plan, 2605 W. 22nd Street, Suite 25, Oak Brook, IL 60523.

Other Information

We may change Our privacy and practices from time to time. We will send Our current customers Our privacy notice in writing at least once a year. You can also see the privacy notice online at www.concerthealth.com.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another group health plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

Benefits are paid pursuant to the terms of a group health Policy issued and insured by:

Concert Health Plan Insurance Company
2605 W. 22nd Street, Suite 25
Oak Brook, IL 60523

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(312) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

SECTION 1
SCHEDULE OF BENEFITS – PH24

This Schedule of Benefits is a summary of coverage and limitations provided under this group Policy. A more detailed explanation of Your coverage, its limitations and exclusions is provided in the succeeding sections of this certificate and any applicable riders. Benefits are payable only for a Medically Necessary Covered Expense incurred for diagnosis and treatment of a Bodily Injury or Sickness.

You must meet the Precertification requirements for some benefits prior to obtaining those benefits. If You do not meet the Precertification requirements, Your benefits may be reduced. If You do not notify Us as required, benefits will not be payable for the first $1,000 of Covered Expense, or benefits will be reduced to 50% of Covered Expense, whichever is less. The $1,000 penalty or the reduction in benefit is not applied to the deductible or Out-of-Pocket limits. These Precertification requirements are described in the Utilization Management section of this certificate.

Your certificate contains a PREFERRED provider organization provision. Benefits may be paid at an increased percentage if Services are provided by a PREFERRED provider and at a decreased percentage if Services are provided by a Non-Participating Provider as explained in this certificate. All Covered Expenses from Non-Participating Providers are payable on a Maximum Allowable Amount basis and are subject to specific conditions, durational limitations and all applicable maximums of the Policy.

If You are traveling and are unable to access care from a PREFERRED provider, benefits will be paid at the Non-Participating Provider level. If You need Emergency Care and are unable to access care from a PREFERRED provider, benefits will be paid at the PREFERRED provider benefit level up to the Maximum Allowable Amount.

If a PREFERRED provider finds it medically necessary to refer You to a Non-Participating Provider, benefits will be paid at the level applicable to the referring provider, but ONLY if there is no PREFERRED provider reasonably available to provide that Service. If there is no PREFERRED provider within 50 miles, We may, at Our discretion, require You to travel to a PREFERRED provider of Our choice. If We do, We will pay the reasonable travel expenses of the Covered Person who is receiving treatment from the PREFERRED provider.

MEDICAL BENEFITS
Lifetime Maximum Benefit per Covered Person: $5,000,000.00

Deductibles. Individual calendar year deductible means the amount of Covered Expense that a Covered Person is responsible to pay per calendar year before any benefits are payable by Us with respect to that Covered Person. Copayments are not included in calculating whether You have met a deductible. Any Covered Expense incurred by You during the last 3 months of the calendar year that is used to satisfy all or part of the deductible for that calendar year will be used to satisfy all or part of the deductible for the following calendar year.

The individual deductible is
$1,000 per Covered Person when You see a Participating Provider, and
$2,000 per Covered Person when You see a Non-Participating Provider. The deductibles for Participating Providers and for Non-Participating Providers are mutually exclusive. Amounts allocated to one deductible do not also satisfy any part of the other.

Maximum family calendar year deductible means the amount of Individual deductibles that a family must pay. Once met, any remaining Individual deductibles will be waived for that calendar year.

The family deductible is
$3,000 when You see a Participating Provider, and
$6,000 when You see a Non-Participating Provider. The deductibles for Participating Providers and for Non-Participating Providers are mutually exclusive. Amounts allocated to one deductible do not also satisfy any part of the other.

Out-of-Pocket Coinsurance Limits. The Out-of-Pocket Coinsurance Limit does not include the annual deductible, any Copayments, charges which exceed the Maximum Allowable Amount, any charges for non-covered services, amounts in excess of the lifetime maximum benefit, and amounts in excess of the annual maximum benefit for any covered Service.

Individual Out-of-Pocket Limit means the maximum amount of Coinsurance that a Covered Person must pay. It is
$2,000 per Covered Person when You see a Participating Provider, and
$4,000 per Covered Person when You see a Non-Participating Provider.
The Out-of-Pocket Coinsurance Limits for Participating Providers and for Non-Participating Providers are mutually exclusive. Amounts allocated to one Coinsurance Limit do not also satisfy any part of the other.

Family Out-of-Pocket Limit means the maximum amount of Coinsurance that You and Your covered Dependents must pay. It is
$6,000 when You see a Participating Provider, and
$12,000 when You see a Non-Participating Provider.
The Out-of-Pocket Coinsurance Limits for Participating Providers and for Non-Participating Providers are mutually exclusive. Amounts allocated to one Coinsurance Limit do not also satisfy any part of the other.

COVERED MEDICAL SERVICES. All claims from out-of-network providers are subject to the Maximum Allowable Amount.

ALCOHOLISM

Inpatient Care
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

Outpatient Care
Maximum benefit is $2,500 per calendar year for any Covered Person.
PREFERRED PROVIDER BENEFITS: $30 Copayment per visit
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance subject to the Maximum Allowable Amount.

AMBULANCE

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

CHEMICAL AND SUBSTANCE ABUSE

Maximum benefit is 2,500 per calendar year for any Covered Person.
Inpatient Care
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

Outpatient Care
PREFERRED PROVIDER BENEFITS: $30 Copayment per visit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

DIAGNOSTIC RADIOLOGY, LABORATORY AND PATHOLOGY SERVICES (not performed in the office).

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

DURABLE MEDICAL EQUIPMENT – Subject to Precertification requirements for any Durable Medical Equipment with a cost in excess of $1,000.

Maximum benefit is 5,000 per calendar year for any Covered Person.
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

EMERGENCY CARE. Subject to Precertification requirements. We must be notified of any Emergency admission within 48 hours after the admission or as soon as reasonably possible. If You are Confined for the same condition within 24 hours of the Emergency admission the claim will be treated as Inpatient Care.

Outpatient Hospital Services and Outpatient Physician Services:
PREFERRED PROVIDER BENEFITS: $100 Copayment per visit.
NON-PARTICIPATING PROVIDER BENEFITS: $100 Copayment per visit subject to the Maximum Allowable Amount.

HOME HEALTH CARE – Subject to Precertification requirements. Must be in lieu of a Hospital Confinement or Skilled Nursing Facility.

50 Home Health Care visits per year.
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

HOSPICE CARE – Subject to Precertification requirements.
Limited to a Lifetime Maximum Benefit of 180 days.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

HOSPITAL SERVICES. Subject to Precertification requirements.

Inpatient Care (Semi-Private Room, Intensive Care Unit, Operating Room, Ancillary Services)
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

Outpatient care (All Services)
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

HUMAN ORGAN TRANSPLANTS – Precertification is required and benefits are provided only for transplants performed at an approved facility. No benefits will be provided for transplants performed at a facility that is not approved in advance by Us. The lifetime maximum benefit, including pre-transplant and post-transplant care, is $300,000 for any covered person.

APPROVED FACILITY BENEFITS: 80% to Out of Pocket Coinsurance Limit.

IMMUNIZATIONS (covered only to age 18). Does not include related office visits.

PREFERRED PROVIDER BENEFITS: $30 Copayment per visit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

IMPLANTS – Precertification is required. The maximum benefit is $30,000 per calendar year for any covered person.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.

NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

JAW JOINT BENEFIT

Benefit is $1,000 per calendar year per Covered Person up to a lifetime maximum benefit per Covered Person of $2,500.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.

NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

MAMMOGRAMS AND PAP SMEARS (Routine)

PREFERRED PROVIDER BENEFITS: $30 Copayment per visit.

NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

MANIPULATIVE THERAPY SERVICES

We will cover up to $100 visit and/or treatment to a maximum benefit of $1,000 per calendar year for any Covered Person.

PREFERRED PROVIDER BENEFITS: $30 Copayment per visit.

NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

MENTAL HEALTH COVERED SERVICES. See attached Policy Rider.

PHYSICAL MEDICINE

Maximum benefit is $2,500 per calendar year for any Covered Person.

PREFERRED PROVIDER BENEFITS: $30 Copayment per visit.

NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

PHYSICIAN SERVICES – OFFICE VISITS

Annual Physical Exam (one per calendar year) for a Covered Person over age two.

Diagnostic Office Visits. Home visits billed by the physician. Diagnostic Radiology, Laboratory, and Pathology services when performed in the office and billed by the physician. Allergy testing and injection.

PREFERRED PROVIDER BENEFITS: $30 Copayment per visit.

NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

PHYSICIAN SERVICES – INPATIENT/OUTPATIENT

Chemotherapy, Hospital visits and charges, Surgical Procedures, Therapy. Assistant Surgeon, if a Physician, paid at 20% of the Covered Expense for the Surgery; if not a Physician, paid at 10% of the Covered Expense for the Surgery.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.

NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

PREGNANCY

Covered as any other Sickness for any Female Covered Person.

PROSTHETIC DEVICES – Subject to Precertification requirements for any Prosthetic Device with a cost in excess of $1,000.

Maximum benefit is $5,000 per calendar year for any Covered Person.
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

SKILLED NURSING FACILITY – Subject to Precertification requirements.

15 Days per calendar year.
PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PARTICIPATING PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

URGENT CARE CENTER SERVICES

PREFERRED PROVIDER SERVICES: $30 Copayment per visit.
NON-PARTICIPATING PROVIDER SERVICES: 60% to Out of Pocket Coinsurance Limit.

SECTION 2
DEFINITIONS

The following are definitions of terms as they are used in this certificate.

Active Status means the Employee is performing all of his/her customary duties whether performed at the Employer's business establishment or another location when required to travel on the job:

1. On a regular full-time basis;
2. For the number of hours per week shown on the Employer Group Application;
3. For 48 weeks a year; and
4. Is maintaining a bona fide Employee-Employer relationship with the sponsor of the Policy on a regular basis.

Each day of a regular vacation and any regular non-working holiday is deemed Active Status, if the Employee was in Active Status on his or her last regular working day prior to the vacation or holiday.

Bodily Injury means injury due directly to an accident, independent of disease or bodily infirmity.

Coinsurance means the percentage of the Covered Expense that You are required to pay until You reach the Out-of-Pocket Limit as shown on Your Schedule of Benefits. The out-of-pocket coinsurance limits for Participating Providers and for Non-Participating Providers are mutually exclusive. Amounts allocated to one coinsurance limit do not also satisfy any part of the other coinsurance limit.

Complications of Pregnancy means:

1. Conditions with diagnoses which are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis; nephrosis; cardiac decompensation; hyperemesis gravidarum; pueperal infection; toxemia; eclampsia; and missed abortion;
2. A nonelective cesarean section;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does NOT mean:

1. False labor;
2. Occasional spotting;
3. Rest prescribed during the period of pregnancy;
4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct Complications of Pregnancy; or
5. An elective cesarean section.

Confinement and **Confined** mean: (1) an uninterrupted stay following formal admission to a Hospital or Qualified Treatment Facility and (2) detainment in Observation Status for more than 24 hours even if You are not formally admitted to a Hospital or Qualified Treatment Facility.

Copayment is the charge, expressed as a defined dollar amount, which You are required to pay for certain Services provided under the Policy. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service or when billed by the provider. Copayments are not included in calculating whether You have met the Out-of-Pocket Limit.

Cosmetic Surgery means Surgery performed to reshape normal structures of the body in order to improve Your appearance and self-esteem.

Covered Expense is payable on a negotiated fee basis with respect to services provided by Participating Providers and on a Maximum Allowable Amount basis with respect to services provided by Non-Participating Providers and as shown on Your Schedule of Benefits, up to any maximum benefit. Amounts charged by a Non-Participating Provider in excess of the Maximum Allowable Amount are not a Covered Expense.
Covered Expense means:

1. A Medically Necessary expense;
2. For the benefits stated in this certificate; and
3. An expense incurred when You are insured for that benefit under the Policy on the date that the Service is rendered.

Covered Person means the Employee or the Employee's covered Dependents.

Creditable Coverage does not include coverage under accident only, disability, liability, credit-only, workers' compensation or similar insurance, automobile medical payment insurance, coverage for on-site medical clinics or other similar insurance. Creditable Coverage means prior coverage of an insured person under the following:

1. An insured or self-insured group health plan including governmental or church plans;
2. Individual health insurance;
3. Medicare or Medicaid;
4. Military-sponsored health care, including CHAMPUS;
5. A program of Indian Health Service or medical care under a tribal organization;
6. A state High Risk Health Benefit Pool;
7. Federal Employee Health Benefit Plan (FEHBP)
8. A Public Health Plan;
9. A Health Plan run by the Peace Corps Act;
10. A state children's health insurance plan; or
11. Any other similar coverage.

Custodial Care means Services given to You if:

1. You need Services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or
2. The Services You require are not likely to improve Your condition.

Services may still be considered Custodial Care by Us even if:

1. You are under the care of a physician; or
2. The physician prescribed Services are to support or maintain Your condition; or
3. Services are being provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.); or
4. Services involve the use of skills which can be taught to a lay person; or
5. You do not require the technical skills of a licensed nurse at all times.

Dental Injury is an injury that could not be predicted in advance and could not be avoided. It does not include chewing injuries.

Dependent means a covered Employee's:

1. Legally recognized spouse; or
2. Unmarried natural blood related child, stepchild, or legally adopted child whose age is less than the limiting age. Adopted child includes a child who is in the custody of the Employee, pursuant to an interim court order of adoption vesting temporary care of the child to You, regardless of whether a final order granting adoption is ultimately issued. Dependent DOES NOT mean a grandchild, great grandchild, or foster child UNLESS such child is in the custody of a covered Employee pursuant to a court order. Each child must:
   A. Meet all of the qualifications of a Dependent as determined by the Internal Revenue Service; and
   B. Be declared on and legally qualify as a Dependent on the Employee's federal personal income tax return filed for each year of coverage.

The limiting age for each Dependent child is:
1. The child's 19th birthday; or
2. The child's 25th birthday if such child is in regular full-time attendance at an accredited secondary school, college or university. The Dependent child must be enrolled for sufficient course credits to maintain full-time status as defined by that school. A Dependent child continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

You must furnish satisfactory proof to Us upon Our request that the above conditions continuously exist. If satisfactory proof is not submitted to Us, the child's coverage will not continue beyond the last date of eligibility. A covered Dependent child who becomes an Employee eligible for other group coverage through employment is no longer eligible as a Dependent for coverage under the Policy.

A covered Dependent child who attains the limiting age WHILE INSURED under the Policy remains eligible for benefits if:
1. Dependent on the Employee or other care providers for lifetime care and supervision;
2. Incapable of self-sustaining employment by reason of a handicapped condition which started prior to the date the child attained the limiting age for Dependent children;
3. The child meets all of the qualifications of a Dependent as determined by the Internal Revenue Service;
4. Declared on and legally qualified as a Dependent on the Employee's federal personal income tax return filed for each year of coverage; and
5. Unmarried.

We may request proof two months prior to the Dependent child's attainment of the limiting age that the Dependent child is, in fact, a disabled and Dependent person. You must provide this first proof within 31 days of Our request. After two years from the date the first proof was furnished, We may not request such proof more often than annually. If satisfactory proof is not submitted to Us, the child's coverage will not continue beyond the last date of eligibility.

Durable Medical Equipment (DME) means equipment for a Covered Expense that must:
1. Be able to withstand repeated use;
2. Be not disposable;
3. Be primarily and customarily used to serve a medical purpose;
4. Be appropriate for use in the home;
5. Not be generally useful to a person except for the treatment of a Bodily Injury or Sickness; and
6. Be Medically Necessary.

Emergency Care means Services for an acute, sudden onset of a Sickness or Bodily Injury which:
1. Is life threatening; or
2. Will significantly worsen without immediate medical or surgical treatment.

Emergency Care does not mean Services for the convenience of the Covered Person or the provider of treatment or Services.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Employee means a person who is employed in an Active Status and paid a salary or a wage by the Employer that meets the minimum wage requirements of Your state or federal minimum wage law. Employee also includes a sole proprietor, partner or corporate officer where:

1. The Employer is a sole proprietorship, partnership or corporation; and
2. The sole proprietor, partner or corporate officer is actively performing duties relating to the business and gains his or her livelihood from the sole proprietorship, partnership or corporation and is in an Active Status at the Employer's place of business.

Employer means the sponsor of this group insurance plan, or any subsidiary described in the Employer Group Application. To be covered by this plan, an Employer must also meet the definition of Employee.

Enrollment Date is the earlier of the following:

1. The first day Your coverage is effective under the Policy; or
2. The first day of the waiting period for enrollment, if any waiting period is applicable.

Your Enrollment Date is the first day Your coverage is effective under the Policy, if You are enrolled on a Special Enrollment Date.

Experimental, Investigational or for **Research Purposes**. A Service is Experimental, Investigational or for Research Purposes if:

1. The Service requires approval of the U.S. Food and Drug Administration and approval had not been given at the time the Service was furnished; or
2. The Service is not approved by the American Medical Association or other appropriate medical specialty society; or
4. The Service is the subject of on-going phase I or phase II clinical trials; is in the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
5. The Service is unproven; which means that it has not been demonstrated through peer-reviewed medical and scientific literature to be safe and effective in treating or diagnosing the proposed condition or illness.

Family Member means You, Your spouse, and Your or Your spouse's child, brother, sister, or parent.

Free-Standing Surgical Facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide services or accommodations for patients to stay overnight.

Health Insurance Coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or HMO contract offered by a Health Insurance Issuer. Health Insurance Issuer means an Insurance Company, Insurance Service, Insurance Organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance.

Home Health Care Provider means an agency licensed by the proper authority as a Home Health Agency, or Medicare Approved as a Home Health Agency and provides 24-hour-a-day, 7-day-a-week Service, supervised by a Qualified Practitioner.

Home Health Care Plan means a plan of health care established with a Home Health Care Provider. The Home Health Care Plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.); or
2. Physical, speech, occupational, respiratory therapy, or
3. Medical appliances and equipment, if such supplies would have been covered if You were Hospital confined.

For purposes of Home Health Care, a Qualified Practitioner must:

1. Review and approve the Home Health Care Plan; and
2. Certify and verify the Home Health Care Plan is required in lieu of continued Hospital, Qualified Treatment Facility or Skilled Nursing Facility Confinement; and
3. Not be related to the Home Health Care Provider by ownership or contract.

Home Health Care Visit means Services provided by any one Qualified Practitioner for four (4) consecutive hours or any portion thereof.

Hospice Care Agency means an agency which:

1. Has the primary purpose of providing hospice services to Hospice Patients;
2. Is licensed and operated according to the laws of the state in which it is located; and
3. Meets all of these requirements:
   A. Has obtained any required certificate of need;
   B. Provides 24-hour-a-day, 7-day-a-week service, supervised by a qualified physician;
   C. Has a full-time administrator;
   D. Keeps written records of services provided to each patient;
   E. Has a coordinator who:
      i) Is an R.N., and
      ii) Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
   F. Has a licensed social service coordinator.

Hospice Care Program means a written plan of hospice care which:

1. Is established and reviewed by:
   A. The Qualified Practitioner attending the person, and
   B. The Hospice Care Agency; and
2. Provides:
   A. Palliative and supportive care to Hospice Patients,
   B. Supportive care to the families of Hospice Patients,
   C. An assessment of the Hospice Patient's medical and social needs, and
   D. A description of the care to meet those needs.

Hospice Facility means a licensed facility or part of a facility which:

1. Principally provides hospice care;
2. Keeps medical records of each patient;
3. Has an ongoing quality assurance program;
4. Has a physician on call at all times;
5. Provides 24-hour-a-day skilled nursing services under the direction of an R.N.; and
6. Has a full-time administrator.

Hospice Patient means a terminally ill person with six months or less to live.

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is licensed by the appropriate governmental agency and legally operated as a hospital in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services.

Hospital does NOT include an institution which is principally a rest home, nursing home, convalescent home, residential treatment facility or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or chemical dependency or Mental Disorders.

Implant means an artificial device made to replace and act as a missing biological structure.

Lifetime Maximum Benefit means the maximum amount paid for Covered Expenses during the entire time a Covered Person is covered under the Policy, or any policy issued by Us to the enrolling group that replaces the Policy. The Lifetime Maximum Benefit is stated in the Schedule of Benefits.

Maintenance Care means any Service or activity which seeks to prevent disease, prolong life or promote health of an asymptomatic Covered Person who has reached the maximum level of improvement and whose condition is resolved or stable.

Manipulative Therapy Services means medical services for the diagnosis and treatment of the head, neck and spine. This includes ultrasound and manipulative, heat and other related treatment.

Maximum Allowable Amount means the amount determined by Concert Health Plan as payment in full for a particular Covered Expense. The Maximum Allowable Amount for a Covered Expense will be at least equal to 100% of the Medicare Resource Based Relative Value Scale (RBRVS). All benefit payments for Covered Expenses rendered by Non-Participating Providers will be based upon the Maximum Allowable Amount. All benefit payments for a human organ transplant Covered Expense performed at a non-approved facility will be based upon the Maximum Allowable Amount.

Medically Necessary means the extent of Services required to diagnose or treat a Bodily Injury or Sickness which is known to be safe, effective, and consistent with the standard of care recognized by the majority of Qualified Practitioners who are licensed to diagnose or treat that Bodily Injury or Sickness. Such Services must be:

1. Consistent with and appropriate for Your symptoms or diagnosis of the Sickness or Bodily Injury under treatment;
2. Furnished for an appropriate duration and frequency in accordance with accepted medical practices;
3. Not provided primarily for the convenience of You or any provider of Services;
4. Substantiated by the records and documentation maintained by the provider of the Service; and
5. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered Service. When applied to the care of an inpatient, it further means that the Services cannot be safely provided on an outpatient basis.

We do not cover the cost of medical services or supplies that are not medically necessary. The fact that Your Physician or another health care provider may prescribe, order, recommend or approve a healthcare service or supply does not make such service or supply medically necessary for purposes of coverage under this plan. We do not determine Your course of treatment or whether You receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between You and Your Physician. Our determination of medical necessity is limited to merely whether something is medically necessary for purposes of coverage under this plan. In the event that We determine that all or a portion of any healthcare service or supply is not medically necessary, We will not be responsible for any charges incurred with respect to that service or supply.

Mental Disorder means mental, nervous, or emotional diseases or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder.

Network means a group of providers who have entered into a contract with Us to provide Services at negotiated rates.

Non-Participating Provider means a provider of medical services that is not a member of a Preferred, Select or Exclusive Provider network affiliated with this plan of insurance.

Observation Status means a stay (not to exceed 24 hours) in a Hospital or Qualified Treatment Facility if:

1. You have not been admitted as an inpatient; or
2. You are physically detained in an emergency room, treatment room, recovery room, observation room or other such area; or
3. You are being observed to determine whether an inpatient Confinement will be required.

Participating Provider means a provider of medical services that is a member of a Preferred, Select or Exclusive Provider network affiliated with this plan of insurance.

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

Policy means this certificate of insurance and the Master Group Policy as contracted for by the Policy Owner and Us.

Pre-admission Testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a Hospital. The tests must be for the same Bodily Injury or Sickness causing You to be Hospital confined. The tests must be accepted by the Hospital in place of like tests made during Confinement. Pre-admission Testing does NOT mean tests for routine physical check-ups.

Pre-Existing Condition means a physical or mental condition for which You have received medical attention, care, advice, examination, treatment, services, medication, procedures, tests, consultation, referral or diagnosis during the six (6) months prior to Your Enrollment Date. The time period for a Pre-Existing Condition exclusion under the Policy is described in Section 4 of this certificate.

Precertification is a determination by Us, based upon complete, accurate and truthful information provided by You or Your medical service providers, that a proposed Service is Medically Necessary. Precertification of medical necessity is subject to the limitations, exclusions, and provisions of this certificate and does not guarantee that any or all charges will be covered if subsequent information indicates a lack of medical necessity. The Precertification requirements are described in the Utilization Management section of this certificate. Precertification also determines if the use of alternative care is appropriate, such as:

A. Skilled Nursing Facilities;
B. Home health care services;
C. Inpatient or outpatient Hospice Care Programs;
D. Partial hospitalization;
E. Intensive outpatient programs; or
F. Any other alternatives.

Qualified Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a Bodily Injury or Sickness, and who provides Services within the scope of that license. A Qualified Practitioner's Services are not covered if the practitioner resides in Your home or is Your Family Member.

Qualified Treatment Facility means only a facility, institution, or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

Service(s) means procedures, Surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, or technologies.

Sickness means a disturbance in function or structure of Your body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body.

Skilled Nursing Facility means only an institution licensed as a Skilled Nursing Facility and lawfully operated in the jurisdiction where located. A Skilled Nursing Facility is not a rest home, a home for the care of the aged, or engaged in the care and treatment of chemical or alcohol dependence.

It must maintain and provide:

1. Permanent and full-time bed care facilities of resident patients;
2. A Qualified Practitioner's services available at all times;
3. 24-hour-a-day skilled nursing services under the full-time supervision of a physician or registered nurse (R.N.);
4. A daily record for each patient;
5. Continuous skilled nursing care for sick or injured persons during their convalescence from illness or injury; and
6. A utilization review plan in effect.

Sound Natural Tooth means a tooth that:

1. is organic and formed by the natural development of the body (not manufactured);
2. has not been extensively restored;
3. has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth.

Surgery means excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

We, **Us**, and **Our** means the Concert Health Plan Insurance Company.

You and **Your** means any Covered Person.

SECTION 3
COVERED MEDICAL SERVICES
For groups of more than 25 employees on the contract date.

This section describes Services which will be considered Covered Expense(s). Benefits will be paid for such Covered Expenses for a Bodily Injury or Sickness as shown on Your Schedule of Benefits subject to:

1. The deductible and Copayments, if applicable;
2. Any Coinsurance percentage;
3. Up to any maximum benefit; and
4. All other terms, provisions, limitations and exclusions listed in this certificate.

DIABETES
Benefits for covered services for a covered person with diabetes includes: (a) up to three medically necessary visits to a qualified provider for diabetes self-management training including nutrition counseling upon initial diagnosis (b) up to two medically necessary visits to a qualified provider for diabetes self-management training including nutrition counseling upon a physician's determination that a significant change has occurred in the covered person's medical condition, (c) routine foot care, limited to two exams per calendar year. Coverage is provided for the following equipment, pharmaceuticals, and supplies when medically necessary and prescribed by a physician licensed to practice medicine in all of its branches: blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets and lancing devices, insulin, syringes and needles, test strips for glucose monitors, FDA approved oral agents used to control blood sugar, and glucagon emergency kits.

DURABLE MEDICAL EQUIPMENT (DME).
Coverage for DME must be ordered or provided by or under the direction of a Physician for use outside a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility. Coverage is provided for DME that meets the minimum specifications that are Medically Necessary. Replacement of DME for the sole purpose of technical modification or enhancement is excluded at Our discretion. We will provide for the purchase or rental, up to but not to exceed the purchase price, of a non-motorized wheelchair, hospital bed, ventilator, hospital type equipment or other DME. Repair or maintenance of the DME or duplicate DME rentals is not considered a Covered Expense. DME Covered Expenses are subject to the Precertification requirements and benefit maximums described in Your Schedule of Benefits.

HOME HEALTH CARE BENEFIT
Covered Expense for Home Health Care as described below is payable under the Policy. A Home Health Care Provider must render Services at Your home under a Home Health Care Plan, as described below. The Home Health Care Plan must begin within 14 days after discharge from a Hospital, Qualified Treatment Facility or Skilled Nursing Facility, unless waived by Us. Nothing in this provision will increase benefits to cover Home Health Care Services which are not otherwise covered under the Policy.

Covered Expense is only payable when You are homebound and when:
1. Precertification is received from Us; and
2. Home Health Care is in lieu of a covered Confinement in a Hospital, Qualified Treatment Facility or Skilled Nursing Facility.

Home Health Care benefits do NOT include:
1. Charges for mileage or travel time to and from the Covered Person's home;
2. Wage or shift differentials for Home Health Care Providers; or
3. Charges for supervision of Home Health Care Providers.

HOSPICE CARE BENEFIT
Covered Expense for Hospice Care as described below is payable under the Policy. Benefits for a Hospice Care Program must be furnished in a Hospice Facility or in Your home by a Hospice Care Agency. A physician must certify that You are terminally ill with a life expectancy of six months or less. For this benefit only, Your immediate family is considered to be Your parent, spouse and Your children or stepchildren.

Covered Expense is only payable when:
1. Precertification is received from Us; and
2. Hospice Care is in lieu of a Confinement in a Hospital or Skilled Nursing Facility.

Hospice Care benefits are payable as shown on the Schedule of Benefits for the following Hospice Services, subject to the Policy Lifetime Maximum Benefit:
1. Room and board;
2. Other Services;
3. Part-time nursing care provided by or supervised by an R.N. for up to eight hours per day;
4. Counseling by a licensed:
   A. Clinical social worker; or
   B. Pastoral counselor for the Hospice Patient and the immediate family. This counseling is limited to a total of 15 visits per family;
5. Medical social services provided to You or Your immediate family under the direction of a Qualified Practitioner, up to a maximum benefit of $100, including:
   A. Assessment of social, emotional and medical needs, and the home and family situation; and
   B. Identification of the community resources available;
6. Psychological and dietary counseling;
7. Physical therapy;
8. Part-time home health aide Services for up to eight hours in any one day; and
9. Medical supplies, drugs and medicines prescribed by a Qualified Practitioner.

HOSPICE CARE BENEFITS DO NOT INCLUDE:
1. Private duty nursing when confined in a Hospice Facility.
2. A Confinement not required for pain control or other acute chronic symptom management;
3. Funeral arrangement;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker Services, including:
   A. Sitter or companion Services;
   B. Housecleaning;
   C. Household maintenance.
6. Services of a social worker other than a licensed clinical social worker;
7. Services by volunteers or persons who do not regularly charge for their Services;
8. Services by a licensed pastoral counselor to a member of his or her congregation. These are Services in the course of the duties to which he or she is called as a pastor or minister; and
9. Bereavement counseling Services.

HOSPITAL SERVICES. Subject to Precertification requirements.
Covered Expense includes charges made by a:
1. Hospital for daily semi-private, ward, intensive care or coronary care room and board charges for each day of Confinement. The maximum amount payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the Maximum Allowable Amount charged for a semi-private room in the Hospital while a registered bed patient.
2. Hospital for Services furnished for Your treatment.
3. Free-Standing Surgical Facility for Services furnished for Your treatment,
4. Qualified Practitioner, whether billed directly or separately by the Hospital for:
   A. Professional Services of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy, or
   B. Professional Services of an anesthesiologist.
5. Hospital or Free-Standing Surgical Facility for medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ.
6. Hospital for Outpatient Services when incurred for Pre-admission Testing.
7. Hospital for Outpatient Services when incurred for Emergency Care due to a Sickness.
8. Hospital for Outpatient Services when incurred for Emergency Care rendered within 48 hours of an accident.

9. Hospital for Outpatient Services when incurred for a surgical procedure.
10. Hospital for Outpatient Services when incurred for regularly scheduled treatment such as chemotherapy, inhalation therapy, or radiation therapy as ordered by Your attending physician.
11. Hospital for Outpatient Services not to exceed the average semi-private room rate when You are in Observation Status.

HUMAN ORGAN TRANSPLANTS. Subject to Precertification and facility approval requirements. When Your physician recommends an organ, tissue or bone marrow transplant, You must contact Us before Your transplant surgery has been scheduled. We will furnish You with a list of facilities which have been selected for such transplants. No benefits will be provided for transplants performed at a facility that is not included on that list. This provision is applicable to pre-transplant evaluations, organ procurement, donor expenses, all pharmacy costs for immunosuppressant medications and follow-up care for one year from the date of transplant.

Benefits will be provided for human organ or tissue transplants but only for cornea, kidney, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants. Benefits will be provided for bone marrow transplants (allogenic, autologous and peripheral blood stem cells), but only for neuroblastomas, lymphomas, Ewing's sarcoma, aplastic anemia, Wiskott-Aldrich syndrome, breast cancer and leukemia.

Benefits are available to both the recipient and donor of a covered transplant as follows:
1. If both the donor and recipient have Concert Health Plan coverage, each will have their benefits paid by their own Concert Health Plan program.
2. If You are the recipient of the transplant, and the donor has no coverage from any other source, the benefits under this certificate will be provided for both You and the donor. In this case, payments made for the donor will be charged against your benefits.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:
1. Your benefits under this coverage will begin no earlier than 5 days prior to the transplant Surgery and shall continue for a period of no longer than 365 days after the transplant Surgery. Benefits will be provided for all inpatient and outpatient covered Services related to the transplant Surgery.
2. Benefits will also be provided for the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the other exclusions of this certificate, benefits will not be provided for the following:
1. Cardiac rehabilitation services when not provided to the transplant recipient within 3 days after discharge from a Hospital for transplant Surgery.
2. Transportation by air ambulance for the donor or the recipient.
3. Travel time and related expenses required by a medical Services provider.

IMPLANTS. Subject to Precertification requirements. The benefit for implants is payable up to the limits stated in the Schedule of Benefits.

INFERTILITY SERVICES. Subject to Precertification requirements.
Limitations: Coverage of infertility treatment only applies to a Policy providing coverage for more than 25 employees at issuance or at the beginning of the Policy's renewal period. If You are unsure whether You are eligible for this benefit, please call the number on Your ID card to verify benefits.

Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. Services for the diagnosis and treatment of infertility shall include: medically necessary hormonal and related services for the external augmentation of ovulatory cycles; artificial insemination, in vitro fertilization, uterine embryo lavage, and embryo transfer. In vitro fertilization, ZIFT (zygote intrafallopian tube transfer), and GIFT (gamete intrafallopian tube transfer) shall only be covered if:

A. The Covered Person has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatment for which coverage is available under this certificate; and
B. The Covered Person has not undergone four completed oocyte retrievals per lifetime of the Covered Person, except that if a live birth follows a complete oocyte retrieval, then two more completed oocyte retrievals shall be covered; and
C. The procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

JAW JOINT BENEFIT (Including temporomandibular joint, or TMJ)
Covered Expense incurred by You during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull, is payable for You and each of Your covered Dependents up to the limits stated in the Schedule of Benefits.

The following are Covered Expenses:
1. A single examination including a history, physical examination, muscle testing, range of motion measurements and psychological evaluation, as necessary.
2. Diagnostic x-rays.
3. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of Service.
4. Therapeutic injections.
5. Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the Maximum Allowable Amount for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic Services, office visits, adjustments, training, repair and replacement of the appliance.
6. Surgical procedures.

Covered Expense does NOT include charges for:
1. CT scans, magnetic resonance imaging except in conjunction with surgical management.
2. Electronic diagnostic modalities.
3. Occlusal analysis.
4. Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, inlays, fixed or removable partial dentures, and full dentures.

MENTAL HEALTH COVERED SERVICES. See Policy Rider.

PHYSICAL MEDICINE BENEFIT
Covered Expense for outpatient Physical Medicine is payable to a maximum benefit amount as shown on the Schedule of Benefits. Physical Medicine expenses include charges incurred during the diagnosis and treatment of physical conditions relating to bone, muscle or neuromuscular pathology, including but not limited to, speech, physical, occupational, growth and cognitive therapies; biofeedback; adjustments and manipulations of any spinal or bodily area; and cardiac exercise programs.

Physical Medicine treatment for cerebral vascular accidents (CVA), burns and fractures for which You are hospitalized or had Surgery and when Physical Medicine immediately follows discharge, is payable as any other Sickness or Bodily Injury and is not limited to the Physical Medicine Benefit.

PREGNANCY AND NEWBORN SERVICES
Normal pregnancy and well baby charges are Covered Expenses ONLY if shown as a Covered Expense on the Schedule of Benefits.
1. If provided, normal pregnancy charges including prenatal HIV testing ordered by an attending physician are a Covered Expense for any female Covered Person.
2. Complications of Pregnancy are payable as any other covered Sickness at the point the complication occurs for any female Covered Person.

3. Well baby Covered Expense is expense incurred by a covered Dependent newborn child during his or her first five days of life for:
   A. Hospital charges for nursery room, board and care;
   B. The Qualified Practitioner's charges for circumcision of the newborn child; and
   C. The Qualified Practitioner's charges for routine examination of the newborn child before release from the Hospital.

   Well baby coverage for newborns will be provided ONLY under the following circumstances:
   A. Normal pregnancy benefits are shown as a Covered Expense on the Schedule of Benefits; and
   B. The mother's delivery charges are a Covered Expense under this certificate and the newborn child is a covered dependent, or if the mother is not covered under this certificate, the father is and the father's insurance is chosen to cover the newborn child.
4. For a covered pregnancy, Hospital Services for inpatient care provided to the mother and the Dependent newborn child will be covered for:
   A. A minimum of 48 hours, following a vaginal delivery; or
   B. A minimum of 96 hours, following a caesarian section;

   UNLESS the following applies:
   A. Post-discharge office visit to the physician or in-home nurse visit is provided in the first 48 hours after discharge; or
   B. Earlier discharge is:
      i. Consistent with the most current version of "Guidelines for Prenatal Care" prepared by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists; and
      ii. Consented to by the mother and the attending physician.
5. Benefits for sick baby Covered Expense are payable for any covered Dependent newborn child. Sick baby Covered Expense is expense incurred by a covered Dependent newborn child for the following:
   A. Bodily Injury or Sickness;
   B. Medically Necessary care and treatment for premature birth; and
   C. Medically diagnosed congenital defects and birth abnormalities.

   Covered Expense does NOT include expense incurred for Cosmetic Surgery, EXCEPT Surgery for:
   A. Reconstruction due to Bodily Injury, infection or other disease of the involved part; or
   B. Congenital defects and birth abnormalities of a covered Dependent child.

PROSTHETIC DEVICES. Subject to Precertification requirements and benefit maximums described in Your Schedule of Benefits. Coverage for prosthetic devices must meet the following criteria: (1) Obtained from a vendor or provider selected by Us, and (2) ordered or provided by or under the direction of a Physician for use outside a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility. Coverage is provided for Medically Necessary prosthetics (artificial limbs, artificial eyes, and other prosthetic devices required as a result of Injury or Sickness). Coverage is limited to a single purchase of each type of prosthetic device during the entire period of time You are enrolled for Coverage under the Policy. Except when necessitated due to a change in Your medical condition, such that Your present prostheses no longer functions adequately, no Coverage is provided for repair, replacement or duplicates nor is coverage provided for services related to the repair or replacement. No coverage is provided for replacement due to breakage or malfunction. Replacement of prosthetics for the sole purpose of technical modification or enhancement is excluded.

QUALIFIED PRACTITIONER SERVICES

Covered Expense includes charges made by a:
1. Physician for office, home or inpatient Hospital visits;
2. Qualified Practitioner for administration of anesthesia;
3. Qualified Practitioner for diagnostic x-ray or laboratory tests;
4. Qualified Practitioner for a surgical procedure, including post-operative care. If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to:
   A. 100% of the Covered Expense for the primary procedure,
   B. 50% of the Covered Expense for the secondary procedure, and
   C. 25% of the Covered Expense for the third and subsequent procedures.

5. Qualified Practitioner for services in performing certain oral surgical operations as follows:
   A. Excision of partially or completely unerupted impacted teeth;
   B. Excision of tumors and cysts for the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
   C. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   D. Reduction of fractures and dislocation of the jaw;
   E. External incision and drainage of cellulitis;
   F. Incision of accessory sinuses, salivary glands or ducts; and
   G. Frenectomy (the cutting of the tissue in the midline of the tongue).

SECOND SURGICAL OPINION

Second surgical opinion means a consultation with a Board Certified surgeon after an insured person has received a recommendation to have surgery. This consultation includes the physical examination, laboratory work and x-rays not previously performed by the original surgeon. The consulting surgeon must not be affiliated in practice with the surgeon who first recommended surgery.

A benefit will be payable for charges incurred by an insured person in obtaining a second surgical opinion, after he or she has received a recommendation to have elective surgery which is covered under this Policy. The charges will not be subject to a deductible/Copayment and will be treated as a Covered Expense if:

1. the consulting physician personally examines the insured person and We receive a copy of the written opinion; and
2. the consulting physician does not perform the surgery to correct the condition for which the original recommendation was given.

If both the conditions stated above are not met, the applicable deductible and benefit amount or percentage will be applied to the charges for the second opinion. If the second opinion does not confirm the original recommendation, the insured person may consult another physician for a third opinion. The third opinion must be obtained, and benefits will be payable in the same manner as the second opinion.

SKILLED NURSING FACILITY BENEFIT.

Covered Expense for daily room and board and general nursing services for each day of Confinement in a Skilled Nursing Facility is payable as shown on the Schedule of Benefits when Precertification is received from Us. A Skilled Nursing Facility Confinement means only a Confinement in a Skilled Nursing Facility which occurs when You are under the regular care of a Qualified Practitioner who has reviewed and approved the Confinement.

OTHER COVERED EXPENSES

1. Local professional ground transportation ambulance service to the nearest Hospital equipped to provide the treatment covered, if the Bodily Injury or Sickness requires special treatment not available in a local Hospital.
2. Blood and blood plasma which is NOT replaced by donation; administration of blood and blood products including blood extracts or derivatives.
3. Oxygen and rental of equipment for its administration.
4. Casts, splints (other than dental), trusses, and braces (other than orthodontic).
5. Prescription drugs and medicines that are administered by a Qualified Practitioner, except that prescription drugs dispensed in an outpatient setting, including but not limited to the covered person's home, or a physician's office, outpatient facility, hospice or skilled nursing facility will be covered at the Average Wholesale Price (AWP) as published by Thomson Medical Economics in the Red Book.
6. Dental treatment only if:
   A. The charges are incurred for treatment for a Dental Injury to a Sound Natural Tooth;
   B. The Pre-Existing Condition Exclusion period, if applicable, has been satisfied;
   C. The treatment begins within 90 days after the date of the injury; and
   D. The treatment is completed within 12 months after the date of the injury.
7. A baseline mammogram for a female Covered Person between the ages of 35 and 39 years; an annual mammogram for a female Covered Person 40 years of age or older; a mammogram at the age and intervals considered medically necessary by the woman's health care provider for a female Covered Person under 40 years of age having a family history of breast cancer or other risk factors.

8. For a female Covered Person, an annual cervical smear or Pap smear test.
9. For a female Covered Person who has tested positive for BRCA1 or BRCA2 mutations or who has one or more first-degree relatives with ovarian cancer or clusters of women relatives with breast cancer or nonpolyposis colorectal cancer, Covered Expense includes annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination.
10. For a male Covered Person, 40 years of age or older, an annual digital examination and a prostate-specific antigen (PSA) test, when recommended by a Qualified Practitioner.
11. Well child care according to the American Academy of Pediatrics guidelines is provided for Covered Persons to age two.
12. Routine immunizations for Covered Persons under age 18. TB tine and allergy desensitization injections are not considered routine immunizations.
13. Colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a physician in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies.
14. When prescribed by a physician, outpatient contraceptive services and outpatient contraceptive drugs and devices approved by the U.S. Food and Drug Administration.
15. Services and anesthetics provided in conjunction with dental care to a Covered Person in a hospital or ambulatory surgical treatment center if any of the following applies:
    A. The Covered Person is a child age six or under;
    B. The Covered Person has a medical condition that requires hospitalization or general anesthesia for dental care; or
    C. The Covered Person is disabled.
16. For a Covered Person, who is receiving benefits in connection with a mastectomy, Services for:
    A. Reconstructive surgery of the breast on which the mastectomy has been performed;
    B. Surgery and reconstruction of the other breast to achieve symmetrical appearance; and
    C. Prostheses and physical complications from all states of mastectomy, including lymphedemas.
    D. Medically Necessary post-surgery stay for inpatient care and post-discharge office visit to the physician or in home nurse visit provided in the first 48 hours after discharge.
17. Medically necessary bone mass measurement; diagnosis and treatment of osteoporosis.

SECTION 4
LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Exclusion
Benefits are excluded for a Pre-Existing Condition until the date the Covered Person has been insured by this Policy for twelve consecutive months.

The Pre-Existing Condition exclusion will NOT apply to:
1. A newborn child who is covered on his/her date of birth; or
2. A legally adopted child, including a child placed with the Employee for the purpose of adoption, if coverage is effective on the child's eligibility date,
3. Pregnancy, when covered under Your Schedule of Benefits.

You are eligible for Portability of Creditable Coverage if Your Coverage was continuous without a break of more than 63 days between the termination of coverage under Creditable Coverage and the Enrollment Date under the Policy. The Pre-Existing Condition exclusion period will be reduced by the number of days of coverage that You had under the Creditable Coverage, if Your coverage was continuous to a date NOT more than 63 days prior to the Enrollment Date under the Policy. If on a particular day You have Creditable Coverage from more than one source, all the Creditable Coverage on that day will be counted as one day. Any day of the waiting period for a plan or policy is not counted as Creditable Coverage.

NOTICE: You must submit to Us certification of Creditable Coverage from Your prior plan(s). Upon request and authorization from You, We can contact Your prior carrier(s) for Your Creditable Coverage certification.

Other Limitations and Exclusions
The Policy does NOT provide benefits for:
1. Investigational or experimental drugs or substances not approved by Us or by the United States Food and Drug Administration (FDA); drugs or substances used for other than FDA approved indications; or drugs labeled: "Caution – limited by Federal law to investigational use" or for any Service which is Experimental, Investigational, or for Research Purposes.
2. Services:
   A. Not furnished by a Qualified Practitioner or Qualified Treatment Facility;
   B. Not authorized or prescribed by a Qualified Practitioner;
   C. For which no charge is made, or for which You would not be required to pay if You did not have this insurance;
   D. Furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law;
   E. Furnished while You are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies;
   F. Which are not rendered;
   G. That are not listed as a Covered Expense;
   H. Provided by a person who is a Family Member or ordinarily resides in Your home; or
   I. Any Hospital, ancillary or other Service performed in association with a Service that is not covered under this plan.
3. Any expense incurred after the date Your coverage under the Policy terminates.
4. Elective abortions, reversal of sterilizations, or medical care or Surgery to change gender.
5. Accupressure, hypnotism, rolfing, massage therapy, aroma therapy, and acupuncture.
6. Therapy and testing for treatment of allergies, including but not limited to Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and /or treatment UNLESS such therapy or testing is approved by:
   A. The American Academy of Allergy and Immunology, or
   B. The Department of Health and Human Services or any of its offices or agencies.
7. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing, or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

8. Birth control drugs, contraceptive implant systems and devices unless prescribed by a physician.
9. Blood derivatives which are not classified as drugs in the official formularies.
10. Cosmetic procedures including but not limited to pharmacological regimens; nutritional procedures or treatments; plastic surgery; salabrasion, chemosurgery and other skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or which are performed as a treatment for acne; radial keratotomy and other refractive eye surgery; any surgery for breast reduction, replacement of an existing breast implant if the earlier breast implant was for cosmetic purposes, unless the removal and replacement is medically necessary and otherwise covered under this plan.
11. Cosmetic Surgery, including rhinoplasty and septoplasty, or any complication therefrom, unless for reconstructive surgery resulting from a Bodily Injury, infection or other disease of the involved part which occurs while You are covered under the Policy.
12. Loss due to the insured's being engaged in an illegal occupation or the commission or attempt to commit a felony.
13. Custodial Care and Maintenance Care.
14. Dental Services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral or periodontal Surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental Services related to a Bodily Injury or Sickness unless otherwise indicated in this certificate.
15. Educational or vocational therapy, services and schools, including but not limited to videos and books.
16. Enteral feedings, nutritional or electrolyte supplements, vitamins, dietaries, and any other non-prescription supplements.
17. Treatment of erectile dysfunction including penile implants.
18. Eye refractive disorders, eyeglass frames and lenses or contact lenses, or radial keratotomy and any other Surgery to correct myopia, hyperopia or stigmatic error, vision therapy, orthopic treatment (eye exercises), unless specifically described in this certificate.
19. Treatment of weak, strained, flat, unstable or unbalanced feet; arch supports, heel wedges, lifts, orthopedic shoes, orthotics, or the fitting of orthotics to aid walking or running.
20. Charges for physical fitness equipment, health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs.
21. Gastric bypass surgery and any other Services and any associated expenses for the surgical treatment and non-surgical medical treatment of obesity, including morbid obesity.
22. Medications, drugs or hormones to stimulate growth unless there is a laboratory confirmed diagnosis of growth hormone deficiency.
23. Hearing aids, hair prosthesis, hair transplants or implants, and wigs.
24. Immunization required for foreign travel for Covered Persons of any age.
25. Repair or replacement for any otherwise covered implant.
26. Inpatient Hospital Services when You are in Observation Status unless Medically Necessary.
27. Outpatient prescribed or non-prescribed medical supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, needles and syringes; over the counter drugs and treatments.
28. Massage therapy.
29. Mechanical transplants (except for mechanical heart valves) or animal organ transplants.
30. The treatment of Mental Disorders or chemical or alcohol dependence other than inpatient Services for alcohol dependence unless specifically provided in the Mental Health Covered Services provision of this certificate and shown on Your Schedule of Benefits.
31. Treatment of nicotine habit or addiction, including but not limited to nicotine patches, hypnosis, smoking cessation classes or tapes.
32. Prescription drugs dispensed at any time from a retail pharmacy.
33. Routine physical, hearing, or eye exams including those for health checkups, occupation, employment, school, travel, the purchase of insurance, or premarital tests or examinations, unless specifically described in this certificate.
34. Removal or destruction of skin moles or skin tags.
35. Surrogate parenting, non-medically necessary amniocentesis, nonmedical egg procurement and donor expenses, treatment of normal pregnancy and well baby expenses, unless provided on the Schedule of Benefits.
36. Services rendered by a standby physician or assistant surgeon unless Medically Necessary.
37. Sleep disorder studies, diagnosis, therapy or services including equipment and supplies.
38. Televisions, telephones or other communications equipment or services, barber or beauty services, lodging accommodations, and transportation or travel time or expenses even though prescribed by a Physician.

39. Removal of an organ from a Covered Person for purposes of transplantation into another person, except as may be otherwise covered by the organ recipient's coverage under this plan.
40. Travel or transportation expenses, even if prescribed by a Physician.
41. Private duty nursing while confined in a Hospital, Qualified Treatment Facility or other institution.
42. Treatment for injury, illness or medical condition arising out of attempted suicide or intentionally self-inflicted injury, whether sane or insane.
43. Any loss caused by:
    A. War or any act of war, whether declared or not; or
    B. Any act of armed conflict, or any conflict involving armed forces of any authority.
44. Charges for Services that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including but not limited to air conditioners, humidifiers, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers, and related equipment or similar items or equipment.
45. Charges for failure to keep a scheduled visit or charges for completion of a claim form.
46. Services and supplies for the analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, or for muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).
47. Any charges, including Qualified Practitioner charges, which are incurred if You are admitted to a Hospital on a Friday, Saturday or Sunday unless:
    A. Your Hospital admission is due to Emergency Care; or
    B. Treatment or Surgery is performed on that same day.
48. Treatment of any Bodily Injury or Sickness that is sustained by an Employee or a covered Dependent that arises out of, or as the result of, any work for wage or profit when covered under any Workers' Compensation Act or similar law that is required for the Employee or covered Dependent.
49. Any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any alcohol, drugs, or narcotics unless used as prescribed by a physician.

SECTION 5
NOTICE OF CLAIMS AND APPEALS

LEGAL ACTIONS
You cannot bring an action at law or equity to recover on the Policy until 60 days after the date written proof of loss is furnished in accordance with the Policy. You cannot bring such action more than three years after such written proof of loss is required to be furnished.

NOTICE AND PROOF OF LOSS
You must give written proof of loss within 90 days after the date of loss, except for loss of life. Your claim will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written notice must be given within one year after the date proof of loss is otherwise required, except if You were legally incapacitated. Failure to provide proof of loss as required will result in the denial of the claim.

CLAIM APPEAL PROCEDURE
Decisions by Us on payment of claims is based only on whether benefits are available under the Policy. Whether a treatment, service or procedure is appropriate for You is a decision between You and Your physician. If You disagree with a claim denial, a review may be requested. You must present a written request for a review of a claim denial to Us within 365 days of Your receipt of the notice of denial. You must give all additional information to Us within 365 days of Your receipt of the notice of denial. We will advise you of the final decision and the reasons for the decision. You may appeal any denial of a claim by calling the number on Your ID card, or by writing to Us at:

Concert Health Plan
Customer Service
2605 West 22d Street, Suite 25
Oak Brook, Illinois 60523

SECTION 6
UTILIZATION MANAGEMENT

PRECERTIFICATION

This provision applies to all Precertification requirements listed in this certificate. The fact that We precertify services or supplies does not guarantee that all charges for a precertified expense will be covered. We reserve the right to review each claim if there are questions regarding medical necessity. In such a circumstance, coverage of some services or supplies may be denied. You will be notified in writing of any subsequent adjustment of benefits as a result of the claim review. Nothing in this provision will increase benefits to cover a Confinement or Service that is not Medically Necessary or otherwise not covered under the Policy.

PRECERTIFICATION PROCEDURES

WHAT YOU ARE REQUIRED TO DO: You must obtain Precertification for some benefits prior to obtaining those benefits. If You or Your covered Dependent are to be admitted to a Hospital or Qualified Treatment Facility as an inpatient or for non-emergency outpatient surgery, You or Your Qualified Practitioner must contact Us by telephone or in writing at least seven days before Your admission. We must be notified of any Emergency admission within 48 hours after the admission or as soon as reasonably possible. If You do not meet the Precertification requirements, Your benefits may be reduced.

PENALTY FOR NOT OBTAINING PRECERTIFICATION. If You do not obtain Precertification from Us as required, benefits will not be payable for the first $1,000 of Covered Expense or benefits will be reduced to 50% of Covered Expense, whichever is less. The $1,000 penalty or the reduction in benefit is not applied to the deductible or Out-of-Pocket Limit shown in the Schedule of Benefits.

WHAT WE WILL DO: We will precertify the proposed treatment to determine if it is medially necessary. Your Qualified Practitioner will be notified of the approval, need for additional cinical information, or denial. Inpatient services will be reviewed for continued stay. If initially, or at anytime during your treatment, services are not eligible under the terms and provisions of the Policy, benefits will only be paid for Services (both Qualified Practitioner and Hospital or Qualified Treatment Facility) that are determined to be an eligible Covered Expense.

UTILIZATION REVIEW FOR ORGAN AND BONE MARROW TRANSPLANTS.

PRE-TRANSPLANT CERTIFICATION. When a physician recommends an organ or bone marrow transplant, the proposed transplant must be reviewed and Precertified and the facility approved by Us before the transplant commences. You must notify Us to initiate Pre-Transplant Certification.

FAILURE TO COMPLY WITH PRE-TRANSPLANT CERTIFICATION. If You do not notify Us and obtain precertification before services are rendered, benefits will not be payable for the first $1,000 of Covered Expense, or benefits will be reduced to 50% of Covered Expense, whichever is less. No benefits will be provided for transplants performed at a facility that is not approved in advance by Us.

RIGHT TO CONSIDER SUBSTITUTION FOR COVERED EXPENSES

We reserve the right to consider for payment expenses incurred for Services that are substitutions for the Covered Expenses of the Policy. The expenses are considered at Our option and must:

1. Be Medically Necessary;
2. Have Your knowledge and agreement while receiving the Service;
3. Be prescribed and approved by Your Qualified Practitioner; and
4. Offer a medical therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

We will review advance requests for substitute procedures. If such a request is made, We may allow or disallow a substitute Service at any time at Our sole option by sending a written notice to You and Your Qualified Practitioner.

CONCURRENT CARE REVIEW AND APPEALS

We will review Emergency admissions and extended periods of non-Emergency care on a concurrent basis to ensure that your ongoing care is Medically Necessary and is provided at the most appropriate setting. If You disagree with any decision by Us, You may appeal by calling the number on Your ID card.

SECTION 7
ELIGIBILITY DATE, ENROLLMENT AND EFFECTIVE DATE

ELIGIBILITY DATE
Subject to the payment of any required premium, the Employee is eligible for coverage on the date:
1. The eligibility requirements stated in the Employer group application are satisfied; and
2. The Employee is in an Active Status.

The Employee may cover his or her Dependents ONLY if the Employee is also covered. Each Dependent is eligible for coverage on:
1. The date the Employee is eligible for coverage, if he or she has Dependents who may be covered on that date;
2. The date of the Employee's marriage, for any Dependents (spouse or child) acquired on that date;
3. The date of birth of the Employee's natural-born child;
4. The date the child is placed in the Employee's home for the purpose of adoption by the Employee; or
5. The date specified in the court or administrative order which requires the Employee to provide coverage for a child, if You are eligible for Dependent child coverage.

A Dependent child who becomes eligible for other group coverage through any employment is no longer eligible for group coverage under the Policy. If a Dependent child becomes an Employee of the participating Employer, he or she is no longer eligible as a Dependent and must make application as an eligible Employee.

RETIRED EMPLOYEE ELIGIBILITY DATE
Retired Employees are an eligible class of Employees if requested on the Employer Group Application and if approved by Us. An Employee who retires WHILE INSURED under the Policy is considered eligible for Retired Employee medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.

EMPLOYEE ENROLLMENT
The Employee must enroll on forms furnished and accepted by Us. Depending on the total number of Employees covered by the Employer's plan, We may require any Employee to provide evidence of health status whenever an enrollment form is submitted.

DEPENDENT ENROLLMENT
Check with the Employer immediately on how to enroll for Dependent coverage. The Employee must enroll for Dependent coverage and enroll additional Dependents on forms furnished and accepted by Us. Depending on the total number of Employees covered by the Employer's plan, We may require any Dependent to provide evidence of health status whenever an enrollment form is submitted.

NEWBORN DEPENDENT ENROLLMENT
If You have or acquire a newborn child as a dependent, the child is automatically insured from the moment of birth for 31 days if You are insured for dependent insurance. In order for coverage for the child to continue beyond the 31-day period, You must notify Us of the child's birth and make any required premium payment within 31 days of the child's birth. If You are insured for yourself, but not for Your dependents, Your newborn child will become insured from the moment of birth only if You apply for dependent coverage and pay any required premium within 31 days of the child's birth.

SPECIAL ENROLLMENT
LOSS OF OTHER COVERAGE
If You are an Employee or Dependent who was previously eligible for coverage under this plan and had waived coverage, You may be eligible for the Special Enrollment provision if:

1. You declined enrollment under this plan at the time of initial enrollment because:
   A. You were covered under a group health plan or other Health Insurance Coverage at the time of eligibility and Your coverage terminated as a result of:
      i. Termination of employment or eligibility;
      ii. Reduction in number of hours of employment;
      iii. Divorce, legal separation or death of a spouse; or
      iv. Termination of Your Employer's contribution for the coverage; or
   B. You had COBRA continuation coverage under another plan at the time of eligibility and such coverage has since been exhausted; and
   C. You stated, at the time of the initial enrollment, that coverage under the group health plan or other Health Insurance Coverage or COBRA continuation was Your reason for declining enrollment; and
   D. You apply for coverage within 31 days after termination of coverage under the group health plan or other Health Insurance Coverage or COBRA; or
2. You were covered under an alternate plan provided by the Employer and You are replacing coverage with this plan; or
3. Your request for enrollment is made within 31 days of, and because of, a court order to provide coverage under Your plan for Your minor child.

DEPENDENT SPECIAL ENROLLMENT PERIOD
The Special Enrollment Period is a 31-day period from the Special Enrollment Date.
Special Enrollment Date means:

1. The date of change in family status after the initial Eligibility Date, as follows:
   A. Date of marriage;
   B. Date of birth of a natural born child; or
   C. Date of adoption of a child or date of placement of a child with the Employee for the purpose of adoption; or
2. The date of termination of coverage under a group health plan or other Health Insurance Coverage, as specified under the Special Enrollment provision.

If Dependent coverage is available under the Employer's group plan or added to the plan, an Employee who is a Covered Person can enroll eligible Dependents during the Special Enrollment Period. An Employee, who is otherwise eligible for coverage and had waived coverage under this plan when eligible, can enroll himself/herself and eligible Dependents during the Special Enrollment Period.

RETIRED EMPLOYEE ENROLLMENT
Notification of the Employee's retirement must be submitted to Us by the Employer or You within 31 days of the date of retirement. Failure to do so will require You to submit an enrollment form and evidence of health status.

EFFECTIVE DATE OF COVERAGE FOR CONFINEMENT FOR EMPLOYEE, DEPENDENT AND RETIRED EMPLOYEE.
If You are confined on Your effective date of coverage and You do not have coverage for that confinement under a prior plan, "services" related to the confinement are covered, beginning on the Effective Date of Your Coverage, as long as: (a) You notify Us of the confinement within 48 hours of the effective date or as soon as is reasonably possible; and (b) "services" are received in accordance with the terms, conditions, exclusions and limitations of the Policy. For purposes of the preceding sentence "confined" means an uninterrupted stay following admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

EMPLOYEE EFFECTIVE DATE
Effective date is the first date of coverage under this plan. The Employee's Effective Date Provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the probationary period, or the Special Enrollment Date.

EMPLOYEE DELAYED EFFECTIVE DATE
If the Employee is not in Active Status on the eligibility date, coverage will be effective the day after the Employee returns to Active Status. The Employer must notify Us in writing of the Employee's return to Active Status.

DEPENDENT EFFECTIVE DATE
1. If We receive the enrollment form on, prior to or within 31 days of the Dependent's eligibility date that Dependent is covered on the date he or she is eligible.
2. If We receive the enrollment form on, prior to or within 31 days of the Dependent's Special Enrollment Date, that Dependent's coverage is effective on the Special Enrollment Date.

However, NO Dependent's effective date will be prior to the Employee's effective date of coverage.

NEWBORN DEPENDENT EFFECTIVE DATE
A newborn Dependent's effective date is determined as follows. If We receive the enrollment form and any additional premium within 31 days of the newborn's date of birth, Dependent Coverage is effective on the newborn's date of birth.

RETIRED EMPLOYEE EFFECTIVE DATE
The effective date of coverage for an eligible Retired Employee is the date of retirement for an Employee who retires AFTER the date We approve the Employer's request for a retiree classification, provided We receive notice of the retirement within 31 days. If We receive notice more than 31 days after retirement, We require evidence of health status. We have the right to accept or decline coverage for the Retired Employee based upon the evidence of health status. If accepted, the effective date of coverage will be the date We specify. Please also refer to Section 8, "Termination and Continuation of Coverage."

BENEFIT CHANGES EFFECTIVE DATE
Benefit changes will become effective on the date specified by Us, if the Employee is in Active Status on that date. Otherwise, the change will be effective on the day the Employee returns to Active Status.

RETIRED EMPLOYEE'S BENEFIT CHANGES
Additional or increased insurance will become effective on the approved date of change, subject to the Retired Employee Delayed Effective date. A decrease in insurance will be effective immediately on the approved date of change.

RETIRED EMPLOYEE DELAYED EFFECTIVE DATE
If the Retired Employee is:
1. Confined in a Hospital or Qualified Treatment Facility; or
2. Receiving Home Health Care or Hospice Care benefits, the Retired Employee's effective date of coverage will be delayed.

In such case, the Retired Employee's Coverage will be effective:
1. On the day after discharge from Confinement, if the discharge is certified by a Qualified Practitioner; or
2. On the day after a Qualified Practitioner certifies that Home Health Care is no longer needed.

SECTION 8
TERMINATION AND CONTINUATION OF COVERAGE

Insurance terminates on the earliest of the following:

1. The date this group Policy terminates for any reason;
2. The last day for which the policy owner has made any required premium contribution for insurance on your behalf;
3. The date You are no longer eligible for coverage under this certificate;
4. The date You enter full-time military service;
5. The date the Employee retires, except if the Employer Group Application provides coverage for a retiree class of Employees and the retiree is in an eligible class of retirees, selected by the Employer, and We are notified by the Employer;
6. The date the Employee requests termination of insurance to be effective for the Employee or Dependents;
7. For any benefit, the date the benefit is deleted from the Policy;
8. The date We stop writing new business for participating employer groups on this plan. We will give the participating employer (and participants and beneficiaries covered under such coverage) 90 days advance notice of termination of coverage under this item. The participating employer will be offered the option to purchase any other health benefit plan that We are then offering to employer groups in the state;
9. The date We stop writing new business for participating employer groups. We will give the participating employer (and participants and beneficiaries covered under such coverage) 180 days advance notice of termination of coverage under this item.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If the Employer continues to pay required premiums and continues participation under the Policy, Your coverage, other than Short Term Disability benefits, if any, will remain in force for:

1. No longer than three consecutive months if the Employee is:
   A. Temporarily laid-off;
   B. In part-time status; or
   C. On an Employer-approved leave of absence.
2. No longer than 12 consecutive months if the Employee is Totally Disabled.

If this coverage terminates, the Employee may exercise the rights under any applicable Continuation of Medical Benefits provision, or the Medical or Life conversion Privilege described in this certificate. If the Employee utilizes the Conversion Privilege, he or she thereby waives the right to continue coverage. If the Employee returns to an Active Status, he or she will be considered a new Employee and must re-enroll for Employee Coverage.

CONTINUATION AFTER LOSS OF EMPLOYMENT

If Your medical coverage under the Policy terminates due to loss of employment, You may continue medical coverage for You and Your covered Dependents if:

1. You were covered under the Policy for at least three consecutive months immediately prior to termination;
2. You are not eligible for Medicare or other group coverage for which You were eligible but not covered immediately prior to termination; and
3. You were not discharged from Your employment due to commission of a felony or a theft in connection with Your work.

HOW TO ELECT CONTINUATION COVERAGE

The Employer will notify You in writing of Your right to continue coverage. In no event will You be eligible to elect continuation of coverage more than 60 days after the date Your coverage would otherwise terminate. If You elect to continue coverage You must notify the Employer in writing within ten days following:

1. The date Your coverage would otherwise terminate; or
2. The date You received written notification of Your right to continue coverage.

If You elect to continue coverage You must pay the total monthly premium in advance to the Employer. The premium for continuing Your coverage will be the rate that would have been applicable to the Employer for Your group coverage during the continuation period.

If You do not choose to continue Your group medical coverage, or if You do and it terminates, You have the right to exercise the Medical Conversion Privilege described in this certificate. If You do not continue coverage and utilize the Conversion Privilege, You thereby waive the right to continue coverage. The Medical Conversion Privilege is available to Your covered Dependents while You are insured under this continuation privilege.

TERMINATION OF CONTINUATION COVERAGE
Medical coverage may be continued under this continuation privilege until the earliest of the following:
1. Nine months after the date Your coverage would otherwise have terminated;
2. The end of any month for which You fail to make timely payment of premium;
3. The date the Policy terminates or the date the Employer terminates participation under the Policy. If the group Policy is replaced, coverage will continue under the new policy;
4. The date You become eligible for Medicare or other group coverage; or
5. For Your Dependent, the date he or she no longer meets the definition of Dependent.

If the Employee returns to Active Status while insured under this continuation privilege, he or she must re-enroll for Employee Coverage.

SURVIVORSHIP CONTINUATION

If the Employee dies while Dependent Coverage is in force, the surviving Dependent spouse and Dependent children may continue to be insured for medical coverage only. Coverage may continue for 90 days after the death without application, subject to all terms and provisions of the Policy. This 90-day continuation will run concurrently with the following continuation that must be applied for.

CONTINUATION FOR DEPENDENTS DUE TO DIVORCE, DEATH OR RETIREMENT OF THE EMPLOYEE
If Your medical coverage under the Policy terminates due to legal annulment, dissolution of marriage, divorce, or the death of the Employee, or due to the retirement of the Employee (if You, the Dependent spouse, are age 55 or over at the time of retirement) You may continue medical coverage for You and Your covered Dependents if You:
1. Notify the Employer and Us within 30 days after the date Your coverage would otherwise terminate;
2. Elect to continue group medical coverage within 30 days after receipt of written notice of Your right to continue coverage; and
3. Pay the total monthly premium in advance to the Employer. The premium for continuing Your coverage will be the rate that would have been applicable to the Employer for Your group coverage during the continuation period.

TERMINATION
If the former spouse has not attained the age of 55 at the time the continuation coverage begins, coverage may be continued until the earliest of the following:
1. Two years after the date the continuation coverage began;
2. The date the former spouse remarries;
3. The end of any month for which You fail to make timely payment of premium;
4. The date coverage would terminate under the terms of the existing Policy if the Employee and former spouse were still married to each other; except that the continuation coverage shall not be modified or terminated during the first 120 days following the divorce or death of the Employee unless the Policy is modified or terminated as to all Employees;
5. The date the Policy terminates or the date the Employer terminates participation under the Policy. If the Policy is replaced, coverage will continue under the new policy.
6. The date the former spouse first becomes, after the date of election of continued coverage, an insured Employee under any other group health plan; or
7. For a Dependent child, the date no longer qualified as a Dependent.

If the former spouse or retiree's spouse has attained the age of 55 at the time the continuation coverage begins, coverage may be continued until the earliest of the following:

1. The date the former spouse remarries;
2. The end of any month for which You fail to make timely payment of premium;
3. The date coverage would terminate, except due to the retirement of an Employee, under the terms of the existing Policy if the Employee and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce, death or retirement of the Employee unless the Policy is modified or terminated as to all Employees;
4. The date the Policy terminates or the date the Employer terminates participation under the Policy. If the Policy is replaced, coverage will continue under the new policy;
5. The date the retiree's spouse or the former spouse first becomes, after the date of election of continued coverage, an insured Employee under any other group health plan;
6. For a Dependent child, the date no longer qualified as a Dependent; or
7. The date the retiree's spouse or former spouse reaches the qualifying age or otherwise becomes eligible for Medicare.

If You do not choose to continue Your group medical coverage, or if You do and it terminates, You have the right to exercise the Medical Conversion Privilege described in this certificate. If You do not continue coverage and utilize the Conversion Privilege, You thereby waive the right to continue coverage. The Medical Conversion Privilege is available to Your covered Dependents, in lieu of, or at the termination of eligibility for, the Continuation Privilege, while You are insured under this Continuation Privilege.

SECTION 9
MEDICAL CONVERSION PRIVILEGE

ELIGIBILITY
Only persons covered under the Policy on the date coverage terminates are eligible to be covered under the Conversion Policy. Subject to the terms below, if Your medical coverage under the Policy terminates, a medical Conversion Policy is available without medical examination. You must have been covered under the Policy for at least 90 days and:

1. Your coverage ends because the Employee's employment terminated;
2. You were the covered Dependent spouse or any covered Dependent child of an Employee whose marriage ended due to legal annulment, dissolution of marriage or divorce.
3. You are the surviving covered Dependent spouse or covered Dependent child, in the event of the Employee's death or at the end of any "Survivorship Continuation" as provided by the Policy; or
4. You have been a covered Dependent child but no longer meet the definition of Dependent under the Policy.

The Conversion Policy may be issued covering each former Covered Person on a separate basis or it may be issued covering all former Covered Persons together. However, if conversion is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be Dependents of the Employee are eligible to exercise the Conversion Privilege.

This privilege does NOT apply when the Employer's participation in the Policy terminates and medical coverage is replaced within 31 days by another group insurance plan.

NOTICE
Election of Conversion coverage would eliminate Your federal eligibility for coverage under Illinois Comprehensive Health Insurance Plan (CHIP).

OVERINSURANCE-DUPLICATION OF COVERAGE
We may refuse to issue a Conversion Policy if We determine that You would be overinsured. The medical Conversion Policy will not be available if it would result in overinsurance or duplication of benefits. We will use Our standards to determine overinsurance. Where overinsurance DOES NOT exist but other insurance is in force, benefits payable under the medical Conversion Policy may be reduced.

CONVERSION PLAN
The Conversion Policy which You may apply for will be the policy customarily offered by Us as a conversion from group coverage. The Conversion Policy is a new policy and not a continuation of Your terminated coverage. The Conversion Policy benefits will differ from those provided under Your group coverage. The benefits that may be available to You will be described in an Outline of Coverage provided to You when You request an application for Conversion from Us.

EFFECTIVE DATE AND PREMIUM
You have 31 days after the date Your coverage terminates to apply and pay the required premium for Your Conversion Policy. The premium must be paid in advance. You may obtain application forms from Us. The Conversion Policy will be effective on the day after Your Group Medical coverage ends, if You enroll and pay the first premium within 31 days after the date Your coverage ends.

The premium for the Conversion Policy will be the premium charged by Us as of the effective date based upon the Conversion Policy form, classification of risk, age and benefit amounts selected. The premium may change as provided in the Conversion Policy.

SECTION 10
COBRA
(THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986)

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted. This federal law applies to Employers with 20 or more Employees. The law requires that Employers offer qualified beneficiaries (covered Employee and a spouse and/or Dependent children who were covered under the plan on the day before the qualifying event) the opportunity to elect temporary continuation of medical and dental coverage at group rates in certain instances where there is a loss of group insurance coverage due to a qualifying event. Evidence of Your good health is not required for continuation of coverage.

QUALIFYING EVENTS

Covered Employees can elect to continue coverage, if coverage is lost due to either of the following qualifying events: Termination (other than for gross misconduct) of the Employee's employment; or reduction in the hours of the Employee's employment.

A covered spouse of a covered Employee can elect continuation, if coverage is lost due to any of the following qualifying events: Death of the Employee; Termination of the Employee's employment or reduction in the Employee's hours of employment; Divorce or legal separation from the Employee; or The Employee becoming entitled to Medicare.

A covered Dependent child has the right to elect continuation, if coverage is lost due to any of the following qualifying events: The death of the Employee parent; Termination of the Employee parent's employment or reduction in the hours worked; Divorce or legal separation of the parents; The Employee parent becoming entitled to Medicare; The Dependent ceasing to be a "Dependent child" under the terms of the plan.

Also, children born to the Employee or placed with the Employee for adoption during the continuation period are qualified beneficiaries and are entitled to elect continuation of coverage.

NOTIFICATION AND ELECTION

The Employee or a Family Member has the responsibility to inform the Employer of a divorce, legal separation, or a child losing Dependent status under the plan. The Employee or a Family Member must give this notice within 60 days from the later of the date of the qualifying event or the date coverage would be lost under the terms of the plan. If this notice is not given in a timely manner the option of electing continuation coverage is forfeited. If, because this notice is not provided, coverage is effective beyond the date on which it should have terminated, the Employee or Family Member will be required to reimburse the insurer for any claims paid after the date coverage would have terminated, had proper notice been given. Upon timely notification of one of the above three qualifying events, notice of the right to elect continuation should be provided.

If during a continuation period, a child is born or placed for adoption, the child is considered a qualified beneficiary. The covered Employee on continuation or other guardian may elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example: age). The covered Employee or a Family Member must notify the Employer within 31 days of the birth or placement to enroll the child. Failure to do so may result in the loss of the right to cover the child under continuation coverage.

Qualified beneficiaries should be notified of the right to elect COBRA continuation coverage upon the occurrence of a qualifying event that result in a loss of coverage. A qualified beneficiary is not automatically entitled to continuation coverage, the beneficiary must elect continuation coverage within 60 days of the later of: the date coverage is lost; or the date that the notice to the qualified beneficiary is sent. Qualified beneficiaries not electing continuation coverage within the 60-day election period lose the right to continue coverage.

Each qualified beneficiary has an independent right to elect continuation. A covered Employee or the covered Employee's spouse may elect continuation coverage on behalf of another qualified beneficiary. An election on behalf of a minor child can be made by the child's parent or legal guardian.

PREMIUM AND COVERAGE

If continuation coverage is elected and the applicable premium paid, the continuation coverage will be identical to the coverage provided under the plan to similarly situated active Employees and/or their covered Dependents. If coverage is changed or modified for active Employees, then continuation coverage will be changed or modified for individuals on continuation.

If the qualified beneficiary is covered by the medical plan and the dental plan, he/she may elect continuation under one plan or both plans.

The individual continuing the coverage is responsible to pay all of the premium for such coverage directly to the Employer. This includes the Employee's share and any portion of the premium previously paid by the Employer. In addition to the applicable premium the Employer may charge a 2% administration fee. A quote of the total monthly premium may be obtained from the Employer.

The initial premium payment is due by the 45th day after the date continuation coverage is elected. The initial premium payment must include charges back to the date continuation coverage began (the date of loss of coverage). Subsequent premiums are due monthly on the first of the month for which premium is due, subject to a 31 day grace period.

DURATION OF COVERAGE

If coverage is lost due to the death of the Employee, divorce, legal separation, the Employee becoming entitled to Medicare, or the loss of Dependent status under the plan, the maximum coverage period for a spouse and Dependent children is 36 months from the date of the qualifying event.

If coverage is lost due to the Employee's termination of employment (other than for gross misconduct) or reduction in hours, the maximum continuation period for the Employee, spouse and Dependent children is 18 months from the date of the qualifying event. There are two exceptions to this 18-month continuation period:

1. If a qualified beneficiary is determined under the Social Security Act to have been disabled at any time during the first 60 days of continuation, the continuation period for all qualified beneficiaries is 29 months from the date of the qualifying event. For the 29 month continuation period to apply, notice of the determination of disability under the Social Security Act must be provided by the disabled individual to the Employer within the initial 18 month continuation period but no later than 60 days after the date of the determination. For the extended period of continuation (11 months) the Employer may charge up to 150% of the applicable premium.
2. If a second qualifying event occurs (for example the Employee dies or becomes divorced) within the 18 month or 29 month continuation period (for the spouse or Dependent children) becomes 36 months from the date of the initial termination or reduction in hours.

There is a special rule when the Employee becomes entitled to Medicare prior to or at the time of an initial qualifying event due to termination of employment or reduction of hours. If the Employee is entitled to Medicare prior to or at the time of the initial qualifying event, the period of continuation for other qualified beneficiaries is the later of 36 months from the date of Medicare entitlement or 18 months from the date of the qualifying event.
If the Employee becomes entitled to Medicare within the initial continuation period following an initial qualifying event, the other qualified beneficiaries may be entitled to continuation not to exceed 36 months from the date of the Employee's Medicare entitlement.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage will be terminated prior to the end of the maximum continuation period when:

1. Premiums are not paid timely;
2. the Employer ceases to maintain any group health plan;
3. the qualified beneficiary obtains coverage under another group health plan:
   a. that does not contain any exclusion or limitation with respect to any pre-existing condition the individual has; or
   b. when the exclusion or limitation no longer applies, if such plan has an applicable exclusion or limitation. (An exclusion or limitation of the new plan may not apply at all depending on the length of the individual's prior Creditable Coverage under the previous plan(s). Federal law requires that once an individual obtains creditable health insurance, evidence of this coverage can be used to reduce or eliminate any pre-existing medical condition exclusion or limitation period that might otherwise apply under the new health insurance coverage); or
4. the qualified beneficiary becomes entitled to Medicare benefits (even if entitlement is based on end stage renal disease).

OTHER INFORMATION

Please contact Your Employer for any questions regarding COBRA continuation. Notify Your Employer of any change in marital status, or a change of address. When continued coverage terminates, the qualified beneficiaries may have the right to exercise the Conversion Privilege described in this certificate. The plan or a rider to the plan may also provide a continuation privilege, please refer to this certificate for additional continuation provisions.

SECTION 11
COORDINATION OF BENEFITS

If a person is covered by this plan and by any of the other plans described below, a coordination of benefits provision will be used when the amount of benefits payable by this plan and the amount of benefits payable by any of the other plans for the same medical expenses would exceed the total amount of allowable expenses in a claim determination period. A coordination of benefit provision determines the order in which all plans pay their benefits; and when, depending on the order of benefit determination, a plan may reduce its benefit so that not more than 100% of the total amount of allowable expenses are paid jointly by all plans. If You are covered under any plans defined below, Covered Expense You incur under this plan will be coordinated with benefits payable under the other plans defined below.

BENEFITS SUBJECT TO THIS PROVISION
Medical benefits described in this certificate are coordinated with medical and dental benefits provided by other group insurance plans under which You are also covered. This is to prevent the problem of overinsurance and a resulting increase in the cost of medical coverage.

DEFINITIONS
PLAN. For this purpose, a plan is one that covers medical or dental expenses and provides benefits or service through:

A. Group, franchise or blanket insurance coverage;
B. Hospital service prepayment plan on a group basis, medical service repayment plan on a group basis, group practice or other prepayment coverage on a group basis;
C. Any coverage under labor-management plan, Employer plans, trustee plans, union welfare plans, Employee benefit organization plans; and
D. Any coverage under governmental programs, or any coverage mandated by state statute, or sponsored or provided by an educational institution, if such coverage is not otherwise excluded from the calculation of benefits under the Policy. The term "plan" does not apply to any individual policies.

Employers' plans under the same Trust Policy are considered separate plans.

This Coordination of Benefits provision does NOT apply to Blanket Student Accident Insurance provided by or through an education institution.

The term "plan" is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

ALLOWABLE EXPENSE. Allowable Expense means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the plan(s) covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

CLAIM DETERMINATION PERIOD. Claim Determination Period means calendar year, except that if in any calendar year the person is not covered under the Policy for the full calendar year, the Claim Determination Period for that year will be that portion during which he or she was covered under the Policy.

EFFECT ON BENEFITS
We will apply these provisions when You incur Allowable Expenses during a Claim Determination Period for which benefits are payable under any other plan(s). The provisions will apply only when the sum of the Covered Expense under the Policy and any other plan(s) would, in the absence of these Coordination of Benefits provisions or any similar provisions in the other plan(s) would, exceed the Allowable Expenses.

Benefits provided under the Policy during a Claim Determination period for Allowable Expenses incurred by You will be determined as follows:

1. If benefits under the Policy are to be paid after benefits are paid under any other plan, the benefits under the Policy will be reduced so that the sum of the benefits so reduced plus the benefits payable under all other plans will not exceed the total of the Allowable Expenses.
2. If benefits under the Policy are to be paid before benefits are paid under any other plan, benefits under the Policy will be paid without regard to other plan(s).

Covered Expense under any other plan includes the benefits that would have been payable had claim been made.

Under no circumstances will Your reimbursement exceed 100% of the total Allowable Expenses incurred under the Policy and any other plans included under this provision.

ORDER OF BENEFITS DETERMINATION

For the purpose of the Effect on Benefits provision above, the rules establishing the Order of Benefits Determination are:

1. The benefits of a plan which covers the person other than as a Dependent are determined before the benefits of a plan which covers such person as a Dependent.
2. The benefits of a plan which covers the person on whose expenses the claim is based as a Dependent are determined according to which parent's birth date occurs first in a calendar year, excluding year of birth. If the birth dates of both parents are the same, the plan that has covered the person for the longer period of time will be determined first, except if a claim is made for a Dependent child:
   A. When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a Dependent of a parent with custody of the child are determined before the benefits of a plan which covers the child as a Dependent of the parent without custody.
   B. When parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody are determined before the benefits of a plan which covers that child as a Dependent of the stepparent, and the benefits of a plan which covers that child as a Dependent of the step-parent are determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.
   C. Notwithstanding provisions "A" and "B", if there is a court decree which establishes financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility are determined before the benefits of any other plan which covers the child as a Dependent child.
   D. If the 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 plan covering the child shall be determined according to the rules of paragraph 2 above.
3. When rules 1 and 2 do not establish an Order of Benefits Determination, the benefits of a plan which covers the person on whose expense claim is based as a laid-off or retired Employee or as the Dependent of such person are determined after the benefits of a plan which covers such person through present employment.
4. When rules 1, 2, and 3. do not establish an Order of Benefits Determination, the benefits of a plan that has covered the person on whose expense claims based for the longer period of time are determined before the benefits of a plan which has covered such person the shorter period of time.
5. If the provisions under the other plan determining the effect of its Coordination of Benefits. provisions or exclusion are irreconcilable with the above rules, the Policy will waive application of the above rules and incorporate the rules identical with those of the other plan.

When these provisions reduce the total amount of benefits otherwise payable to You under the Policy during any Claim Determination Period, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit of the Policy.

RIGHT TO NECESSARY INFORMATION

We may require certain information in order to apply and coordinate these provisions with other plans. To obtain the needed information, We, without Your consent, will release or obtain from any insurance company, organization or person information needed to implement this provision. You agree to furnish any information We need to apply these provisions.

COORDINATION OF BENEFITS WITH MEDICARE
In all cases, Coordination of Benefits with Medicare will conform to Federal Statutes and Regulations. Medicare means Title XVIII, Parts A and B of the Social Security Act, as amended. If You are eligible for Medicare benefits, but not necessarily enrolled, Your benefits under the Policy will be coordinated to the extent benefits otherwise would have been payable under Medicare as allowed by Federal Statutes and Regulations.

FACILITY OF PAYMENT
Payments made under any other plan which according to these provisions should have been made by Us, will be adjusted by Us. To do this, We reserve the sole right to pay the organization(s) that made such payments the amount(s) the Company determines to be warranted. Any amount(s) so paid are regarded as benefits paid under the Policy. We will be fully discharged from liability under the Policy to the extent of any payment so made.

RIGHT OF RECOVERY
We reserve the right to recover benefit payments made for Allowable Expenses under the Policy in the amount by which the payments exceed the maximum amount We are required to pay under these provisions. We alone shall determine against whom this Right of Recovery will be exercised. This right of Recovery applies to Us against:
1. Any person(s) to, for or with respect to whom such payments were made or
2. Any other insurance companies or organization which according to these provisions owe benefits for the same Allowable Expense under any other plan.

SECTION 12
REPLACEMENT

ENTIRE GROUP REPLACEMENT

APPLICABILITY

The Replacement provision applies when the Employer's previous group medical insurance plan is terminated and replaced within 90 days by coverage under the Policy and:

1. You are eligible to become insured for medical coverage on the effective date of this Policy if the Employer's previous group medical insurance plan is terminated and replaced within 90 days by coverage under the Policy and:
2. You were validly covered under the Employer's previous employer-based medical plan (Prior Plan) on the day before the effective date of the Employer's participation under the Policy.

Benefits are NOT payable under the Policy for medical expense due to any Bodily Injury or Sickness for which You are entitled to receive benefits during any extension period provided by the Prior Plan.

DEDUCTIBLE AMOUNT

Medical expense incurred while You were covered under the Prior Plan may be used to satisfy Your deductible under the Policy.

1. If expenses incurred under the Prior Plan were being accumulated to satisfy a deductible of that plan, We will credit the amount of those expenses toward the same or similar deductible under this Policy.
2. Any amount applied to the Prior Plan's Out-of-Pocket Limit WILL NOT be credited toward satisfaction of any Out-of-Pocket Limit of this Policy.

PRE-EXISTING CONDITIONS

If a Bodily Injury or Sickness is a Pre-Existing Condition under this Policy but would not have been a Pre-Existing Condition under the Prior Plan had it remained in force, it will be a Pre-Existing Condition under this Policy.

If the Prior Plan did not have a Pre-Existing Condition limitation, benefits will be paid by applying the Pre-Existing Condition limitation of this Policy.

If a Bodily Injury or Sickness is a Pre-Existing Condition under both the Prior Plan and the Policy, any benefits payable are applicable only to medical expenses which were incurred after the date such Bodily Injury or Sickness would no longer have been a Pre-Existing Condition under the Prior Plan had it remained in force.

The amount payable for such Bodily Injury or Sickness will be the lesser of:

1. The benefits payable under the Policy regardless of any Pre-Existing Condition Limitation; or
2. The benefits that would have been payable under the Prior Plan had it remained in force reduced by any amount actually paid by the Prior Plan for such Bodily Injury or Sickness.

However, this does NOT apply to any Bodily Injury or Sickness for which You are entitled to receive benefits during any extension period provided by the Prior Plan.

SECTION 13
EXTENDED BENEFITS

If You are totally disabled as a result of a covered Bodily Injury or Sickness existing on the date this group Policy terminates, and if You provide written notice to us of Your intention to receive extended benefits within 31 days of the date this group Policy terminates, We will continue to provide medical benefits for the disabling condition until the earliest of the following:

1. The date Your Qualified Practitioner certifies You are no longer Totally Disabled;
2. The date You receive benefits equal to any maximum benefit shown on the Schedule of Benefits;
3. The end of 12 consecutive months immediately following the date Your coverage terminated. The 12-month period begins on the day Your coverage terminated and ends 12 months later on the same calendar day;
4. The date You become covered by any medical insurance plan carried or sponsored by an employer.

No insurance is extended to a child born as a result of an insured person's pregnancy which existed when this group Policy terminated. This extension provision does not apply to insured retired persons. The Extended Benefits provision applies only to Covered Expenses for the disabling condition that existed on the date Your coverage terminated.

SECTION 14
GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES
This Policy is incontestable after two years from its date of issue, except for non-payment of premiums. No misstatement in any application, except a fraudulent misstatement, made by a person insured under this Policy shall be used in contesting the validity of coverage or in denying a claim for a loss incurred or for a disability commencing after the expiration of such two year period.

FRAUD
If You commit fraud against Us or Your Employer commits fraud pertaining to You against Us as determined by a court of competent jurisdiction, Your coverage ends automatically, without notice.

CLERICAL ERROR, MISSTATEMENT OF AGE OR GENDER
If it is determined that information about the age or gender of You or Your Dependents was omitted or misstated, the amount of insurance for which You are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to You and to Us. If the error was determined after six months from the effective date of Your coverage, no adjustment will be made.

DUPLICATING PROVISIONS
If any charge is described as covered under two or more benefit provisions, We will pay only under the provision allowing the greater benefit. This may require Us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have NO liability for benefits other than those the Policy provides.

PAYMENT OF CLAIMS
We may pay all or a portion of any benefit provided for health care Services to the provider unless You direct otherwise in writing by the time the proof of loss is filed.

Benefits accrued on behalf of You or Your covered Dependent upon death will be paid, at Our option, to any one or more of the following:
1. Your spouse;
2. Your Dependent children, including legally adopted children;
3. Your parents;
4. Your brothers and sisters; or
5. Your estate.

We will rely upon an affidavit to determine benefit payment, unless We receive written notice of valid claim before payment is made. The affidavit will release Us from further liability. Any payment made by Us in good faith will fully discharge Us to the extent of such payment.

RECOVERY RIGHTS
We reserve the right to recover any payments made by Us that were made in error. Our intention is to preserve and assert Our rights to recover for sums paid or benefits provided where circumstances warrant the assertion of Our rights, to the fullest extent allowed by the applicable law. Each provision of this contract shall be considered severable, and if any provision is determined to be unenforceable or void, the remaining provisions shall remain unaffected.

RIGHT TO COLLECT NEEDED INFORMATION
You must cooperate with Us and when asked, assist Us by:
1. Authorizing the release of medical information including the names of all providers from whom You received medical attention;
2. Obtaining medical information and/or records from any provider as requested by Us;
3. Providing information regarding the circumstances of Your injury or accident;
4. Providing information about other insurance coverage and benefits; and
5. Providing information We request to administer the Policy.

PHYSICAL EXAMINATION AND AUTOPSY
We, at Our expense, have the right to have You examined as often as We deem reasonably necessary. We may also have an autopsy performed unless prohibited by law.

ASSIGNMENT OF BENEFITS
Assignment of Benefits may be made only with Our consent. An assignment is not binding until We receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

WORKERS' COMPENSATION
The Policy is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law. If benefits are paid by Us and We determine You received Workers' Compensation for the same incident, We have the right to recover as described under the "Recovery Rights" provision. We will exercise Our right to recover against You.
The Recovery Rights will be applied even though:
1. Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. NO final determination is made that Bodily Injury or Sickness was sustained in the course of or resulted from Your employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by You or the Workers' Compensation carrier; or
4. The medical or health care benefits are specifically excluded from the Workers' compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Policy, You will notify Us of any Workers' compensation claim You make, and that You agree to reimburse Us as described above.

MODIFICATION OF POLICY
The Policy may be modified at any time by agreement between Us and the Policyholder without the consent of any participating Employer or any Covered Person or any beneficiary. No modification will be valid unless approved by Our President or Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy, or waive any of the Policy provisions, to extend the time of premium payment, or bind Us by making any promise or representation.

PREMIUM CONTRIBUTIONS
Your Employer must pay the required premiums to Us as they become due. Your Employer may require You to contribute toward the cost of Your insurance. Failure of Your Employer to pay any required premium to Us on time will result in the termination of Your insurance.

GRACE PERIOD
The premium is due on the first day of each month. A grace period of 31 days will be allowed for payment of each premium after the first premium. If the premium due is paid by the end of the grace period, the Policy will remain in force. If the premium is not paid by the end of the grace period, the Policy automatically terminates effective as of the last day of the month for which the last premium payment was received. Any claims incurred after the last day of the month for which the premium due was received are the responsibility of the Policyholder. Unpaid premium is subject to a late charge of 1½% per month for each month late.

RIGHT OF REIMBURSEMENT
If payment (by settlement, judgment or any other manner) is made, or may be made, by or on behalf of a responsible third party to a Covered Person, expenses arising from the Covered Peson's injury or sickness are not covered by Us. If We receive a claim for which benefits would be payable in the absence of a responsible third party, We will advance an amount equal to the benefits that are payable if a third party is not liable for those benefits subject to the conditions listed below.

If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party:

1. We have the right to reimbursement for all benefits we paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, Covered Person's parents, if the Covered Person is a minor, or Covered Person's legal representative as a result of that sickness or injury; and

2. We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury.

We shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

ASSIGNMENT OF RECOVERY RIGHTS
The Policy contains an exclusion for Sickness or Bodily Injury for which there is Medical Payment/Expense coverage provided or payable under any automobile, homeowner's, premises or other similar coverage.

If Your claim against the other insurer is denied or partially paid, We will process Your claim according to the terms and conditions of the Policy. If payment is made by Us on Your behalf, You agree to assign to Us any right You have against the other insurer for medical expenses We pay.

SUBROGATION
This provision applies when another party (person or organization) is, or may be, considered responsible for causing injury or for payment of benefits due to an insured person's injury or sickness for which benefits under this Policy have been provided or paid. To the extent of such benefits, We are subrogated to all rights and claims for recovery the insured person has against any party (including a health care insurer) responsible for the injury for payment to the insured person on account of the injury.

CONCERT HEALTH PLAN – VISION BENEFITS RIDER

BENEFITS AND COVERAGE

Concert Health Plan (CHP) shall provide the following benefits (hereinafter referred to as "covered services") to its members:

EYE EXAMINATION PLUS OPTION

Summary of Benefits

	Frequency	Copayment
Examination	24 months	$10

	Participating Provider	Non Participating Provider (Reimbursed Upto)
Examination	Paid in full	$25.00

EYE EXAMINATION

A complete analysis of the eyes and related structures will be provided to determine the presence of vision problems or other abnormalities.

Each Covered Person shall be entitled to an eye examination once every twenty four (24) months from the date of service to include the following:

- Interview History – Opportunity to discuss your personal and family history with your doctor, concerning health and occupational factors that may affect your vision.
- Examination – Health evaluation of the eyes and surrounding tissue.
- Vision Analysis – Various tests to determine the level of vision and any need for corrective lenses.
- Tonometry – Measurement of the pressure inside the eye to check for glaucoma.
- Biomicroscopy – Detailed examination of individual components of the eye.
- Visual Acuity – Evaluation of the sensitivity of the central area of vision.
- Peripheral Field Study – Evaluation of the sensitivity of peripheral (side) vision.

ADDITIONAL DISCOUNT

Each Covered Person shall be entitled to receive a discount toward the purchases of additional complete pairs of prescription glasses (lenses, lens options, and frames) from an In-Network Provider. Additionally, each Covered Person shall be entitled to receive a discount off the In-Network Provider's professional fees for contact lenses. Contact lens materials shall be provided at the doctor's usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the In-Network Provider who provided the covered eye examination.

PROCEDURES FOR OBTAINING COVERED SERVICES

A. Benefit Authorization must be obtained prior to a Covered Person receiving services from an In-Network Provider. When a Covered Person desires to receive services from an In-Network Provider, the Covered Person must select an In-Network Provider, schedule an appointment and identify himself as a Covered Person in order for the In-Network Provider to obtain Benefit Authorization from CHP. Should the Covered Person receive services from a In-Network Provider without such Benefit Authorization, then for the purposes of those services provided to the Covered Person, the provider will be considered a Out-of-Network Provider and the benefits available will be limited to those for a Out-of-Network Provider.

B. The Covered Person pays only the Copayment (if any) to the doctor for the services covered by the Plan. The Covered Person also pays for any additional services not covered by the Plan. The doctor will complete the authorization and mail it to CHP. CHP will pay the In-Network Provider directly according to their agreement with the doctor.

C. When services are obtained from an Out-of-Network Provider, the Covered Person should pay the provider the full fee. The Covered person will be reimbursed in accordance with the reimbursement schedule outlined in the Summary of Benefits. All claims for services received from Out-of-Network providers shall be submitted by Covered Persons to CHP within one hundred eighty (180) days of the date of service. CHP reserves the right to reject such claims which are filed more than one hundred eighty (180) days, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as was reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date.

D. When such Benefit Authorization is obtained and services are performed prior to the expiration date shown on the Benefit Authorization, this will constitute a claim against the plan in spite of the Covered Person's termination of coverage or the termination of the plan.

E. In emergency cases, when immediate vision care is necessary, Covered Persons may obtain services by contacting an In-Network Provider or Out-of-Network Provider. Reimbursement and eligibility are subject to the same provisions as stated elsewhere herein.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

A. PATIENT OPTIONS

This Agreement covers visual needs rather than cosmetic materials. When a Covered person selects any of the following extras, CHP will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

1. Blended lenses
2. Contact lenses (except as noted elsewhere herein)
3. Oversize lenses
4. Photochromic lenses: tinted lenses except pink #1 and pink #2
5. Progressive multifocal lenses
6. The coating of the lens or lenses
7. The laminating of the lens or lenses
8. A frame that costs more than the Plan allowance
9. Cosmetic lenses
10. Optional cosmetic processes
11. UV (ultraviolet) protected lenses

B. NOT COVERED

There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses; or two pair of glasses in lieu of bifocals;
2. Replacement of lenses and frames furnished hereunder which are lost or broken except at the normal intervals with services are otherwise available;
3. Medical or surgical treatment of the eyes;
4. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment;
5. Costs associated with securing materials such as lenses and frames under the Eye Examination Plus Option;
6. Low vision aids.

CHP MAY, AT ITS DISCRETION, WAIVE ANY OF THESE LIMITATIONS IF, IN THE OPINION OF CHP'S OPTOMETRIC CONSULTANTS, THE SERVICES OR MATERIALS ARE NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

DEFINITIONS

ANISOMETROPIA	A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.
BENEFIT AUTHORIZATION	Authorization issued by CHP identifying the individual named as a Covered Person of CHP, and identifying those Plan benefits to which the Covered Person is entitled.
BLENDED LENSES	Bifocals which do not have a visible dividing line.
CLAIM	A benefit authorization which has been presented to a In-Network Provider or Out-of-Network Provider at the time the Covered Person secures services.
COATED LENSES	A substance added to a finished lens on one or both surfaces.
COVERED PERSON	The employee and dependents (if dependent coverage is provided) of the employer participating in the program.
KERATOCONUS	A developmental or dystrophic deformity of the cornea in which it becomes cone-shaped, due to a thinning and stretching of the tissue in its central area.
MAXIMUM ALLOWABLE BENEFIT	The maximum amount of benefits provided to each member during the time period in which the Member is covered under the policy.
MATERIALS	Lenses, frame, low vision aids, contact lenses.
ORTHOPTICS	The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.
OVERSIZE LENSES	Larger than standard lens blank, to accommodate prescriptions.
PHOTOCHROMIC LENSES	Lenses which change color with intensity of sunlight.
PLAN ADMINISTRATOR	The person specifically so designated on the application, or if an administrator is not so designated, Vision Services Plan.
PLANO LENSES	Lenses which have no refractive power.
PROFESSIONAL SERVICE	Eye examination, material selection, fitting of glasses, related adjustments, etc.
TINTED LENSES	Lenses which have an additional substance added to produce constant tint (e.g. pink, green, gray, blue, etc.)

PRESCRIPTION DRUG BENEFIT RIDER
RH

This benefit is attached to and made part of Your certificate. The effective date of this change is the later of the effective date of this certificate or the date this benefit is added to Your Policy.

BENEFITS
Prescription drug benefits are payable for covered prescription expense incurred by You and Your covered Dependents. Benefits are payable for such expense for charges made by a Pharmacy for each separate Prescription Order, as specified on the Schedule of Benefits.

ADDITIONAL LIMITATIONS FOR PRESCRIPTION DRUG BENEFITS
Expenses incurred will not be payable under this provision for the following:

1. Legend drugs which are not recommended and not deemed necessary by a prescriber;
2. Therapeutic devices or appliances (except test reagents, hypodermic needles and syringes for diabetes), support garments and other nonmedical substances;
3. Disposable blood, urine, glucose, and acetone testing agents other than those used for diabetic monitoring;
4. Anorectic or any drug used for the purpose of weight control;
5. Nicotine containing drugs or devices or any other drug or device used for the purpose of smoking cessation;
6. Progesterone in any compounded dosage form;
7. Dietaries, nutritional products, and vitamins except prenatal;
8. Any drug used for cosmetic purposes, including but not limited to:
    A. Tretinoin (Retin A) except if You are under the age of 35 or are diagnosed as having adult acne, or
    B. Minoxidil (Rogaine);
9. Non-legend (over the counter) drugs, drugs with over the counter equivalents, and injectables (excluding insulin and anaphylaxis drugs);
10. Fertility medications;
11. Any drug or medicine which is to be taken or administered to You or Your covered Dependents while such person is a patient in a licensed Hospital, rest home or sanatorium, extended care facility, convalescent hospital, nursing home or similar institution;
12. Any drug labeled "Caution-limited by Federal Law to investigation use" or other wording having similar intent, or experimental drugs even though a charge is made to You or Your covered Dependents;
13. Any refill of a prescription drug which is in excess of what is prescribed, or any refill dispensed after one year from the initial Prescription Order;
14. Prescription drugs dispensed at a retail pharmacy in excess of a 30 day supply; however, prescription drugs dispensed by a Mail Order Pharmacy will not be dispensed in quantities that are less than a 30 day supply or more than a 90 day supply;
15. Sickness or Bodily Injury not covered under the group medical benefits plan of which this prescription drug benefit rider is made a part.

DEFINITIONS
Brand Name Prescription Drug or Medicine – a prescription drug which is protected by trademark registration.

Coinsurance – means the percentage of the Covered Expense that You are responsible for as shown in the Schedule of Benefits.

Copayment – means the amount to be paid by You toward the cost of each separate Prescription order or refill of a Covered Drug when dispensed by a Pharmacy. The Copayment amount is shown on the Schedule of Benefits.

Covered Drug – means (a) any Prescription Legend Drug, or (b) injectable insulin, or (c) any medication compounded by the Pharmacy that contains a Prescription Legend Drug, provided that in any case it meets all the following conditions:

1. A written Prescription Order is customarily prepared for it;
2. A separate charge equal to or greater than the Copayment is customarily made for it; and
3. It is not entirely consumed at the time and place of the Prescription Order.

Formulary – a listing of prescription drugs which have been evaluated and selected for their therapeutic equivalency and efficacy. This listing is subject to periodic review and modification by the insurance company.

Generic Prescription Drug or Medicine – a prescription drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name and is bioequivalently rated and has the same therapeutic value as the equivalent common brand name drug or medicine.

Mail Order Pharmacy – an establishment where prescription drugs are legally dispensed by mail.

Non-Participating Pharmacy – means a Pharmacy which has not entered into an agreement with Us to participate in this plan.

Non-Formulary drug – means a drug that is not listed in the formulary.

Participating Pharmacy – means a Pharmacy which has entered into an agreement with Us to dispense Covered Drugs to You and Your covered Dependents and to accept as payment in the sum of the Copayment and/or deductible amount to be paid by You and the amount of the benefit payment provided by Us.

Pharmacy – means any place where medicines are compounded or dispensed, a physician, or other person or business entity that is legally licensed or registered to dispense drugs.

Prescription Legend Drug – means 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 prescription".

Prescription Order – is the request of a person legally licensed to prescribe drugs for a patient.

Specialty Drugs – Those prescription high technology, biotech and self-administered drugs/medications listed on the Specialty Drug List. This listing is subject to periodic review and modification by Us. Specialty drugs will only be dispensed in amounts for up to a 30 day supply at any one time.

SCHEDULE OF BENEFITS - PRESCRIPTION DRUG BENEFIT

Prescription drugs are covered as described in the prescription drug benefit plan rider, subject to the following prescription drug Copayment/Coinsurance. Note: the Prescription Drug Benefit Copayment/Coinsurance does not apply toward any other Copayment/Coinsurance described in the Schedule of Benefits of this certificate.

Retail Pharmacy Copayment/Coinsurance

Generic Drugs……..	$15 Copayment per prescription.
Formulary Brand Name Drugs……	$35 Copayment per prescription.
Non-Formulary Brand Name Drug…….	$50 Copayment per prescription.
Specialty Drugs……	25% Coinsurance per 30 day supply.

The out of pocket coinsurance limit for Specialty Drugs is $2,500.

Mail Order Copayment/Coinsurance

Generic Drugs……	$30 Copayment per prescription.
Formulary Brand Name Drugs……..	$70 Copayment per prescription.
Non-Formulary Brand Name Drugs……..	$100 Copayment per prescription.

When a generic drug is available, but the pharmacy dispenses the brand name drug for any reason other than "DAW" by the physician, you will be responsible for the difference between the cost of the brand name drug and the generic drug in addition to the generic Copayment. Prescriptions for maintenance and long-term medication may be initially filled at a retail pharmacy for up to a sixty day supply but all additional refills must be obtained through mail order.

When You use a non-participating pharmacy, You will also be responsible for any prescription cost differential between the cost of the prescription at a non-participating pharmacy and the cost of the discounted prescription at a participating pharmacy.

MENTAL HEALTH COVERED SERVICES RIDER – PH24

Includes Mental Disorders.
For groups of more than 50 employees on the contract date.

Precertification is required by Us. Limited benefits are payable for Covered Expense incurred for the treatment of Mental Disorders.

Covered Expense is payable as shown on Your Schedule of Benefits and includes:

1. Charges made by a Qualified Practitioner.
2. Charges made by a Hospital.
3. Charges made by a Qualified Treatment Facility.
4. Charges for drugs and medicines which may be obtained only on a written prescription of a Qualified Practitioner.

Coverage for Serious Mental Illness. Serious Mental Illness means the following psychiatric illnesses (as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association): schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), pervasive developmental disorders, obsessive-compulsive disorders, depression in childhood and adolescence, and panic disorder.

Inpatient Care – Subject to Precertification requirements.
Limited to 45 days per calendar year.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PREFERRED PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

Outpatient Care and Office Therapy – Subject to Precertification requirements.
Limited to 35 visits per Calendar Year.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PREFERRED PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

Coverage for Non-Serious Mental Illnesses

Maximum benefit is $10,000 per calendar year for any Covered Person.

Inpatient Care – Subject to Precertification requirements.
Limited to 35 days per calendar year.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PREFERRED PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.

Outpatient Care and Office Therapy – Subject to Precertification requirements.
Limited to 35 visits per calendar year.

PREFERRED PROVIDER BENEFITS: 80% to Out of Pocket Coinsurance Limit.
NON-PREFERRED PROVIDER BENEFITS: 60% to Out of Pocket Coinsurance Limit subject to the Maximum Allowable Amount.