ADVANTAGE HEALTH SOLUTIONS, INC.

CERTIFICATE OF COVERAGE

***Group*:**			
Policy #:		***Group Contract* Eff:**	**01/01/2009**
***Member* ID #: As Shown on ID Card**			
***Policy maximum*:**	**Unlimited** **See definition**		

***Deductible*:**

Except where indicated, benefits are subject to a $250 *deductible* per member, per calendar year.

Covered services for outpatient prescription drugs are subject to a: $100 *deductible per single and $200 deductible per family* on all Brand Name Drugs per member per calendar year this excludes Diabetic Supplies.

All *Covered Service* are subject to the *Policy maximum* applicable to each *member*.

New Hire Eligibility:

New hires shall become effective on the first (1st) of the month following 45 days of employment.

Dependent Age Limit:

Unmarried children are eligible to the last day of the year in which the child reaches age 24. Any Young Adult child age 19 up to the day of the 24th birthday., regardless of marital status, is eligible for coverage under the Young Adult Rider if the Young Adult is: (1) the natural or adopted children of the subscriber; or (2) the stepchild, grandchild, or other blood relative of the subscriber and the subscriber pays more than 50% of the Young Adult's total support; or (3) the subscriber is the Young Adult's legal guardian and the subscriber pays more than 50% of the Young Adult's total support.

IMPORTANT CONTACTS

(*You* write the name, address and phone number of *your Primary care physician (PCP*) in the spaces provided below)

Your PCP:
Address:
Telephone:

Spouse's *PCP*:
Address:
Telephone:

Dependent's *PCP*:
Address:
Telephone:

Dependent's *PCP*
Address:
Telephone:

***ADVANTAGE Health Solutions, Inc.*[SM] (*ADVANTAGE*)** :

Member Services or Eligibility Department
P.O. Box 80069
Indianapolis, IN 46209
(317) 573-6228 or 1-800-553-8933
TDD: 1- 800 743-3333 (hearing impaired)
Monday-Friday, 7:30 am to 5:30 pm
FAX: (317) 573-2839
NOTE: To ensure quality service, *your* call may be monitored.

TDD (for hearing impaired)
1-800-743-3333

If *you* have limited use and/or understanding of English, *ADVANTAGE* will provide interpreter services to *you* or *your* representative through the AT&T Language Line Services. This service provides immediate access to interpreter services in 150 languages. If *you* are hearing impaired, *ADVANTAGE* will provide interpreter services through the Telecommunications Relay System. Interpreter services are available at no charge to *you*.

Appeals Specialist
9045 River Road, Ste 200
Indianapolis, IN 46240
(317) 573-6689 or 1-888-806-1029
TDD: (800) 743-3333 (hearing impaired)
Monday-Friday, 8:00 am to 5:00 pm
FAX: (317) 573-7403 or 1-866-510-7765

Anti-Fraud Help Line:
1-888-333-9576

Web site
www.*advantage*plan.com

Health Promotion Coordinator
9045 River Road, Ste 200
Indianapolis, IN 46240
(317) 573-2922 or 1-888-824-0391
TDD: 1-800 743-3333 (hearing impaired)
Monday-Friday, 8:00 am to 5:00 pm
FAX: (317) 573-2841 or 1-888 771-4905

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SECTION 1: WELCOME TO *ADVANTAGE*

This *Certificate of Coverage* and *Member Handbook* (*Certificate*) explains *your* health care benefits under *ADVANTAGE* Health Solutions, Inc.SM (*ADVANTAGE*). It describes the rules of *ADVANTAGE*, how to access medical care, what health care services are covered under *ADVANTAGE*, and what portion of the health care costs *you* will be required to pay.

This *Certificate* is part of the *Group Services Agreement* (*Agreement*) between *ADVANTAGE* and *your* employer *group* (*Group*). The *Agreement* sets the terms and conditions of *coverage*. This *Certificate* describes the health care *covered services* for *you* and *your eligible dependents*. The *coverage* described in this *Certificate* is subject in every respect to the provisions of the *Agreement* issued to *your Group*. If there is any conflict between the *Agreement* and this *Certificate*, the *Agreement* shall prevail.

Please read this *Certificate* in its entirety so that *you* will know how to get the most out of *your* health care benefits and understand *your* responsibilities. In order to provide *you* with clear information, many words in this *Certificate* have special meanings. These words appear in *italics* type and have been defined for *you* within the body of this *Certificate* or in the Glossary of Terms section at the end of this *Certificate*. The terms *"you," "your"* and *"yourself"* refer to the *member*, whether enrolled with *ADVANTAGE* as a *subscriber* or *eligible dependent*.

Our Company

ADVANTAGE is a health maintenance organization organized and licensed in the State of Indiana. *ADVANTAGE*'s strategy is to serve the growing number of *Group*s and the public sector in Indiana that seek to control health care costs and manage employee health benefit plans through the offering of quality managed care products.

ADVANTAGE is an institution operated in accordance with the *Ethical and Religious Directives* for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. *ADVANTAGE* is not required to provide services that are inconsistent with the medical ethics or precepts of the Catholic Church.

Our Mission

ADVANTAGE will be a statewide leader in managed care, offering access to a broad community-based and high-quality delivery system of *providers*; affordable and comprehensive benefit plans; high quality service to our customers; and a corporate environment that fosters physical, mental and spiritual health for our employees.

Based on the core values of fidelity, excellence and quality, dignity of persons, and stewardship, *ADVANTAGE* will continuously strive to enhance the health of our communities through public-private partnership initiatives, a firm company commitment to volunteerism and the belief that…

- Life is enriched through the delivery of compassionate care
- Each person is respected as having intrinsic worth
- In all matters, honesty and integrity, and
- Common beliefs, mission and values that are supported by our Catholic owners' best serve *ADVANTAGE*.

Should *you* have any questions, please call Member Services toll-free at 1-800-553-8933 or (317) 573-6228. We are pleased that *you* have chosen *ADVANTAGE* and look forward to serving *you*.

ALWAYS REMEMBER. . .

- To show *your ADVANTAGE member* ID card every time *you* check in at an appointment.
- Tell *your Group* within 31 days when *you* have a newborn or adopted child.
- Everyone in *your* family should choose a doctor. This doctor will be *your primary care physician* (*PCP*). Each family member may choose a different *PCP*.
- If *you* do not choose a *PCP*, *ADVANTAGE* will choose one for *you*.
- *Your PCP* belongs to a *provider network*. *You* must receive all non-emergency care through *your PCP*'s *provider network*.
- Once *you* choose a *PCP*, *you* should make an appointment to get to know him.
- If *you* miss a scheduled appointment without canceling ahead of time, the doctor may charge *you* for the missed appointment.
- If *you* change to a different *PCP*, it is important to ask the new doctor which *hospital*s and specialists *you* should use.
- If *you* feel *you* have a medical emergency, and if there is time, *you* should call *your PCP* for advice and instructions. If *you* feel that the emergency puts *your* life in danger or could cause a serious disability or is a major threat to *you* or one of *your* family members, *you* should go to the nearest emergency room or call 911.
- If *you* use the emergency room for <u>non</u>-emergency care that is not approved, *you* will be responsible for the bill.
- If *you* have a student dependent, all non-emergency care must be authorized by the student's *PCP*.
- To keep *your PCP* informed of medications prescribed by specialty care *provider*s or behavioral health *provider*s to prevent adverse drug reactions.

YOUR RIGHTS AND RESPONSIBILITIES

You, *your physician* and other health care *providers* are partners in *your* health care. There are certain rights and responsibilities that are critical to this partnership. The manner in which *you* exercise these rights and responsibilities affects our ability to make appropriate medical care available to all our *members*. *You* are entitled to these rights without regard to sex, race, culture, and economic, educational or religious background.

***You* Have the Right…**

- To select a *Primary care physician* (*PCP*) and to change *your Primary care physician* one time a year by contacting Member Services
- To have twenty-four (24) hour access to *your PCP* and if out of town, receive emergency care if necessary
- To receive prompt and appropriate treatment for physical and emotional disorders and disabilities in the least restrictive environment necessary for that treatment, and remain free from unnecessary or excessive medication
- To be informed by *your* health care *provider* of information about *your* diagnosis, treatment and prognosis in a manner that *you* can understand.
- To participate in decisions involving *your* medical care, *you* should receive enough information to enable *you* to make an informed decision before *you* receive any recommended treatment. The information should include a candid discussion of appropriate or *medically necessary* treatment options for conditions, regardless of cost or benefit *coverage*
- To receive information on early *hospital* discharge and follow-up care, rehabilitation and living arrangements that are available once *you* are released from the *hospital*
- To receive appropriate information so *you* may give an informed, voluntary consent to participate in any *experimental* research. (*Experimental* and *investigational* procedures are not covered under *your* Plan.)
- To refuse treatment and to be informed of the probable consequences of *your* action
- To have *your* guardian, next of kin or legally authorized person exercise *your* rights on *your* behalf if *your* medical condition causes *you* to be incapable of understanding or exercising *your* rights
- To know the cost of *your* care and treatment and to receive an explanation of *your* financial responsibility upon request
- To have *your* health records kept confidential except when disclosure is required by law or permitted by *you* in writing. *You* have the right to review *your* medical records with *your Primary care physician* after adequate notice has been given
- To receive guidance and recommendations for additional medical care when *coverage* ends
- To be provided with information about *your* Plan, its *provider*s and *your* rights and responsibilities
- To provide opinions about ADVANTAGE or the care provided by *your* health care *provider* and to recommend changes in policies and services by contacting Member Services
- To be informed about the *grievance* procedures
- To voice complaints or appeals about ADVANTAGE or the care *you* have received and to receive a response to complaints or appeals within a reasonable amount of time
- To be treated with respect and recognition of *your* dignity and right to personal privacy
- To receive advice or assistance in a prompt, courteous and responsible manner
- To review the criteria utilized to make an adverse decision regarding any services requested but denied by our medical management department
- To continue receiving active treatment from *your provider* even if the *provider*'s network status changes (i.e. terminates from the network) until the current treatment period ends or up to 90 days, whichever is shorter
- To make recommendations regarding ADVANTAGE's *member* rights and responsibilities policies

***You* Have the Responsibility . . .**

- To keep scheduled appointments and give adequate notice of appointment delay or cancellation
- To be considerate of other patients and to be understanding and tolerant if any delays should occur
- To provide, to the extent possible, information that ADVANTAGE and its *provider*s need in order to care for *you*
- To communicate openly with the *provider* and medical staff. If *you* have questions or disagree with the treatment plan, *you* have the responsibility to discuss *your* concerns with the medical staff and make certain *you* understand the explanations and instructions
- To be honest, complete and accurate when providing information to the medical staff
- To follow the instructions and guidelines given to *you* by the medical staff and to consider the potential consequences if *you* do not comply
- To follow the plans and instructions for care that *you* have agreed upon with *your provider*s
- To understand *your* health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To understand what medications *you* are taking and whether follow-up care is needed
- To know how to access care in emergency, urgent and routine situations
- To express *your* opinions, concerns, or complaints in a constructive manner to the appropriate personnel with ADVANTAGE or *your* network *provider*
- To know the benefits and *non-covered services* of *your coverage*
- To contact Member Services for all questions and assistance
- To treat all ADVANTAGE and *provider* personnel in a courteous and respectful manner

SECTION 2 – SELECTING A *PRIMARY CARE PHYSICIAN* (*PCP*):

You must select a *PCP* for *you* and each *eligible dependent*. *You* must live or work within thirty (30) air miles of the *PCP you* select. Each *eligible dependent* of *your* family may select a different *PCP*. When selecting a *PCP*, keep in mind *you* may want to select a *physician* that best meets *your* health care and cultural needs. Each *PCP* belongs to a *provider network* that includes *hospitals, specialists (SCPs)* and other health care *provider*s. When *you* choose a *PCP*, *you* also choose the *provider network*.

You can find a list of *hospitals* and *SCPs* included in *your PCP's network* in the *Provider Directory*, or visit *ADVANTAGE*'s web site at www.advantageplan.com.

What is the role of a *PCP*?
Your PCP is *your* primary health care *provider* responsible for coordinating all of *your* health care needs. It is very important that *you* establish a relationship with *your PCP* as soon as possible. *Your PCP* needs to be familiar with *your* heath care needs in order to properly manage *your* care. For *your* safety and well-being, *you* are encouraged to discuss all of *your* health care services with *your PCP*, including specialty care, prescriptions, medical history, etc. If *you* have selected a *PCP* who has not been providing care for *you*, we encourage *you* to contact him/her as soon as possible.

How do I schedule an appointment with my *PCP*?
Call the *PCP*'s office to schedule an appointment. Always identify *your*self as an *ADVANTAGE member*.

Please follow these scheduling tips:
- Always schedule routine visits in advance
- Always have *your member ID card* available.
- If a copayment or coinsurance is required, *you* will be asked to make that payment at the time of *your* visit. The *copayment* or c*oinsurance* amount is shown on *your member ID card*.
- If *you* are unable to keep an appointment with *your physician*, please call *your physician's* office at least twenty-four (24) hours in advance of *your* appointment time to cancel.

ADVANTAGE ensures *you* can obtain health care services in a timely manner for preventive, routine and urgently needed services. The *ADVANTAGE* appointment standards for primary care are:

• Routine preventive care appointments	30 business days
• Routine primary care appointments	10 business days
• *Urgent care* appointments	48 hours
• *Emergency* care appointments	Immediate
• After-hours access	7 days/week; 24 hours/day
• Wait time in *physician* office	Not to exceed 30 minutes

If *your PCP* is not available for *your* appointment and *you* are seen by a partner or on-call *physician*, *you* will only be responsible for the *physician* office visit *copayment* or *coinsurance* shown on *your ID card*.

NOTE: *Members,* who miss scheduled appointments, without canceling with reasonable notice, may be charged by the *provider* for missed appointments.

What do I do if I need medical services after my *PCP*'s normal office hours?
If *you* must reach *your PCP* after normal office hours, *you* may do so by calling the *PCP*'s telephone number listed on *your ID card*. *You* may be uncertain if *you* should call the *PCP* immediately or wait until normal office hours. Remember, routine questions and problems should be handled during normal business hours. Examples of routine questions or problems may include:
- Scheduling appointment for physical exam
- Requesting information regarding *your* child's vaccinations
- Non-*emergency* conditions, such as:
  - Cold or flu symptoms
  - Muscle sprain
  - Skin rash
  - Earache
  - Other symptoms or conditions that do not require immediate medical treatment

If *you* feel *you* should speak with the *physician* immediately, call the *PCP*'s telephone number and follow the instructions provided to *you* by the after-hours answering service.

What if I want to change my *PCP*?
You and *your eligible dependents* may change to a different *PCP* anytime, unless you are under acute treatment and care, or you can change to a different PCP during *your open enrollment period***.** To change to a different *PCP*, please refer to the *Provider Directory* to be sure that the *PCP you* select is accepting new patients. To change to a different *PCP*, *you* may contact the *ADVANTAGE* Member Services Department by phone or visit our website at www.advantageplan.com. See Important Contacts located at the front of this *Certificate. Your* new *PCP* selection will become effective the first of the following month after we receive *your* request for change.

A new *ID card* will be mailed to *you* and any of *your eligible dependents* that have changed *PCPs*. It is important to review the *PCP* information on *your ID card* to verify that the *PCP* listed on the card is the *PCP you* selected.

When *you* select a new *PCP* from a different *provider network*, it is important that *you* understand that the *hospital*, *SCPs*, ancillary services, and *behavioral health providers* associated with that *provider network* may be different.

SECTION 2A – SPECIALTY CARE SERVICES:

What are the *covered services*?
Except for services and items listed as *non-covered services* in this *Certificate*, *covered services* include those services for consultation or treatment by a *SCP*, which are *medically necessary*.

What is a *specialty care physician* (*SCP*)?
A *physician* whose training has been concentrated in a specialized field is considered a *SCP*. Examples of *SCPs* would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc. For mental health and substance abuse services, please read the information in the Behavioral Health section of this *Certificate.*

What do I do when I need to see a *SCP*?
You can self-refer to the appropriate *SCP* in *your PCP's provider network* for office visits and consultations. If the *SCP* schedules you for any procedures or special treatment, the services may require *prior authorization*. Please ask the *SCP* to contact *ADVANTAGE*.

ADVANTAGE ensures *you* can obtain health care services in a timely manner for specialty services. The *ADVANTAGE* appointment standards for specialty care are:

- Non-Urgent — Within 20 business days
- Urgent *complaint*s — Within 48 business hours
- *Emergency* Care — Immediate
- After-hours access — 7 days/week; 24 hours/day
- Wait time in *physician* office — Not to exceed 30 minutes

What if my *physician* wants to refer me to a *SCP* outside the *provider network*?
Your physician may determine *you* require treatment by a type of *SCP* that is not available in *your provider network*. When *your physician* refers you to a provider outside of the *provider network*, be sure you or your physician contacts ADVANTAGE prior to your appointment to ensure your benefits are paid correctly.

IDENTIFICATION CARD
Your actual *ID card*(s) will be mailed to *you* in a separate envelope. Each *eligible dependent* is provided with a separate *ID card*. If *you* need replacement *ID cards*, call Member Services at 1-800-553-8933 or (317) 573-6228. Also, you can request a replacement card or print a temporary ID card by visiting our website at www.advantageplan.com.

Your ID card provides important information regarding *your copayments* and *coinsurance* (if any) for *physician* office visits, *emergency* and *urgent care* visits, and *hospital coverage*. *Your PCP* name and office telephone numbers are provided on the card. *You* should always carry *your ADVANTAGE* ID card with *you*. The card also has other very important information that *you* and *your physician* will need.

Please note that any claims *you* may receive should be directed to the "Claims Address" shown on the card.

COVERAGE INFORMATION

You must enroll *yourself* and members of *your* family who are *eligible dependents* during *your Group's open enrollment period*. The initial *open enrollment period* will be held for a period no longer than 31 days and will be closed prior to the *effective date* of the *Agreement* with *your Group*. Subsequent *open enrollment period*s will be held at least annually for a period of not more than 31 days, beginning on a date agreed to by the *Group* and *ADVANTAGE* and closing prior to the *renewal date*. During an *open enrollment period*, any *eligible person* and/or *eligible dependent* may join *ADVANTAGE*.

By enrolling in this Plan, *you* understand that *ADVANTAGE* has the right to utilize *your* personal medical information for future, known or routine needs for the purposes of treatment, payment, and health care operations. This may include: coordination of care; case management; disease management; quality assessment and measurement; accreditation; decisions about the payment of services; and other normal business operations related to administering the health plan. Information may be transmitted to or from ADVANTAGE for the purpose of arranging for *your* health care and benefits. ***You* understand this consent is a condition of *your* enrollment in *ADVANTAGE* and *you* have the right to revoke this consent in writing at any time.** *You* also understand you have the right to file a grievance if *you* feel there is a violation regarding use or disclosure of *your* personal health information.

A person who previously had *coverage* voided under *ADVANTAGE* because of: fraud; misrepresentation; misusing an ID card; or failure to make payment, unless payment has since been made in full; may not enroll in *ADVANTAGE*.

Who can be covered under dependent *coverage*?

- *Your* legal *spouse*
- Any unmarried children dependent upon *you* for support through the age specified on the cover page to this *Certificate*.
- Disabled *eligible dependents* already enrolled and are incapable of self-supporting due to mental retardation or physical handicap and are chiefly *dependent* upon the *subscriber* or *subscriber's spouse* for support and maintenance at the time he or she reaches the limiting age may remain a covered *eligible dependent for the duration of the disability and dependency.* *ADVANTAGE* must certify the *dependent's* eligibility under a disability status. *ADVANTAGE* must be informed of the *dependent's* eligibility for continuation of *coverage* within 120 days after the *dependent* reaches the limiting age and subsequently, at reasonable intervals during the two years following the *dependent's* attainment of the limiting age. *ADVANTAGE* may require proof once per year in the time following the two year period after the *dependent's* attainment of the limiting age. The proof must include a statement by a licensed psychologist, psychiatrist, or other *physician* and proof of continued dependency. *ADVANTAGE* requires such proof of the person's disability/dependency within 30 days of the request.

  If a *dependent* of the *subscriber* or *spouse* who attained the limiting age while covered under another health care policy meets the criteria specified above, the *dependent* is an *eligible dependent* for enrollment so long as no break in *coverage* longer than 63 days has occurred immediately prior to enrollment. *ADVANTAGE* will require proof of disability as described above.
- Court-Ordered *Coverage*: A court or administrative agency of competent jurisdiction orders *you* or *your* family members to provide health *coverage* for a child under age 18. The child may be enrolled by his custodial parent; his non-custodial parent; the office of Medicaid Policy and Planning; or a Title IV-D agency. The date of status change is the date the order is issued.

  If *you* are required by a Qualified Medical Child Support Order or court order, as defined by the Employee Retirement Income Security Act or applicable state law, *you* may enroll *your* child in *ADVANTAGE* without regard to any enrollment limits. *Your* child will be eligible to receive the *covered services* described in this *Certificate* in accordance with the requirements of such order. A child's *coverage* under this provision will not extend beyond the age limits described on the cover page of this *Certificate*. Any claims payable under this *Certificate* will be paid at *our* discretion to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. *ADVANTAGE* will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to *us* directly.

NOTE: Enrollment is allowed any time after the order is issued. The amount *you* must contribute toward the *premium* fee may increase when *your* newly *eligible dependent* is added.

- Who is eligible for coverage under the Young Adult Coverage Rider?

  - A *Young Adult,* regardless of marital status, between the ages of 19 and 24 can be covered on the *Young Adult* Coverage Rider if the *Young Adult* meets any of the following criteria:
    (1) the natural or adopted child of the subscriber;
    (2) the step-child, grandchild, or other blood relative of the subscriber and the subscriber pays more than fifty percent (50%) of the *Young Adult's* total support; or
    (3) The subscriber is the *Young Adult's* legal guardian and the subscriber pays more than fifty percent (50%) of the *Young Adult's* total support.
  - The *Young Adult's* coverage is a Rider to the subscriber coverage with ADVANTAGE, it is not individual coverage. If the subscriber's coverage terminates for any reason, coverage under the *Young Adult* Rider terminates.
  - A *Young Adult* may elect coverage at open enrollment. If a group does not have an annual open enrollment the Young Adult may elect coverage upon renewal of the group contract.
  - For a *Young Adult* that is entitled to a *Special Enrollment Period*, the provisions for all *Special Enrollment Periods* apply.
  - Medical care for a *pre-existing condition* of a *Young Adult* may be subject to a six (6) month limitation of benefits as provided in Section 5 of this *Certificate.*
  - A *Young Adult* may not enroll his/her spouse or children.

What do I do when there is a change in my family status?
In order to avoid problems for proper claims payments, it is very important that *you* let *your Group* know of any and all changes in *your* family status. Examples of family status changes include:

- Marriage – *you* must notify your employer within 31 days from the date in which you married that you wish to enroll your spouse in ADVANTAGE for coverage.
- Newly Adopted Child **-** Adopted children are eligible for *coverage* as of the earlier date of placement with *you* and/or *your spouse*, or the date of the entry of the order granting the adopting parent custody of the child for purposes of adoption. The adopted child is automatically entitled to receive *covered services* for the first 31 days as of earlier date of placement with *you* and/or *your spouse*, or the date of entry of the order granting the adopting parent custody of the child for purposes of adoption. In order for *coverage* to continue beyond the first 31 days, *you* must notify *your* employer that *you* wish to enroll the child in *ADVANTAGE* for *coverage* to continue beyond the first 31 days. If *you* do not notify *your Group* within 31 days, then the rules applicable to *late enrollees* apply, as discussed later in this *Certificate*. In that case, *you*, not *ADVANTAGE*, will be responsible for payment of services, which were provided to the child after the 31st day.
- Birth of a child - A child newly born to *you* or to *your* enrolled *eligible dependent*, or adopted by *you* within 31 days of birth, is automatically entitled to receive *covered services* for the first 31 days from date of birth. **Within 31 days of birth, *you* must notify *your* employer that *you* wish to enroll *your* newborn in *ADVANTAGE* for *coverage* to continue beyond the first 31 days.** If *you* do not notify *your Group* within 31 days, the child will be declared ineligible for *covered services* after 31 days from date of birth. In that case, *you*, not *ADVANTAGE*, will be responsible for payment of services, which were provided to the child after the 31st day. Nor will *ADVANTAGE* arrange or provide for the child's care after the 31st day in that case. If newborn is not a child born to *you* or *your spouse*, or is not covered as an adopted child or guardian situation, then newborn shall not be eligible for *coverage* beyond the 31st day. If *you* do not notify *your Group* within 31 days, then the rules applicable to *late enrollees* apply, as discussed later in this *Certificate*.
- Guardianship – Children under the guardianship of *you* or *your spouse* are eligible for *coverage* as of the earlier of:
  - the date of placement with *you* or *your spouse*, or
  - The *effective date* of guardianship under *you* or *your spouse*.
  - The enrollment process and applicable *premium* payment must occur within 31 days of either the placement or date of the legal guardianship for *coverage* to continue beyond the first 31 days. If the child is not enrolled within the 31 days, then the rules applicable to *late enrollees*, as described later in this *Certificate, apply*.
- Court-Ordered Guardianship - A court newly-orders an *eligible dependent* under *your* legal guardianship. The date of status change is the date the court order is issued
- A child who marries or reaches the *dependent* age limit **-** *Coverage* for *your eligible dependent* child will end without notice when *your eligible dependent* marries or reaches the limiting age as described on the cover page of this *Certificate*. If your dependent loses coverage due to dependent age limits and/or marries and you wish to continue coverage under the Young Adult Coverage

Rider, once that child meets the definition of *Young Adult* you must notify your employer that you wish to obtain the Young Adult Coverage Rider within 31 days of the dependent reaching the limiting age.

NOTE: If both parents are *subscribers*, only one parent can enroll the child as an *eligible dependent*. No one will be refused enrollment or re-enrollment because of: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of violence; or disability.

A *subscriber* and a *spouse* working for the same *Group* cannot be both *subscriber* and *dependent.*

The requirements of this *Certificate* will apply equally to *you* and to *your* enrolled *eligible dependents,* except when there is a change in *your* family status as described above.

All benefits and privileges made available to *you* shall be available to *your* enrolled *eligible dependents* except for:

- *eligible dependent* children who marry may not enroll their *spouses* and they cease to be eligible for *coverage* as an *eligible dependent;*
- when required by law, a minor *dependent* may not convert to *Individual Conversion Contract*, other than as an *eligible dependent* of an adult *subscriber*.

***Late enrollee*s -** A *late enrollee* is a *subscriber* or *eligible dependent* who did not request enrollment in *ADVANTAGE*:

- During the initial enrollment period in which he/she was first entitled to enroll; or
- During any special enrollment period, as provided in this *Certificate*.

The term "*late enrollee*" does not include:

- A *subscriber* or *eligible dependent* who:
  - was covered under another health insurance *carrier* or had other health insurance at the time *ADVANTAGE* was previously offered to him/her; and
  - requests enrollment within 31 days after losing that other health insurance due to:
    - exhausting his/her COBRA benefits;
    - loss of eligibility for the other health insurance, including as a result of legal separation, divorce, death, termination of employment, or reduction in work hours;
    - termination of *Group* contributions toward other health insurance.
- A *subscriber* who:
  - is employed by an *Group* that offers multiple health insurance *carriers*; and
  - elects a different *carrier* during an *open enrollment period*.
- A *subscriber* and his/her *spouse*, minor child, or *eligible dependent* child, when:
  - a court orders that health insurance for the *spouse*, minor child, or *eligible dependent* child be provided under *ADVANTAGE*; and
  - enrollment is requested within 31 days after the order was issued.
- A child under age 18, when a court orders the *subscriber* or an *eligible dependent* to provide health insurance for the child.
- A *young adult*

A *late enrollee* may request enrollment at any time. The *coverage* will become *effective* on the next *renewal date* or at the end of 12 months after the date enrollment is requested; whichever occurs first.

Special Enrollment Periods

If *you're eligible dependent* or a *young adult* did not enroll with *ADVANTAGE* when *you* enrolled due to other *coverage*, and that *eligible dependent* has since lost the other *coverage*, *your eligible dependent* or *young adult* does not have to wait until *your Group's* next *open enrollment period*. They are entitled to a special enrollment period.

- *You* must request a special enrollment period within thirty (30) days from the date *your eligible dependent* loses the other *coverage*.
- If *your eligible dependent's* other *coverage* is through COBRA, special enrollment can only be requested after the COBRA continuation *coverage* is exhausted (Refer to the Continuation of *Coverage* Section of this *Certificate* for an explanation of COBRA *coverage*).
- Special enrollment period can only be requested after losing eligibility for the other *coverage* or after *Group* contributions have stopped.

An employee who loses *coverage* is effective on the first day of the month following the date the employee submits the election form to the *Group*.

Special enrollment period also occurs if *you* have a new dependent by birth, marriage, adoption or placement for adoption. If *you* are an *ADVANTAGE subscriber, your* newly acquired *spouse* may become enrolled with *ADVANTAGE* by the first of the following month. If *you* are an eligible employee and not an *ADVANTAGE subscriber, your* newly acquired *spouse* can be enrolled together with *you* when *you* marry or when a child is born, adopted or placed for adoption. A child who becomes *your dependent* as a result of marriage, birth, adoption or placement for adoption can be enrolled if *you* enroll at the same time. Refer to the Enrollment, Eligibility and *Coverage* Information section of this *Certificate*. The election to enroll newly acquired dependents under special enrollment must be made within thirty (30) days following the birth, marriage, adoption, or placement for adoption.

If you are an eligible employee who is an ADVANTAGE subscriber you are not eligible for "special enrollment." However, your new spouse, newborn or newly adopted child is eligible for special enrollment. These new dependents must be enrolled in the same product option in which you are currently enrolled.

What do I do if my name or address changes?
If *your* name or address changes, it is very important that *you* notify *your Group* as soon as possible. *Your Group* will notify *ADVANTAGE*, at which time, *your* records will be updated.

Other Rules of Enrollment

Service area
ADVANTAGE defines *service area* as the 30 air mile radius surrounding the *PCP* selected by *you*. With the exception of a full-time student as described in this *Certificate*, *you* and *your eligible dependents* must select a *participating PCP* within 30 air miles of *your* permanent residence or place of employment. If *you* change *your* permanent residence or place of employment, and *you* no longer live or work within a 30 mile radius of *your* assigned *PCP*, *you* must select a new *participating PCP*. If there is no *participating PCP* in the *Provider Directory* available within 30 air miles of *your* new residence or place of employment, then *you* should contact *your Group* to determine if other *coverage* is available. An absence from the *service area* for more than ninety (90) consecutive days will be considered a change in permanent residence, unless otherwise indicated by *your Group*. *You* must notify *ADVANTAGE* of any move or extended absence from the *service area*. Failure to notify *ADVANTAGE* of a move or extended absence may result in *your* having to pay for services obtained outside of the *service area*. Should *you* have questions regarding *service area* requirements, please contact *ADVANTAGE*'s Member Service Department.

Non-Custodial Parent
Whenever a child of a non-custodial parent has *coverage* with *ADVANTAGE*, the custodial parent may receive information that is necessary for the child to obtain *covered services*. However, *ADVANTAGE* will not be obligated to provide information to the custodial parent unless *ADVANTAGE* is provided with the correct address. The custodial parent will be entitled to submit claims to *ADVANTAGE* or the *provider network* for payment to be made to *providers* for *covered services*.

SECTION 4: *COVERED SERVICES* – BENEFITS

Each *covered services* category is shown with any applicable *copayment, deductible, or coinsurance* for which *you* are responsible to pay at the time of service. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions explained in this *Certificate*, including any attachments. All *copayments, deductibles* and *coinsurance* in effect at the time of service will apply to all *covered services*. **Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate*.**

You are entitled to the *covered services* listed in this section when those services meet the following criteria:

- Services are *medically necessary*; and
- Services are provided or *authorized* by *your PCP*; and
- Services are not excluded elsewhere in this *Certificate*
- Except for *emergency services* and services otherwise *authorized* by *your PCP*, all *covered services* must be obtained from *participating providers.*

Prior *Authorization*

Certain services require prior *authorization* before obtaining those services. For a list of services that require prior *authorization* please refer to *your* Member Reference Guide, contact *ADVANTAGE* Member Services Department by phone or log onto www.advantageplan.com via the internet. *Member* is responsible for obtaining all prior *authorization*s as indicated in the Member Reference Guide.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Allergy Tests and Procedures		
• Serum		50% *coinsurance*
• Administration of serum	Refer to *Physician* Services benefit	Refer to Physician Services benefit
• Allergy testing	Refer to *Physician* Services benefit	Refer to Physician Services benefit

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Ambulance* Transportation** *Ambulance* transportation is covered for *emergency service*. Other *medically necessary ambulance* transport is covered when *authorized* and ordered by *your PCP* (*ambulance*, medi-van or similar medical ground, air or water transport to or from the *hospital* or both ways). Transfer from a *hospital* to a lower level of care is covered only when *medically necessary* and *authorized* by *your physician*. The *medically necessary ambulance* transport *coinsurance* applies to each transport. *Coinsurance* waived if transferred from one acute *inpatient* facility to another.		20% *coinsurance* per transport (*Coinsurance* is waived if transferred from one acute *inpatient* facility to another)

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Behavioral Health All Behavioral health services require an authorization from *your* assigned *behavioral health network*. *You* may access those services directly by calling the Mental Health telephone number listed on *your ID card*. When *you* call this number, identify *yourself* as an *ADVANTAGE member* and *you* will be assisted. *You* will be asked for specific information in order to provide *you* with *authorization* to the appropriate behavioral health services and *participating providers*.		

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
ADVANTAGE ensures *you* can obtain behavioral health services in a timely manner. The *ADVANTAGE* appointment standards for behavioral health care are: • Routine office visits within 10 business days • Initial non-urgent appointments within 10 business days • Urgent appointments within 24 hours • *Emergency* Care is immediate		
Mental Health Services *Option*:		
• *Inpatient psychiatric hospital* services, including evaluation and treatment in a psychiatric day treatment facility, when *medically necessary*, ordered by *your* designated behavioral health *provider* for mental health services and *authorized* by the *behavioral health network*. Limited to 2 *copayments* per *calendar* year.	$250 *copayment*	
• *Outpatient visits* will be provided when *medically necessary* and ordered by *your* designated behavioral health *provider*. *Copayment* applies to both individual therapy and Group therapy sessions.	$35 *copayment*	
• *Partial hospitalization* Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.	$125 *copayment*	
Substance Abuse Option:		
Covered services are provided without limits when treatment of substance abuse and chemical dependency services are required in the treatment of mental *illness*.		
Detoxification for *alcohol* or other drug addiction is covered on an *inpatient* and/or *outpatient* basis, whichever is determined to be *medically necessary*. To be covered, services must be *authorized* by *your* designated *behavioral health network*. *Covered services* are subject to the limitations listed below: • The treatment setting, e.g., *inpatient, outpatient*, residential or transitional, for the treatment of alcohol or other drug dependency shall be determined by your *behavioral health network* designated by *ADVANTAGE* in accordance with *medical necessity*. • The number of rehabilitation days covered represents the days per Contract year of *inpatient* or intensive *outpatient* daycare. Depending on the level of care *medically necessary* for the treatment of alcohol or other drug dependency, covered *inpatient* days will be counted against the rehabilitation day limitations as follows: – One (1*) inpatient* day = one (1) residential day – One (1) extended day *outpatient* treatment = one half *inpatient* day		
• Uniformed *Inpatient* Substance Abuse Services: Limited to 30 days per *calendar* year. Additional 30 days available at 50% *coinsurance*. Lifetime maximum of 2 detoxification admissions.	$250 *copayment*	
• Non-Uniformed *Inpatient* Substance Abuse Services: Limited to 14 days per *calendar* year. Lifetime maximum of 2 detoxification admissions.	$250 *copayment*	
• *Outpatient* Substance Abuse Services: Limited to 20 visits per *calendar* year.		50% *coinsurance*
• *Partial hospitalizations*: Two (2) days of *partial hospitalization* count as one (1) day of *inpatient* services.	$125 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Pervasive Development Disorder		
Pervasive Developmental Disorder means a neurological condition, including, but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. *Coverage* for services will be provided as prescribed by the insured's treating *physician* in accordance with a treatment plan. Any exclusion within the policy, *Certificate,* or C*ontract* that is inconsistent with the treatment plan does not apply. The benefits for pervasive developmental disorder will not be subject to dollar limits, *copayments*, *deductibles*, or *coinsurance* provisions that are less favorable than the dollar limits, *copayments*, *deductibles*, or *coinsurance* provisions that apply to physical *illness* generally under the accident and sickness insurance C*ontract.*	Included in *physician* office visit *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Corrective Appliances and Prosthetics		
Corrective appliances and prosthetics must be *medically necessary* and used to restore function or to replace body parts. They must be provided with a *proper referral* and as prescribed by the *participating physician*. Examples of corrective appliances include, but are not limited to • Pacemakers • Hemodialysis equipment • Breast prostheses • Prosthetic limbs • Back braces • One pair of eyeglass lenses following cataract surgery not to include tinting, scratch-proofing or transitioning. • Ostomy supplies *Covered services* include the purchase, replacement or adjustment of artificial limbs or eyes, when required due to a change in *your* physical condition or body size due to normal growth.		50% *coinsurance*

What are the *non-covered services* or limitations?

- Appliances and aids which are not necessary for the restoration, function or replacement of a body part.
- Non-durable appliances.
- Hearing aids.
- Dental appliances.
- Dentures.
- Foot Orthotics

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate.*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Dental – Limited *Covered services*		
Medical services related to *injury* to sound and natural teeth when *injury* is reported immediately, and treatment must be sought with proper referral to a *participating provider* within a 72-hour period. *Injury* must be traumatic (an *injury* to living tissue caused by an extrinsic agent) or caused by the force of an external object striking the tooth. After *emergency* treatment, follow-up care must be obtained from a *participating provider* upon a *proper referral* from the *PCP* and initiated within sixty (60) days of the *injury*. All treatment must be completed within one year from the initiation of treatment and accident must have been incurred on or after the *effective date of coverage*	$35 *copayment*	

Hospital and anesthesia services related to dental care are covered if:

- *You* are under age 19, or *you* are 19 or older and have a record of, or are regarded as having, a physical or mental impairment that substantially limits one or more of your major life activities; and
- *Your* mental or physical condition requires that dental care be provided in a *hospital* or *outpatient* surgical center.

The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the standards for determining whether performing dental procedures necessary to treat the individual's condition under general anesthesia constitutes appropriate treatment.

The dental procedure is excluded from *covered services*. The "*Inpatient Hospital* Services" *copayment or coinsurance* will apply to *inpatient* services. The "Outpatient Surgical Services" *copayment or coinsurance* will apply for *outpatient* services in a *provider network hospital* or *provider network outpatient* facility.

What are the other *non-covered services* or limitations?

- Injured teeth must be sound and natural, including teeth that have been filled, capped, or crowned
- Accident must have been incurred on or after the *effective date of coverage* with *ADVANTAGE*
- All unauthorized services, or services rendered by a non-*participating provider* are *non-covered services*
- All services not completed within one year from initiation of treatment are *non-covered services*
- Repair of *injury* caused by an intrinsic force, such as the force of the upper and lower jaw in chewing, are *non-covered services*
- Repair of artificial teeth, dentures or bridges are *non-covered services*

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate*.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Diabetes Self Management Training		
Covered services are limited to • *Physician* authorized visit(s) after receiving a diagnosis of diabetes • *Physician* authorized visit(s) after receiving a diagnosis that represents a significant change in *your* symptoms or condition and there is a *medically necessary* change in *your* self-management • *Physician* authorized visit(s) for re-education or refresher training		
Diabetes self-management training	No *copayment*	No *coinsurance*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Dialysis		
Outpatient or *inpatient* dialysis services with a *proper referral* and provided by a *participating provider*.	$0 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Durable medical equipment (DME)		
Rental or purchase of *DME*, including all durable and non-durable supplies required to operate the *DME* and are integral to the *DME* set-up. The following *covered services* apply if there is a *proper referral and:* • When *medically necessary* • When equipment can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of *illness* or *injury* and is suitable for use in *your* home. Examples of *DME* include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, *hospital* beds, monitoring devices, oxygen-breathing apparatus, and insulin pumps. • Training in the use of any *medically necessary* covered *DME* is also covered, when so authorized		50% *coinsurance*
Rental payments apply to purchase of equipment		

What are the *non-covered services* or limitations?

- Equipment that cannot withstand repeated use.
- Equipment that is not medical or not primarily and customarily used to serve a medical purpose; equipment that serves as useful in the absence of illness or injury.
- Equipment that is not suitable for use in the home.
- You are entitled only to the basic type of DME necessary to provide for your medical needs as determined by your physician and authorized by ADVANTAGE.
- Items and equipment specifically fitted to an individual and not appropriate for repeated use by multiple patients.

Examples of non-covered items: corrective shoes; arch supports; hearing aids; dental prostheses; deluxe equipment; common first aid supplies; and non-durable supplies which are not required to operate a durable medical device and are not an integral part of the *DME* set-up.

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Emergency services and Urgent care		
An emergency service means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to: • place an individual's health in serious jeopardy; • result in serious impairment to the individual's bodily functions; • or result in serious dysfunction of a bodily organ or part of the individual. Examples include, but are not limited to, heart attacks, strokes, poisonings, severe bleeding and convulsions.		
Emergency Room: Includes all related services *Copayment* waived if admitted	$125 *copayment*	

What should I do first?
If *you* feel *you* have a medical *emergency*, and if there is time, *you* are encouraged to call *your PCP* for advice and instructions. *Your PCP* may direct *you* to a *hospital emergency* room or *urgent care* center, or *your PCP* may be able to see *you* in the office. If a medical *emergency* is so serious that in the absence of immediate medical attention it could be life-threatening or cause serious disability or significant jeopardy to *your* health, go immediately to an *emergency* facility or call 911.

What do I do if I need follow-up care?
If *you* receive *emergency services* or *urgent care* services, *you* should contact *your participating provider*'s office within 48 hours or as soon as reasonably possible after *you* receive the services to allow *your PCP* to arrange follow up treatment.

Notice to the *PCP* allows the *PCP* to be informed of *your* condition and, once *you* are stabilized, to coordinate *your* care. In the case of a non-*participating hospital*, contact ADVANTAGE as soon as possible. ADVANTAGE and your attending physician may direct *your* transfer to a *hospital* in the *provider network* once *your* health condition has been stabilized.

To "stabilize" means to provide medical treatment to an individual in an *emergency* as may be necessary to assure, within reasonable medical probability that material deterioration of the individual's condition is not likely to result from or during any of the following:

- The discharge of the individual from an *emergency* department or other care setting where *emergency services* are provided to the individual;
- The transfer of the individual from an emergency department or other care setting where emergency services are provided to the individual to another health care facility;
- The transfer of the individual from a *hospital emergency* department or other *hospital* care setting where *emergency services* are provided to the individual to the *hospital's inpatient* setting.

What if I need *emergency services* while I am outside the *service area*?
If *you* become *ill or injured* while *you* are temporarily away from the *service area*, *ADVANTAGE* will cover care for *emergency services* and *urgent care*. If you are hospitalized outside of the service area, contact ADVANTAGE as soon as you are able. If *you* have any questions about how to obtain medical services when *you* are out-of-area, please call the *ADVANTAGE* Member Services phone number listed on the back of *your ID card*. If there is time, *you* should try to call *your PCP* for advice and instructions.

Always remember. . .

- *You* are encouraged to call *your PCP* to arrange for *emergency* care if there is time.
- Be sure to contact *your participating* provider within forty-eight (48) hours after receiving *emergency care*.
- If *you* use the *emergency* room or urgent care for non-*emergency* care that is not *properly referred* and *authorized*, you will be responsible for the entire cost.
- If *you* are admitted following *emergency* care, you must contact ADVANTAGE or *your PCP* (or someone may contact *your PCP* on your behalf) **within forty-eight (48) hours** of admission or when you are medically able to do so. If the *member* is a minor, the parent or guardian must contact the *PCP*. If *you* are admitted to the *hospital* directly from the *emergency* room, *your copayment* is waived for the *emergency service*.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Urgent care: includes related services and after hours and *physician* home visits.		
• In-area	$50 *copayment*	
• Out-of-area	$50 *copayment*	

Remember, *urgent care* is determined by medical condition, not the place of service. *Urgently needed services* or *urgent care services* are instances when *you* need *covered services* urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen illness or injury;
- while outside of the service area; or
- for which treatment cannot be delayed until you return to the service area without your condition growing much worse.

If *you* have an *urgent* medical problem that is not an *emergency*, but needs timely attention, simply call *your PCP's* office, even if *you* are out of the *service area*. *Your PCP* knows *your* medical history and will be in the best position to evaluate *your* needs. *You* may be directed by *your PCP* to an *urgent care* center or *emergency* room. Please follow *your* PCP's instructions to ensure services are covered.

An *urgent care* center is a medical facility, where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive *urgent care services*. *Coverage* for *urgent care* includes after hours and *physician* home visits.

As explained in this Section, if *you* receive *emergency services* or *urgent care services*, *you* must contact ADVANTAGE or *your PCP's* office within 48 hours or as soon as reasonably possible after *you* receive the services.

- **Full time students are covered for *emergency services* or *urgent care* while they are outside the *service area.* However, all follow-up care and care that is not considered *emergency services* or *urgent care* under this *Certificate* must be *properly referred* and *authorized* by the student's *PCP* to receive *covered benefits*.**

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Health Education Health education provided by the *PCP* as part of preventive health care and other health education classes approved by *ADVANTAGE*. Classes in nutrition or smoking cessation will be approved up to three (3) visits when referred by *your physician.*	No *copayment* applies to health education provided by the *PCP* as part of preventive health care.	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Home Health Services *Medically necessary home health services* with a *proper referral*, including: • Skilled medical services. If continuous medical or skilled nursing services are required, *ADVANTAGE* may require transfer to a *SNF* or other facility if medically appropriate and more cost effective. • Nursing care given or supervised by a *Registered nurse (RN)*. • Nutritional counseling furnished or supervised by a registered dietician. • Home hospice services. • Home health aides • Medical supplies, laboratory services, drugs, and medicines prescribed by a *physician* in connection with home health care. • Medical social services. • Training of family member*s* or significant other to provide those *home health services* that can be performed by laypersons.	$0 *copayment*	

Services are considered *covered services* only if they are not considered *custodial care* and the services are prescribed in writing by a *participating physician:*

- As *medically necessary* for the care and treatment of *your illness* or *injury* at home;
- As being in place of *inpatient hospital* care or a convalescent nursing home that would be required in the absence of such services; and
- The services are furnished to *you* while under a *participating physician's* care.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Hospital Care (*Inpatient* and *Outpatient* Medical and Surgical)		
Inpatient Hospital Services: *Inpatient biologic/biopharmaceutical medications* do not require additional *copayment or coinsurance*. Copayment limited to 2 inpatient admissions per calendar year.	$250 *copayment* per admission after deductible (waived if re-admitted within 24 hours of discharge)	
Outpatient Surgical Services: *Outpatient* surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia.	$125 *copayment after deductible*	

What do I do when I need to be *hospitalized*?
Your physician will arrange *your* admission to a *hospital* in the *provider network*.

How do I select a *hospital* or *outpatient* facility?
- When *you* select a *PCP*, *you* agree to utilize the *hospitals* and facilities in *your PCP's provider network*.

What are the *covered services*?
The *inpatient* and *outpatient* medical and surgical *hospital* services are covered when *medically necessary* and *prior authorized*, by *ADVANTAGE*.
- *Inpatient* medical and surgical services;
- Semi-private room and board (Private room provided when *medically necessary*);
- Intensive Care Unit/Coronary Care Unit;
- *Inpatient* cardiac rehabilitation, limited to annual maximum of 90-days;
- *Inpatient* rehabilitation therapy which includes physical, occupational, speech and pulmonary of acute *illness* or *injury* to the extent that significant potential exists for progress toward a previous level of functioning limited to an annual maximum of 90 days.
- *Outpatient* medical and surgical services, including those diagnostic invasive procedures, which may or may not require anesthesia;
- Other *medically necessary inpatient hospital* services, including but not limited to: general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in *hospital*; laboratory and x-ray examinations; electrocardiograms; and special duty nursing (when requested by a *physician* and certified as *medically necessary*).
- *Inpatient* biologic/biopharmaceutical medications do not require additional *copayment* or *coinsurance*.

Medically necessary professional services for surgical operations (major and minor), include but are not limited to:
- Reconstructive procedures performed to restore or improve impaired physical function or defects resulting from an accident occurring while a *member* (if services begin within one year of the accident);
- Replacement of diseased tissue surgically removed while a *member*;
- Treatment of a birth defect in a Dependent child;
  ADVANTAGE is a health maintenance organization responsible for arranging for the provision of *covered services* under *your* benefits. Federal law requires health *carriers* that provide medical and surgical benefits for mastectomies to also cover reconstructive surgery and other related services following a mastectomy. Under the law, if a *member* has a mastectomy and, in consultation with the *physician*, elects to have reconstructive surgery, the *covered services* would include:
  - Reconstruction of the breast upon which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications at all stages of mastectomy, including lymphedemas.
- The manner of treatment for any given patient is to be decided in consultation with the attending *physician* and patient. The law permits *copayments, coinsurance and deductibles* to apply.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Infertility diagnostic testing up to diagnosis of infertility only, and infertility counseling:		
For *medically necessary* treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies for the reproductive system	$35 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Injections (Therapeutic) and Infusion Therapy:		
Outpatient therapeutic injections which are *medically necessary* and which may not be self-administered. Injections include, but are not limited to chemotherapy, antibiotics, analgesics, hydration, total parenteral nutrition (TPN), Prolastin, and Factor 8 injections, which are *medically necessary*. Self-injectables are *covered services* only when authorized by *ADVANTAGE*. *Biopharmaceutical Drugs* are subject to the *copayment* or *coinsurance* indicated.		
Therapeutic injections and infusions (non-*Biopharmaceutical drugs* or insulin drugs):	$0 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Maternity Care		
• Professional obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including *physician services*, laboratory and x-ray services as *medically necessary* and appropriate.		
	One time copayment of:	$20 initial visit (PCP)
	One time copayment of:	$35 initial visit (PCP)

Please refer to "Hospital Care" for inpatient benefits

The benefits include *physician* services, *hospital* services, and laboratory and x-ray services as *medically necessary* and appropriate.

After a normal, vaginal delivery, a woman and her newborn child may stay in the *hospital* for a minimum of 48 hours. After a Cesarean section, a woman and her newborn child may stay for a minimum of 96 hours. A shorter length of stay is included in *covered services*, if: the woman and attending *physician* agree that the woman or newborn child does not need further *inpatient* care; in the attending *physician's* opinion the newborn meets the criteria for medical stability under the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines; and an "*at home post delivery care*" visit is provided.

Unplanned interruption of pregnancy (miscarriage) will be treated as any other *illness*, including, but not limited to *medically necessary physician's* services, *hospital*izations, x-ray and laboratory services.

Always remember…
You MUST make an election to enroll the newborn within the first 31 days of birth for *coverage* to continue past the 31st day.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Medical Social Services *Hospital* services to assist *you* and *your* family in understanding and coping with the emotional and social problems affecting health status. There is no copayment for this covered service.	$0 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Medical Supplies Casts, dressings, splints, and other devices used for reduction of fractures and dislocations. There is no *copayment* for this covered service	$0 *copayment*	

What are the *non-covered services*?
Non-durable supplies and/or convenience items are not covered.

Please refer to Section 5, *Other Non-covered services and Limitations on Benefits* for additional explanation of the specific services not covered under this *Certificate.*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Morbid Obesity *Option* *Morbid Obesity* means: • A body mass index of at least thirty-five (35) kilograms per meter squared, with co-morbidity coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or • A body mass index or at least forty (40) kilograms per meter squared without co-morbidity. **Non-surgical Treatment for Morbid Obesity** As an alternative to surgical treatment for *morbid obesity*, *ADVANTAGE* will pay for enrollment in an in-network *physician*-supervised weight loss treatment program when referred by your physician and authorized by *ADVANTAGE*.	Enrollment fees in excess of $50 after $35 *copayment* per visit. Maximum of 6 visits per *calendar* year.	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Newborn Examinations Newborn examinations are covered under maternity care, or *hospital* care, or *physician* office visits. Newborn examinations include the detection of: • *Inherited Metabolic Disease* includes services for *medical food* and *low protein modified food products,* (not subject to *copayment,* regardless of supplier) as defined in the Glossary of Terms. • Hypothyroidism • Hemoglobin paths, including sickle cell anemia • Galactosemia • Maple Syrup Urine Disease	No additional *copayment*	

- Homocystinuria
- Inborn errors of metabolism that result in mental retardation and that are designated by the State Health Department
- Physiologic hearing screening examinations for detection of hearing impairments

If a parent of an infant objects in writing, for reasons pertaining to religious beliefs only, the infant is exempt from the examinations.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Outpatient* Services**		
Outpatient Services including but not limited to: laboratory, pathology, radiology ;		
Services in *PCP* or *SCP* office	Included in office visit *copayment*	
Services in other *outpatient* setting	$0 *copayment after deductible*	
Electrocardiology (EKG) and electroencephalography (EEG),	$0 *copayment*	
MRI, CT, MRA, SPECT and PET scan	$0 *copayment after deductible*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Physician* Services – Office visits for the treatment of *illness* or *injury		
Office visit Services:		
• *Primary care physician* Office Visit	$20 *copayment* per office visit	
• Specialty and Referral *Physician* Office Visit	$35 *copayment* per office visit	
• Office visits, services and supplies for the determination and/or treatment of *illness* or *injury*. These services include medical consultations, and procedures performed in the *physician*'s office, *second opinion* consultations, and specialist treatment services.		
• Allergy Testing		
• Diabetes self-management training		
• Maternity care – refer to Maternity Care benefit		

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
***Physician* Services – Non-Office Visit Services**		
• *Primary care physician*, Specialty and Referral for all *Physician* Services in the *Hospital* or *Outpatient* Facility	$0 *copayment*	
• *Primary care physician*, Specialty and Referral *Physician* visits in the Home when provided by *your participating physician*	$50 *copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*

Physician **Services for wellness and preventive services**

The following services will be included in the office visit *copayment* when services are performed in the *physician* office. Services performed outside of the *physician* office will not have a *copayment*.

Included in the *physician* office visit *copayment*

Provided by the *PCP* or other authorized *provider* including, but not limited to:

- Routine physical exam – Periodic health appraisal examinations for *members* who are less than 18 years of age for the prevention and detection of disease as recommended by the American Academy of Pediatrics. For *members* age 18 and older, history and periodic health evaluations (physical examinations for the prevention and detection of disease) limited to the extent *medically necessary* or appropriate.
- Routine total blood cholesterol screening
- Colorectal Cancer screening – Colorectal cancer examinations and laboratory tests, as mandated by Indiana State Law, must be covered for any non-symptomatic individual in accordance with current American Cancer Society Guidelines for a covered person who is:
  a) at least fifty (50) years of age; or
  b) Less than fifty (50) years of age and at high risk for colorectal cancer.

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine gynecological services
- Routine mammographies – Breast cancer screening tests as mandated by Indiana State Law, include;
  a) One (1) baseline screening mammography before the age of forty (40) for a *member* who is at least thirty-five (35) years old;
  b) Annual screening mammography if at risk and less than forty (40);
  c) Annual screening mammography for *members* forty (40) years old and older;
  d) Any additional mammogram views needed for proper evaluation and ultrasound services; if *medically necessary.*

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine Prostate Specific Antigen (PSA) Test as mandated by Indiana State Law, include;
  a) At least one (1) PSA test annually for an individual who is at least fifty (50) years old;
  b) At least one (1) PSA test annually for an individual less than fifty (50) who is at high risk of prostate cancer according to the American Cancer guidelines.

Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.

- Routine immunizations- Immunizations and inoculations (vaccine and administration of vaccine) based on the guidelines of the Advisory Committee on Immunization Practices (ACIP) or at *ADVANTAGE*'s discretion, other nationally recognized organizations, such as the American Academy of Pediatrics (AAP) or the Academy of Family *Physician*s (AAFP).
- Hearing tests – Hearing examinations,as mandated by Indiana State Law, including an infant physiological hearing screening examination at the earliest feasible time for the detection of hearing impairments.
- Vision screening

PHARMACY SERVICES

Outpatient **Prescription Drug** ***Option***

All *covered services* for *outpatient* prescription drugs will be subject to inclusion on the *formulary* and a mandatory generic requirement. This means when the *member* or *physician* chooses a *brand-name drug* instead of the available *generic*, the *member* must pay the higher *copayment or coinsurance* plus the cost difference between the *brand* and the *generic.* You must satisfy the outpatient prescription drug *deductible.*

All prescriptions must be prescribed by a *participating provider* in order to receive this *covered service*. *ADVANTAGE* requires that all prescriptions be filled with the most cost-effective *generic* medication, if available, and approved by the Food and Drug Administration (FDA) for the prescribed indication, dosage and administration, and subject to the limitations and exclusions described in this Section. *Covered services* include: all drugs requiring a prescription either by State or Federal law, except injectables (other than insulin); All compound prescriptions that contain at least one covered prescription ingredient; and insulin and insulin needles and syringes, when prescribed by a *participating*

physician and dispensed to you. The quantity dispensed shall be limited to that sufficient to treat acute phase of *illness* or a thirty-(30) day supply, whichever is less, per *copayment or coinsurance*.

Please refer to the cover page of this *Certificate* to determine if *you* have any *deductible* or *Out- of- pocket Maximum* applicable to *your* prescription *covered services.*

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Outpatient* Prescription Drug THREE TIER *Option **INCLUDES: DIABETES SUPPLIES (Please refer to the *formulary*)**		
TIER 1 – Preferred Generic Drug When *you* receive a Preferred *Generic drug*, *you* pay the lowest out-of-pocket cost for the prescription.	Retail: $10 *copayment* per prescription up to a 30-day supply Mail Order: $20 *copayment* per prescription up to a 90-day supply	
Tier 2 – Non-Preferred Generic Drug	Retail: $20 copayment per prescription up to a 30-day supply Mail Order: $40 copayment per prescription up to a 90-day supply	
TIER 3 - Preferred *Brand-name drug* If *you* or *your physician* requests a *brand-name drug* when there is a *generic* equivalent available, *you* will be charged the Preferred *Brand-name drug copayment* PLUS the difference between *ADVANTAGE*'s maximum allowable charge for the *generic* and the *brand-name* contract price.	Retail: $30 copayment per prescription up to a 30-day supply Mail Order: $60 copayment per prescription up to a 90-day supply	
TIER 4 -Non-Preferred *Brand-name drug* If *you* or *your physician* requests a *non-formulary brand-name drug* when there is a *generic* equivalent available, *you* will be charged the Non-Preferred *Brand-name drug copayment* PLUS the difference between *ADVANTAGE*'s maximum allowable charge for the *generic* and the Non-Preferred *Brand-name drug* contract price.		Retail: 50% coinsurance per prescription up to a 30-day supply Mail Order: 50% coinsurance per prescription up to a 90 day supply.

What is a *formulary*?
ADVANTAGE utilizes a prescription drug *formulary*. A *formulary* is a list of preferred *generic* and *brand name* prescription medications that have been approved by the Food and Drug Administration (FDA). Each "Tier" is described in the *formulary* document, and *you* may review the most-recent *formulary* by logging onto www.advantageplan.com.

ADVANTAGE has a team of *physicians* and pharmacists who meet regularly throughout the year to review and update the *formulary*. It includes medications for most conditions treated outside the *hospital*. *Your participating physician* will refer to the *formulary* to select medications that are appropriate to meet *your* healthcare needs, while helping *you* maximize *your* prescription drug benefit. *Participating physicians* and pharmacists are provided with information about *ADVANTAGE*'s *formulary* and updates as new medications are approved to be added to the *formulary* or when current medications are replaced.

What is a *generic drug*?
A *generic drug* is a copy of a *brand name* drug for which the patent has expired. The *generic drug* may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the *brand name* drug. The same quality and safety standards that apply to *brand name* drugs also apply to the *generic* form. The FDA sets standards and reviews all *generic* medications before marketed.

What is a *brand-name drug*?
A *brand name* drug is a drug that has been manufactured under a patent and in accordance with the approval for the FDA.

Is prior *authorization* required for *outpatient* prescription drugs?

A limited number of prescription drugs require prior *authorization*. The pharmacist will advise *you* if *your* prescription requires prior *authorization*. *Your* prescribing *physician* is required to complete a "Letter of Medical Necessity" and fax it to the pharmacy benefits manager's *authorization* unit. The information is reviewed for clinical information that would indicate the prescription drug is covered under *your* benefit plan for *your* circumstances. *Participating physicians* have been educated about the prior *authorization* drug process. Many *physicians* will complete the "Letter of Medical Necessity" at the time he/she provides *you* with the prescription.

If the prescription is *authorized* after review, a Member Services Representative will notify *you* as quickly as possible. If *authorization* is denied, a clinical specialist will notify the prescribing *physician* to discuss the clinical guidelines used for the denial, and *you* will be notified of the denial in writing and of *your* right to appeal.

If *you* have questions about the prior *authorization* process for prescription drugs, please contact a Member Services Representative for assistance.

What are the *non-covered services* or limitations?

LIMITATIONS
You will be reimbursed, less the applicable *copayment, coinsurance and deductible*, if applicable for prescription drugs obtained from other than the designated *ADVANTAGE participating pharmacies*, only when the drug was:

- Ordered in connection with an out-of-area *emergency* covered under the *emergency services* section described in this *Certificate* ;
- Ordered by a *physician* for immediate use because of *medical necessity* and because *your* designated pharmacy is not open for business at that time.

Reimbursement in the above two circumstances will be limited to the *Maximum allowable amount* of cost for a quantity of the drug sufficient to treat the acute phase of the *illness* or to a maximum of thirty (30) day supply, whichever is less.

A drug not approved by the FDA may be prescribed if one of the following conditions is met:
- the drug is recognized for treatment of the indication in at least one (1) standard referenced compendium; or
- the drug is recommenced for that particular type of cancer and found safe and effective in informal clinical studies; the results which are published in the United States or Great Britain.

***Covered services* will only be provided in the quantity equal to the amount prescribed for use through the last day of eligibility.**

NON-COVERED SERVICES
- Injectables, which are not listed on the *formulary*;
- Implantable drugs; implantable devices for the administration of drugs;

- Devices and appliances other than insulin syringes/needles (e.g., diaphragms, cervical caps or intrauterine devices (IUDs);
- Drugs administered in *physician's* offices, *hospitals*, nursing homes, *ADVANTAGE* Skilled Nursing Facilities and hospices;
- Except for Nicotine Patches obtained through a prescription, all over the counter (OTC) drugs;
- Drugs whose purpose is the treatment of infertility or impotence; except for drugs approved through the *ADVANTAGE* review process, drugs prescribed that are investigative or *experimental* in nature. A drug shall be considered *experimental* if it has not been approved by the FDA and if the FDA has not approved the drug for the route of administration, the dosage involved, or except as otherwise required by law for certain cancer drugs, the specific indications for which the drug is being prescribed;
- Drugs used for *cosmetic* or recreational purposes (e.g., anabolic steroids, anorexiants, topical minoxidil, or Retin-A for wrinkles, however, retonic acid creams are covered when used in connection with the treatment of severe acne.) Drugs prescribed as part of the treatment for congenital defects or anomalies, shall not be considered *cosmetic* for purposes of this Section;
- Anorexiants, food supplements and other drugs when prescribed for the treatment of obesity;
- *Hospital* discharge drugs; take-home drugs;
- Oral prescription medications when prescribed for foreign travel;
- Replacement of drugs due to loss, theft or negligence;
- Maintenance drugs when filled at a Non-*ADVANTAGE participating pharmacy*;
- Excluded prescriptions may be purchased at a participating *ADVANTAGE participating pharmacy* at *ADVANTAGE*'s negotiated discount price.
- Growth Hormones and related products
- Vitamins and Nutritional Supplements

Where do I get my prescriptions filled?

Retail Pharmacy Locations

ADVANTAGE contracts with Pharmacy Benefit Manager to provide retail prescriptions at the following store pharmacies

- CVS
- Meijer
- Wal-Mart
- Kroger
- Kmart
- Walgreens
- Target
- Marsh

Other local and regional pharmacies may participate in our pharmacy network. *You* can find a complete listing of pharmacies that participate with our network and *ADVANTAGE* by calling 800-553-8933. All prescriptions must be filled through Pharmacy Benefit Manager, or *you* may save money by having *your* refillable prescriptions provided through the Pharmacy Benefit Manager mail order program (see below for more information).

Mail Order Program

Under the Prescription Drug Program, *you* may receive covered maintenance prescriptions through the Pharmacy Benefit Manager approved mail order program. Maintenance prescriptions are those that eligible *members* may receive a savings for up to a maximum 90-day supply per prescription.

You may begin using the mail order prescription program by completing the Mail Order Form provided with *your* new *member* welcome packet (contact an *ADVANTAGE* Member Services Representative if *you* need a Mail Order Form). *You* must call *your physician's* office and request a new prescription for the maximum days supply allowed. Mail *your* new prescription(s) and *your copayment(*s) or *coinsurance* along with the completed form in the envelope attached to the order form. Please allow for an average delivery time of two weeks.

If *you* have questions about the prescription drug benefits, please contact an *ADVANTAGE* Member Services representative for assistance.

Always remember…
Keep *your PCP* informed of medications prescribed by specialty care *providers* or behavioral health *providers* to prevent adverse drug interactions.

Biopharmaceutical Drugs	*COPAYMENT*	*COINSURANCE*
Biopharmaceutical drugs means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. *Biological* or *biopharmaceutical products* typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct *physician* involvement, and significant *member* education. These services must be *authorized* by *ADVANTAGE*. *Coinsurance* applies to drugs dispensed up to a 30 day supply.	$125 *copayment/30-day supply applies PLUS applicable office visit copayment*	

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Skilled nursing facility/hospice facility:		
Limited to 100 days per "*Benefit period*" as defined by Medicare and in this *Certificate*. Day limits do not apply to hospice.		
*Skilled nursing facility (SNF)/*Extended Care Services, *inpatient* hospice:	$0 *copayment*	

Covered services when *medically necessary* with a *proper referral* include:

- Semi-private room; private room provided when *medically necessary*.
- Drugs, biologicals, medical social services, short term physical, speech, occupational therapies (subject to limitations listed in the Short-term Therapies indicated below) and other services generally provided by skilled nursing facilities.
- Hospice care provided if you are terminally ill, in accordance with a treatment plan developed before your admission to the hospice care program. Treatment plan must include a statement from the physician documenting that life expectancy is six months or less.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Therapies – Short-Term:		
Short-Term Therapies are limited to a combined 60 visits per each distinct condition or episode, or as authorized through a medical management regimen	$35 *copayment*	

Short-term Physical Therapy
Short-term physical therapy – covered with *prior authorization* for a condition that the *physician* believes is subject to continuing improvement.

Short-term Speech and Occupational Therapy
Short-term speech or occupational therapy – services are covered with *prior authorization*, if provided to correct an impairment due to *injury* or *illness*; or a congenital defect.

Covered services for speech therapy when provided to restore speech after a loss or impairment of a previous, demonstrated ability to speak; or develop or improve speech after surgery to correct a defect that existed at birth and impaired, or would have impaired, the ability to speak. ***Covered services*** **do not include speech therapy due to a delay in speech development.**

Short-term Cardiac Rehabilitation
Short-term services that may be *medically necessary* for the improvement of cardiac disease or dysfunction.

Short-term Pulmonary Rehabilitation
Short term services that may be *medically necessary* for the improvement of pulmonary disease or dysfunction that has a poor response to treatment. Examples of poor response include but are not limited to patients with respiratory failure, frequent *emergency* room visits, progressive dyspnea, hypoxemia, or hypercapnia.

DESCRIPTION OF *COVERED SERVICES*	*COPAYMENT*	*COINSURANCE*
Transplant Services		
Transplants: Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a *member*; Includes a maximum lifetime limit of $10,000 for *covered services* related to transportation and lodging for the donor. The maximum lifetime limit for *covered services* related to transportation and lodging applies to the *policy maximum*. No *coverage* is provided for the donor or the recipient when the recipient is not a *member*. The *inpatient* medical *copayment/coinsurance* applies as specified. The *SCP* office visit *copayment/coinsurance* applies as specified for pre-transplant evaluation. Non-*experimental,* non-*investigational* organ and other transplants are covered. *ADVANTAGE* will cover the donor's medical expenses if the person receiving the transplant is an *ADVANTAGE member* and the donor's expenses are not covered by another health benefit *carrier*.	Applicable inpatient/outpatient *copayment/coinsurance* will apply and, in addition any applicable office visit *copayment/coinsurance* applies for pre-transplant evaluation	Applicable inpatient/outpatient *copayment/coinsurance* will apply and, in addition any applicable office visit *copayment/coinsurance* applies for pre-transplant evaluation

SECTION 5: OTHER *NON-COVERED SERVICES* AND LIMITATIONS ON BENEFITS

The following section indicates the items which are not *covered services* under this *Certificate* and are thus *your* financial responsibility. This information is provided as an aid to identify certain common items which may be misconstrued as *covered services*, but is in no way a limitation upon, or a complete listing of, such items considered not to be *covered services*.

1. Services and supplies that are not performed, arranged, *authorized*, or approved in advance, except as specifically stated in this *Certificate* and/or Member Reference Guide
2. Services and supplies that are not *medically necessary*;
3. Services and supplies that are not specifically listed as covered services;
4. Services not within the scope of the provider's license;
5. Services of a provider who is a member of the patient's immediate family or who normally resides in the patient's household.
6. Services and supplies provided by your family, i.e., parent, brother, sister, or child, or someone who lives with you;

7. Services of a provider treating himself or herself.
8. Services and supplies that are furnished by a government plan, hospital, or institution, unless you are legally required to pay for the service;
9. Services and supplies provided prior to your effective date of coverage or after your coverage is terminated;
10. Services and supplies incurred after *you* leave a program of *inpatient* care for the same condition, against the medical advice of *your physician*;
11. Services and supplies that would have been provided at no cost if you did not have coverage under ADVANTAGE;
12. Services and supplies which are covered, or would have been covered, under any worker's compensation or occupational disease act or law;
13. Except when required by law, services and supplies provided to treat an *illness* or *injury* caused by:
    - any act of declared war;
    - service in the military forces of any country, including non-military units supporting such forces;
    - the commission or attempt to commit a civil or criminal battery or felony; or
    - taking part in a riot ("taking part in a riot" means the use or threat to use, force or violence without authority of law, by four or more persons).
14. All treatments, procedures, facilities, equipment, drugs, devices, services, or supplies that are considered experimental;
15. Cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance, but do not restore or improve impaired physical function (except for services covered in accordance with the Women's Health and Cancer Act of 1998 and services covered for newborns as outlined in Indiana Code 27-8-5.6-2;); wigs;
16. Services and supplies provided to treat hair loss, promote hair growth, or remove hair. However, you are entitled to access ADVANTAGE's discount for such drugs through a participating pharmacy;
17. Orthognathic Surgery
18. Services and supplies related to narcotic maintenance treatment for opiate addiction;
19. Storage of blood products when not medically necessary or not provided in conjunction with a scheduled covered surgery; blood products when replaced by donation;
20. Items or devices primarily used for comfort, including, but not limited to air purifiers, humidifiers, dehumidifiers, whirlpools, air conditioning, waterbeds, exercise equipment, and ultraviolet lighting;
21. Non-skilled care, rest cures, respite care, or domiciliary care, regardless of the setting;
22. Services and supplies provided by your family, i.e., parent, brother, sister, or child, or someone who lives with you;
23. Private duty nursing services provided for the convenience of you or the convenience of your family (for example, bathing, feeding, exercising, moving the patient, giving oral medication or acting as a companion or sitter);
24. Room and board services while you are permitted to temporarily leave a hospital, SNF, or hospice facility;
25. Orthodontia and other dental services, except as expressly provided for in this Certificate or any attachment to this Certificate ;
26. All unauthorized dental services, or services rendered by a non-participating provider; dental appliances; dentures; dental prostheses;
27. All dental services not completed within one year from initiation of covered treatment;
28. Repair of dental injury caused by an intrinsic force, such as the force of the upper and lower jaw in chewing;
29. Repair of artificial teeth, dentures, or bridges;
30. Physical exams and related x-ray and lab expenses, when provided for employment, school, sports' programs, travel, immigration, administrative purposes, or insurance purposes;

31. Pre-marital tests or exams;
32. Other services and/or supplies which are not, in the judgment of your participating physician, medically necessary for the maintenance or improvement of your health;
33. Services and supplies for the treatment of: adult hyperkinetic syndrome, learning disabilities, mental retardation, behavioral disorders, developmental delay or disorder, or senile deterioration, beyond the period necessary to diagnose the condition.
34. Marriage counseling, personal growth therapy, or sex counseling or therapy;
35. Hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders by the American Psychiatric Association;
36. Self-help training and other related forms of non-medical self care, which are unrelated to mental health;
37. Services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction
38. Immunizations provided for the purpose of travel;
39. Supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, corns, bunions, and calluses.
40. Routine foot care except when medically necessary for the treatment of diabetes and lower extremity circulatory diseases.
41. Telephone consultants, charges for completion of claim forms;
42. Fees that the provider may charge you if you miss scheduled appointments without canceling with reasonable notice;
43. Chiropractic services;
44. Court-ordered services, unless appropriate, medically necessary, and authorized by your physician;
45. Travel or hospitalization for environmental change, or physician services connected with prescribing environmental changes;
46. Naturopathic medicine or Christian Science medicine;
47. Acupuncture, except where administered by a participating provider and used as an anesthetic agent for covered surgery;
48. Preparation of special medical records or court-ordered appearances for hearing or proceedings;
49. Medical care provided outside the U.S., unless an emergency;
50. Massage Therapy
51. Except for physician-supervised programs referred by your physician and authorized by ADVANTAGE, services, drugs, and supplies for weight loss, diet, health or exercise programs, health clubs dues, or weight reduction clinics. However, you are entitled to access ADVANTAGE's discount for such drugs through a participating pharmacy;
52. Vision examinations, refractions, eyeglasses and contact lenses and their fitting; Eyeglass lenses unless medically necessary following cataract surgery; refractive surgery performed to treat myopia or hyperopia;
53. Contact Lenses unless: medically necessary for the treatment of Keratoconus; or medically necessary for intraocular implant of lenses for Aphakia or after cataract surgery;
54. Non-prescription glasses or vision devices; orthoptics or vision therapy including eye exercises and any associated supplemental testing;
55. Services or supplies for, or related to:
    - sex change operations or reversal, except for congenital deficiency;
    - artificial insemination
    - gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in-vitro or in-vivo fertilization;
    - abortion;

- voluntary sterilization or reversal of sterilization;
- birth control drugs, supplies, or devices; however, *you* are entitled to access *ADVANTAGE's* discount for such drugs through a *contracting pharmacy*;
- use of a surrogate for any reason

56. Hearing aids, Hearing therapy, or cochlear implants and their fitting
57. Audiometric exams for the purpose of hearing aids.
58. Treatment of temporomandibular joint (TMJ) disorder;
59. Extensive long-term neuromuscular rehabilitation, i.e., physical, speech or occupational therapy is excluded. Rehabilitation that the physician reasonably believes will require in excess of 60 days per each distinct condition or episode, beginning with the first rehabilitation treatment for that condition, will be considered "long-term" and is not covered. (When you undergo a rehabilitative treatment for a specific and distinct condition, that visit constitutes one treatment). *ADVANTAGE* reserves the right to extend *covered services* through a formal medical management regimen.
60. Personal comfort items, including but not limited to services and supplies not directly related to *your* care, such as guest meals and accommodations, private room (unless *medically necessary*), personal hygiene products, telephone charges, travel expenses (other than approved *ambulance* services as provided in the basic health services), take-home supplies including prescription drugs and similar items;
61. Service obtained by a *member* from *physicians*, *hospitals* or other *providers* not associated with *ADVANTAGE*, either within the *service area* or outside the *service area* (except *emergency services* or upon proper referral by a *participating physician*);
62. Recreational or educational therapy;
63. Treatment and testing for adolescents and children, which are state mandated services by or of the school system, unless therapy is deemed *medically necessary* by a *participating provider*;
64. Court ordered therapy, unless appropriate, *medically necessary*, and *authorized by your participating behavioral health provider*;
65. Vocational therapy, including work hardening programs;
66. Newborn deliveries performed by a midwife in the home and any charges, including but not limited to supplies and equipment as a result of such deliveries.
67. Treatment or services related to *pre-existing medical condition* which are incurred during the *pre-existing medical condition exclusion period* as defined in this *Certificate*
68. Growth Hormones and related products;
69. Services and supplies for the treatment of alopecia and/or alopecia areata;
70. Corrective appliances and artificial aids which are not necessary for the restoration, function, or replacement of a body part; non-durable appliances;
71. Speech therapy due to a delay in speech development;
72. Common first aid supplies;
73. *Durable medical equipment* that:
    - cannot withstand repeated use;
    - is not medical or not primarily and customarily used to serve a medical purpose;
    - serves as useful in the absence of *illness* or *injury*;
    - is not suitable for use in the home;
    - specifically fitted to an individual and not appropriate for repeated use by multiple patients;
    - is considered deluxe equipment. *Covered services* are only for the basic type of *DME* necessary to provide for *your* medical needs as determined by *your physician* and authorized by *ADVANTAGE*.

74. Non-durable supplies and/or convenience items which are not required to operate a durable medical device and are not an integral part of the *DME* set-up;

75. Non-durable medical supplies for use outside the *hospital* or *physician* office;

76. Surgical treatment of *morbid obesity*;

77. Maternity services when *member* is acting as a surrogate mother.

78. Treatment or services related to *pre-existing medical conditions* which are incurred during the *pre-existing medical exclusion period* as defined in this *Certificate.*

79. Services and supplies provided after *Policy maximum* has been exceeded by the *member.*

80. Medical care for a *preexisting medical condition* of a *Young Adult* until six (6) months after the effective date of the *Young Adult's* coverage with *ADVANTAGE*. This *preexisting medical condition* limitation period will be reduced by the number of days of *prior creditable coverage* the *Young Adult* has at the time of enrollment. The *preexisting medical condition* limitation does not apply to:
    (1) *dependent* who, on the date he or she is otherwise eligible for coverage, is adopted by, or placed for adoption with, the *subscriber;* or
    (2) a newly born *dependent* Child of the *subscriber,*
    if the child, as of the last day of the 30 day period beginning with the date or birth or date of adoption or placement for adoption, is covered under creditable coverage.

Other Limitations

Cost Effectiveness:
ADVANTAGE will not pay the cost of any *inpatient* or other care which could have been provided by a *participating physician's* office, in the *outpatient* department of a *hospital*, or in another less costly location without adversely affecting the patient's condition or the quality of medical care rendered, unless the UM Committee has determined the care to be *medically necessary*. Nor will *ADVANTAGE* pay the cost of any service or article which is significantly more expensive than an available alternative, unless the UM Committee has determined the more expensive service or article has been demonstrated to be of significantly greater therapeutic value than the other, less expensive, alternative.
Circumstances Beyond *ADVANTAGE's* Control:
Neither, *ADVANTAGE*, nor *participating hospitals*, nor any *participating provider* shall have any liability or obligation for delay or failure to provide health care services:

- Due to causes beyond the control of *ADVANTAGE* or *ADVANTAGE*'s *participating providers*. Such causes might include: complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of the *hospital personnel or health professionals*, or similar causes, under which the rendition of medical or *hospital* services hereunder is delayed or rendered impractical.
- Due to lack of available facilities or personnel if caused by disaster or epidemic.

In such events, *physicians and hospitals* shall render medical and *hospital* services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel as are then available.

SECTION 6: COMPLAINTS, *GRIEVANCE*S AND APPEALS

*GRIEVANCE*S – LEVEL 1

Members are encouraged to contact the Appeals Specialist at *ADVANTAGE* with any questions or *grievance*s. *You* may request a *grievance* within 180 *calendar* days from the date of the initial adverse decision. Please address *your* request for a *grievance* to the Appeals Specialist at the address or telephone number listed on page 2 of this *Certificate*, or *you* may call us, toll-free, at (888) 806-1029 between the hours of 8 am through 5 pm, Monday through Friday, excluding holidays. *You* may also call the number on the back of *your* identification card for assistance in filing a *grievance*. Please include the following information in *your* correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Social Security Number
The Nature of the *Grievance*

When the *grievance* is received, it will be recorded in the *Grievance* Log so that it can be tracked and resolved. A confidential file will be opened and maintained throughout the case until resolution, documenting the substance of the *grievance* and actions taken. *You* have the right to submit written comments, documents, or other information relating to the *grievance*.

You shall receive an acknowledgment of *your grievance* within three working days after receipt of *your grievance*.

*Grievance*s will be resolved according to the following time frames:

- Pre-service *grievance*s: A pre-service *grievance* or appeal is a request to change an adverse determination for care or services in advance of the *member* obtaining the care or services. *ADVANTAGE* resolves pre-service *grievance*s within 15 *calendar* days from receipt of the request at each level of review (first and second levels).

- Post-service *grievance*s: A post-service *grievance* or appeal is a request to change an adverse determination for care or services that have already been received by the *member*. *ADVANTAGE* resolves post-service *grievance*s within 20 business days after the *grievance* is filed. If we are unable to make a decision regarding the *grievance* within the twenty (20) day period due to circumstances beyond our control, then we shall: (1) notify *you* in writing advising of the reason for the delay before the twentieth business day, and (2) issue a written decision within an additional ten business days.

APPEALS LEVEL 2

If the *grievance* was not resolved to *your* satisfaction, *you* may appeal within 180 *calendar* days from the *grievance* decision by writing to the Appeals Specialist. Please address *your* request for an appeal to the Appeals Specialist at the address or telephone number listed on page 2 of this *Certificate*, or *you* may call us, toll-free, at (888) 806-1029 between the hours of 8 am through 5 pm, Monday through Friday, excluding holidays. *You* may also call the number on the back of *your* identification card for assistance in filing an appeal. Please include the following information in *your* correspondence, or have this information ready when telephoning:

Subscriber's Name
Patient's Name
Subscriber's Social Security Number
The Date of the Original *Grievance*
The Nature of the *Grievance*

You shall receive an acknowledgment of *your* request for a review by the second level Appeals Committee within three working days.

The appeal will be reviewed by the second-level Appeals Committee which, in the case of a *grievance* regarding medical care or treatment, will be composed of one or more individuals who have knowledge of the medical condition, procedure, or treatment at issue. The individual(s) will be in the same licensed profession as the *provider* who proposed, refused, or delivered the health care procedure, treatment, or service in question and who was not involved in the matter giving rise to the *grievance*.

If *you* wish to appear before the second-level Appeals Committee, *you* should make that request in the letter or telephone call requesting the appeal. *You* may also communicate with the Committee through other appropriate means if *you* are unable to appear in person. The Committee will meet during normal business hours. *You* may submit written comments, documents or other information relating to the appeal.

Appeals will be resolved according to the following time frames:

- Pre-service appeals: A pre-service *grievance* or appeal is a request to change an adverse determination for care or services in advance of the *member* obtaining the care or services. *ADVANTAGE* resolves pre-service appeals within 15 *calendar* days from receipt of the request at each level of review (first and second levels).

- Post-service appeals: A post-service *grievance* or appeal is a request to change an adverse determination for care or services that have already been received by the *member*. *ADVANTAGE* resolves post-service appeals within 30 *calendar* days from receipt of the request.

EXPEDITED *GRIEVANCE*S AND APPEALS

Expedited *grievance*s and appeals (Level I and Level II):

ADVANTAGE offers the *member* an expedited appeal for any *urgent care* request. *Urgent care* involves conditions which: "Could seriously jeopardize the life or health of the *member* or the ability of the *member* to regain maximum function, based on a prudent layperson's judgment or in the opinion of a *physician* with knowledge of the *member's* medical condition would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request."

ADVANTAGE must make the expedited *grievance* or appeal decision as expeditiously as the medical condition requires, but no later than 72 hours after the request at each level of review (Level I and Level II). An expedited review begins when a *member*, a representative of the *member,* or a practitioner acting on behalf of the *member* requests an expedited appeal either verbally, by facsimile, in writing or by any means of electronic communication. *ADVANTAGE* grants an expedited review to all requests concerning admissions, continued stay or other health care services for a *member* who has received *emergency services* but has not been discharged from the facility.

ADDITIONAL INFORMATION

Right to Receive Information

For any level of appeal, *you* are entitled to receive, upon request, reasonable access and copies of all documents relevant to the *grievance* or appeal. Relevant documents include documents or records relied upon in making the decision and documents and records submitted in the course of making the decision. *You* are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or similar criterion on which the decision was based.

Designating a Representative

A *member* may designate a representative to file a *grievance* for the *member* and to represent the *member* in the resolution and/or appeal of any *grievance* or appeal. *You* may need to sign a release in order to allow us to discuss *your* situation with *your* representative.

External Review

If *you* are dissatisfied with our decision of the second-level review, *you* may have the option of requesting an external review by an Independent Review Organization certified by the Indiana Department of Insurance. If *you* choose to request an external review of *your* appeal, send a notice in writing within 180 *calendar* days of receipt of the second-level decision. Per Indiana Code IC 27-13-10.1-1, *you* may request an external review for the resolution of *grievance*s regarding:

1. an adverse utilization determination
2. an adverse determination of medical necessity: or
3. a determination that a proposed service is *experimental* or *investigational* made by a health maintenance organization or an agent of a health maintenance organization regarding a service proposed by a treating *physician*.

Please address *your* request for an external review to the Appeals Specialist at the address listed on page 2 of this *Certificate*:

Under the external review process, the Independent Review Organization will make a determination within 15 working days of *your* request, or for expedited requests, within 72 hours of receipt of *your* request. *You* may provide any requested information to the Independent Review Organization or authorize our release of information to the Independent Review Organization

You may be required to pay up to $25.00 of the costs for the external review. *You* may not file more than one external review request for each *grievance*. If *you* have the right to external review under Medicare, *you* may not request external review through the plan.

QUESTIONS AND CONCERNS

Your satisfaction is very important to us. We have set up the *Grievance* Procedure to help ensure that any problem with any aspect of this Plan is addressed in a fair and timely manner. We fully expect to provide a fair settlement for every valid *grievance* in a timely fashion. However, if *you* feel *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: (800) 622-4461 or
Indianapolis area: (317) 232-2395

Complaints can also be filed electronically at www.in.gov/idoi

You may also have remedies available to *you* through The Department of Labor and ERISA regulations.

SECTION 7: PAYMENT TO *PROVIDERS* AND CLAIMS FILING INFORMATION

Do I need to submit a claim for my in-network medical care?
No, *you* do not need to submit a claim. When *you* receive medical care from an in-*network participating provider*, including a *participating hospital*, that *participating provider* will submit all claims for *you*.

You must pay any *copayment* at the time of service. A *participating provider* may seek payment from *you* only for *deductible*s, *copayments*, *coinsurances* and for charges for *non-covered services*. Most of the time, *you* will not need to make a payment for *covered services*. After claims have been adjudicated, *your participating provider* will bill *you* for any services that are subject to *coinsurance*.

Do I need to submit a claim form for out-of-network care?
When services are provided by a *non-participating provider* or in the case of *emergency* medical services, *you* may need to pay the *provider* and then submit a claim. A *non-participating provider* may require *you* to pay any charges that are above the *Maximum allowable amount*. Please contact Member Services at the number shown on the Important Numbers page of this *Certificate*. They will provide instructions and a mailing address.

When will my claim be paid?
Claims will be paid within 45-days when filed on paper and 30 days when filed electronically after *ADVANTAGE* receives all information required to determine liability under the terms of this *Certificate.* If *ADVANTAGE* denies all or part *your* claim, *ADVANTAGE* (or *ADVANTAGE*'s designated agent) will provide *you* with a written notice that includes the reason(s) for denial.

When do I need to submit my claim?
A claim for a *participating provider* must be submitted within 90-days after the date the services are received or the date *you* made payment.

However, failure to give notice within the 90-day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within the period and that notice was given as soon as was reasonably possible.

Claims for *covered services* rendered by *providers* not *participating* with *ADVANTAGE* should be sent to the mailing address indicated in the "Network Administrator" section of *your ID card*. If a charge is made to *you* for any service that is reimbursable under the *Certificate*, written proof of such charge must be submitted to *ADVANTAGE* within 45-days after delivery of the service and must include an itemized statement plus diagnosis. Failure to furnish this documentation within the specific period will invalidate or reduce the claim unless, for a good reason, it was not possible to submit the claim within the specific period, and proof is produced on a timely basis as soon as possible thereafter.

ADVANTAGE will ordinarily make payment for *covered services* directly to the person or institution providing the services. However, if *you* furnish evidence that payment has been made by the *subscriber* to such person or institution for *covered services*, reimbursement will be made to the *subscriber* after deducting any payment made by *ADVANTAGE* before receipt of such evidence.

ADVANTAGE, at *ADVANTAGE's* own expense, shall have the right and opportunity to examine the *member* whose sickness or *injury* is the basis of a claim as often as it may reasonably require during the claim period.

Claims disputed by *you* will be resolved by the procedures set forth in this *Certificate*.

What do I do if I receive a bill for in-network medical care?
If *you* should receive a bill for in-network medical services for which *you* are not responsible, please call Member Services at the number shown on the Important Numbers page of this *Certificate*.

SECTION 8: *COORDINATION OF BENEFITS* WITH OTHER *COVERAGE*

This *coordination of benefits* (*COB*) provision applies when a person has health care *coverage* under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determines which *plan* will pay as the primary plan. The primary *plan* that pays first pays without regard to the possibility that another *plan* may cover some expenses. A secondary *plan* pays after the primary *plan* and may reduce the benefits it pays so that payments from all *Group plans* do not exceed 100% of the total allowable expense.

Definitions

- A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated *coverage* for members for a *Group*, the separate contracts are considered parts of the same *plan* and there is no *COB* among those separate contracts.
  (1) "Plan" includes: *Group* insurance, closed panel or other forms of *Group* or *Group*-type *coverage* (whether insured or uninsured); *hospital* indemnity benefits in excess of $100 per day; medical care components of *Group* long-term care contracts, such as skilled nursing care; medical benefits under *Group* or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  (2) "Plan" does not include: individual or family insurance; closed panel or other individual *coverage* (except for *Group*-type *coverage*); amounts of *hospital* indemnity insurance of $100 or less per day; school accident type *coverage*, benefits for non-medical components of *Group* long-term care policies; Medicare supplement policies, Medicaid policies and *coverage* under other governmental *plan*s, unless permitted by law.

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

- The order of benefit determination rules determine whether this *plan* is "primary plan" or "secondary plan" when compared to another *plan* covering the person.

  When this *plan* is primary, its benefits are determined before those of any other *plan* and without considering any other *plan*'s benefits. When this *plan* is secondary, its benefits are determined after those of another *plan* and may be reduced because of the primary *plan*'s benefits.

- "Allowable expense" means a health care service or expense, including *deductible*s and *copayment*s that are covered at least in part by any of the *plan*s covering the person. When a *plan* provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plan*s is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expense*s:
  (1) If a covered person is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the *plan*s routinely provides *coverage* for *hospital* private rooms) is not an *allowable expense*.
  (2) If a person is covered by 2 or more *plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expense*.
  (3) If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the primary *plan*'s payment arrangements shall be the *allowable expense* for all *plan*s.
  (4) The amount a benefit is reduced by the primary *plan* because a covered person does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred *provider* arrangements.

- "Claim determination period" means a *calendar year*. However, it does not include any part of a year during which a person has no *coverage* under this *plan*, or before the date this *COB* provision or a similar provision takes effect.

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

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

Order of Determination Benefits Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary *plan* pays or provides its benefits as if the secondary *plan* or *plan*s did not exist.
- A *plan* that does not contain a *coordination of benefits* provision that is consistent with this regulation is always primary. There is one exception: *coverage* that is obtained by virtue of membership in a *Group* that is designed to supplement a part of a basic package of benefits may provide that the supplementary *coverage* shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical *coverage*s that are superimposed over base *plan hospital* and surgical benefits, and insurance type *coverage*'s that are written in connection with a *closed panel plan* to provide out-of-network benefits.
- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is secondary to that other *plan*.
- The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.
  1. Non-Dependent or Dependent. The *plan* that covers the person other than as a dependent, for example as an employee, *member*, *subscriber* or retiree is primary and the *plan* that covers the person as a dependent is secondary. However, if the

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

2. Child Covered Under More Than One *Plan*. The order of benefits when a child is covered by more than one *plan* is:
   a. The primary *plan* is the *plan* of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care *coverage*.

      If both parents have the same birthday, the *plan* that covered either of the parents longer is primary.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care *coverage* and the *plan* of that parent has actual knowledge of those terms, that *plan* is primary. This rule applies to *claim determination period*s or *plan* years commencing after the *plan* is given notice of the court decree.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The *plan* of the *custodial parent*;
      - The *plan* of the *spouse* of the *custodial parent*;
      - The *plan* of the non-*custodial parent*; and then
      - The *plan* of the *spouse* of the non-*custodial parent*.
3. Active or Inactive Employee. The *plan* that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other *plan* does not have this rule, and if, as a result, the *plan*s do not agree on the order of benefits, this rule is ignored. *Coverage* provided an individual as a retired worker and as a dependent of an actively working *spouse* will be determined under the rule labeled B (1).
4. Continuation *Coverage*. If a person whose *coverage* is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an employee, *member*, *subscriber* or retiree (or as that person's dependent) is primary, and the continuation *coverage* is secondary. If the other *plan* does not have this rule, and if, as a result, the *plan*s do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of *coverage*. The *plan* that covered the person as an employee, *member*, *subscriber* or retiree longer is primary.
6. If the preceding rules do not determine the primary *plan*, the *allowable expense*s shall be shared equally between the *plan*s meeting the definition of *plan* under this regulation. In addition, this *plan* will not pay more than it would have paid had it been primary.

Effect on the Benefit of this *Plan*

- When this *plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *plan*s during a *claim determination period* are not more than 100 percent of total *allowable expense*s. The difference between the benefit payments that this *plan* would have paid had it been the primary *plan* and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this *plan* to pay any *allowable expense*s, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will:
  1. Determine its obligation to pay or provide benefits under its *contract*;
  2. Determine whether a benefit reserve has been recorded for the covered person; and
  3. Determine whether there are any unpaid *allowable expense*s during that claims determination period.

  If there is a benefit reserve, the secondary *plan* will use the covered person's benefit reserve to pay up to 100% of total *allowable expense*s incurred during the *claim determination period*. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

- If a covered person is enrolled in two or more *closed panel plan*s and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*; *COB* shall not apply between that *plan* and other *closed panel plan*s.

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, *ADVANTAGE* may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under

this *plan*. *ADVANTAGE* will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

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

SECTION 9: SUBROGATION/RIGHT OF REIMBURSEMENT

Subrogation means: If *your injury* or *illness* is caused by the acts or omissions of another party (including insurance *carriers* who are so liable), and *ADVANTAGE* has provided benefits under this *Certificate*, *ADVANTAGE* will have the right to be reimbursed if *you* receive any payment from the other party.

- *ADVANTAGE* is subrogated to all of *your* rights against any party legally liable to pay for *your injury* or *illness*.
- *ADVANTAGE* may assert this right independently of *you*.
- *You*, or anyone acting legally on *your* behalf must:
  - fully cooperate with *ADVANTAGE* in order to protect *ADVANTAGE*'s subrogation rights;
  - give notice of *ADVANTAGE*'s claim to third parties and their insurers who may be legally responsible;
  - provide *ADVANTAGE* with relevant information and sign and deliver such documents as *ADVANTAGE* reasonably request to secure *ADVANTAGE*'s subrogation claim; and
  - obtain *ADVANTAGE*'s consent before releasing any party from liability for medical expenses or services paid or provided.

If *you* enter into litigation or settlement negotiations regarding the obligations of other parties, *you* must not prejudice, in any way, *ADVANTAGE*'s subrogation rights.

SECTION 10: TERMINATION OF *COVERAGE*

The *coverage* provided in this *Certificate* for *you* and *your eligible dependents* and *young adults*, if any, may be terminated by *ADVANTAGE* upon the occurrence of any of the following events:

- You revoke your consent for ADVANTAGE to utilize your personal medical information for future, known, or routine needs for the purpose of treatment, payment, and health care operations.
- The termination of the *Contract* between *your Group* and *ADVANTAGE*.
- The *Group* fails to pay *ADVANTAGE premium* due on *your* behalf.
- *You* no longer qualify for eligibility based on the requirement of working or residing within the defined *ADVANTAGE service area.*
- Upon thirty-one (31) days prior written notice by *ADVANTAGE* if:
  - *You* fail to pay *copayments* or *coinsurance* required for *covered services*, or *premium* contributions, if any; or
  - *You* are unable to establish and maintain a satisfactory *hospital* or patient-*health professional* relationship with *participating hospitals* and *health professionals*; or
  - *You* commit fraud against *ADVANTAGE* or a *participating provider* by, for example:
    Allowing a non-*member* to use *your ADVANTAGE ID card* to obtain services;
    - Making any false statement or representation on *your* membership application;
    - Falsifying a prescription, stealing or otherwise misappropriating a prescription blank(s) or other property of a *participating provider* of *ADVANTAGE*;
    - Altering *your* medical record; or
    - Obtaining similar drug therapy or prescriptions from two or more *providers*, without *proper referral* or without informing the *providers* of *your* complete prescription profile, when done for the purpose of providing such prescriptions to someone other than the person for whom the medication was intended or for the purpose of self-administration of multiple prescriptions without the knowledge or approval of *your PCP*.
- *You* behave in a violent or abusive manner toward the staff of an *ADVANTAGE participating physician*, a *provider network*, or *ADVANTAGE*;
- *You* otherwise repeatedly violate the terms of this *Certificate* or *ADVANTAGE* rules; or
- *You* fail to cooperate with *ADVANTAGE* in the administration of the *coordination of benefits* provisions set forth in this *Certificate*.
- For other good cause as may from time to time be permitted by law. If membership is terminated for any of the grounds specified in this section, all rights to service cease as of the date of termination and there is no right to convert to an individual *carrier*.
- *Your spouse* will cease to be eligible for *coverage* hereunder on the first of the month following the month in which a final decree of dissolution of the marriage is recorded, unless *coverage* is continued in accordance with the terms of this *Certificate* or unless terminated sooner pursuant to the terms of this *Certificate.*

- If *you* are eligible to be covered under Medicare, *you* must enroll in Part A and Part B Medicare *coverage* on the date eligible in order to continue *coverage* under this *Certificate*. An exception to this rule applies to an actively employed *member* or the *spouse* of an actively employed *member* when *ADVANTAGE* is the primary payor. "Deemed Entitlement to Medicare" means any Covered Person who is an eligible retiree or the *spouse* of an eligible retiree shall be deemed to have enrolled for all Medicare Part A and Part B *Coverage* for which such Covered Person is eligible at the time such Covered Person first becomes eligible as if such Covered Person were enrolled in all such Medicate *Coverage*. In cases where Medicare is primary, the Plan estimates Medicare's primary share and pays only the secondary charges.
- *Your* child's *coverage* will terminate once he/she has reached the attainment of the limiting age, unless *coverage* is extended as described in the "Eligibility, Enrollment, *Coverage*" Section of this *Certificate* or is terminated sooner due to the terms of this *Certificate* . If you wish to obtain coverage under the Young Adult Coverage Rider you must notify your employer within 31 days of the dependent reaching the limiting age otherwise coverage will terminate.
- Termination of *coverage* for *you* and any enrolled family members, including a *young adult* due to termination of employment shall be determined by the *Group*; not withstanding any continuation of *coverage* addressed elsewhere in this *Certificate* .

If *you* believe that *coverage* has been canceled or not renewed because of *your* health status, need for health care services or exercise of *your* rights under the *grievance* procedure, *you* may request review by *ADVANTAGE* or by the Department of Insurance. Please refer to the "*Grievance*s and Appeals" Section of this *Certificate.*

In the event of the termination of the *Contract* between *Group* and *ADVANTAGE* or enrollment termination of any individual *member*, *coverage* for any prescription medication provided for under this *Certificate* will only be provided for the specific quantity of prescription medication that will actually be used or consumed by the *member* through the last day of eligibility, regardless of the pharmacy source for the medication. *Member* will be financially responsible for all quantities of prescription medication that will be used or consumed after the last day of eligibility, even if that medication is dispensed as part of a prescription partially covered by this *Certificate* prior to the termination.

Voluntary termination

- If *you* choose *coverage* under any other Plan that is offered by, through, or in connection with *your Group,* in lieu of *coverage* with *ADVANTAGE*, *coverage* for *you* and *your eligible dependents* will terminate on the date and time that the other *coverage* becomes effective. *Your Group* agrees to notify *ADVANTAGE* immediately when *you* elect other *coverage*.
- *You* may terminate *your coverage* and *your eligible dependent'(s')* or *young adult'(s') coverage*, if there is a qualified change in family status or during open enrollment, by giving written notice to *your Group*. The termination shall be effective on the last day of the month upon receipt of such notice by *ADVANTAGE* unless otherwise specified.

Your coverage (and *dependents* or *young adults* if applicable) shall terminate on the date determined by *your Group*.

Certificates of *Creditable Coverage*

If *your coverage* with *ADVANTAGE* terminates, *you* may be asked by the replacement *carrier* for a Certificate of *Creditable Coverage*. "*Creditable Coverage*," with respect to an individual, is *coverage* of the individual under any of the following types of insurance plans:

- a *Group* health plan or individual health plan;
- Part A or B of Medicare;
- Medicaid;
- CHAMPUS;
- a medical care program of the Indian Health Service or tribal organizations;
- a state health benefits risk pool, such as Children's Health Insurance Program;
- the federal employees health benefits program;
- a public health plan; (a plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance *coverage* to individuals);
- a health benefit plan under the Peace Corps Act; or
- a church plan.

In the event that *you* disenroll from *ADVANTAGE*, the Certificate of *Creditable Coverage* will help *your* new insurance *carrier* determine to what extent its *preexisting medical condition* exclusions apply, if any. If *you* were not without *coverage* for more than 63 days, the new insurance company must reduce its *preexisting medical condition* exclusions under *your* new insurance policy. *ADVANTAGE* will provide *you* with a Certificate of *Creditable Coverage* upon *your* disenrollment that will show the *effective date* of *your coverage* with *ADVANTAGE*. *ADVANTAGE* will make these Certificates available when:

- *You* are no longer eligible with *ADVANTAGE*;
- *You* reach the end of Consolidated Omnibus Budget Reconciliation (COBRA) *coverage*; and/or
- Upon *your* request, but only if the request is made within 24 months after *coverage* ends. *ADVANTAGE* will also provide to *your* new insurance *carrier*, upon request, a *Certificate* explaining *your* benefits under *ADVANTAGE*

SECTION 11: CONTINUATION OF *COVERAGE*

Do I have the option of continuing my *coverage* after termination?

- **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986**

  If *you* are covered under a *Group* which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the following shall apply:

  In order to obtain COBRA to continue *coverage* under this *Certificate*, *your Group* must:
  - notify *you* of *your* right to continued *Group coverage*, as required by federal law;
  - notify *ADVANTAGE* as soon as possible when *you* elect COBRA, including the date *your* COBRA *coverage* becomes effective;
  - collect and forward all applicable *premiums* to *ADVANTAGE* on a timely basis.

  If *you* have any questions about COBRA, *you* should speak with *your Group* directly.

- **Continuation of *Coverage* under Disability**

  You may become totally disabled while covered under this *Certificate* and still be totally disabled at the time this *Certificate* terminates or non-renews. If so, and if *you* pay the *premiums* that apply, *you* will be allowed to extend *your* benefits, under this *Certificate,* for the condition causing such disability, until the sooner of:
  - The date *you* become covered under, or eligible to be covered under, another *carrier* or policy affording similar benefits;
  - A period of three (3) months from the date *coverage* hereunder would have otherwise ended had *you* not been so disabled; or
  - The date *you* cease to be totally disabled.

  Benefits will not be said to be "similar" if *you* would be subject to a *pre-existing medical condition* or waiting period covering the disabling condition under the replacement policy. For the purposes of this *Certificate* , "total disability" means a disease or bodily *injury* (excluding normal pregnancy) which, in fact prevents or may reasonably be expected to prevent *you* from engaging, for a period of at least one (1) year, in any work for which *you* are or become qualified by reason of education, training or experience; or which prevents or may be expected to prevent *you* from performing, for a period of at least one (1) year, the important activities normal for a person of that age and family status. The fact that *you* are in the *hospital* at the time the *Certificate* ends is not by itself proof of "total disability". Nothing in this Section shall be deemed to prevent *ADVANTAGE* from coordinating benefits with the prior *carrier* or with another *Group carrier* with whom a totally disabled *member* may have health care *coverage*.

- **Individual Conversion**

  You may be eligible to obtain Individual Conversion *coverage* after *your* benefits with *your Group*, *ADVANTAGE* and/or COBRA expire. The *Individual Conversion Contract* is provided through *ADVANTAGE* Health Solutions, Inc. To obtain more information, contact ADVANTAGE Health Solutions at 9045 River Road, Ste 200 Indianapolis IN 46240, 1-800-553-8933.

  You may be entitled to an *Individual Conversion Contract*, without evidence of insurability, if:

  - *You* meet the eligibility requirements for an *Individual Conversion Contract* pursuant to Indiana Code 27-8-15-31;
  - *You* were continuously covered under this *Certificate* for at least 90-days;
  - *You* request the conversion policy from *ADVANTAGE* within 30 days of loss of *coverage*; and
  - *You* cease to be covered under this *Certificate* as a result of:
    - leaving *your Group* or a reduction in *your* hours of employment;
    - the *subscriber's* death or termination of marriage; or
    - ceasing to meet the definition of *eligible dependent.*

  If eligible for COBRA *coverage*, *you* must exhaust COBRA *coverage* before requesting a conversion policy. The conversion policy will be issued without regard to health status or requirements for health care services. If *you* elect to exercise this conversion privilege, the conversion shall be effective retroactive to the date and time *coverage* terminated under this *Certificate*, subject to the payment of any applicable *premium* due.

  You must pay *ADVANTAGE*, less any *copayment* and *coinsurance*, for the reasonable value of health services or benefits provided under this *Certificate* during the 30-day election period, if the conversion privilege is not exercised.

- **Extension of *Coverage* If *You* Are Confined to the *Hospital***

  If *you* are *hospital*ized for a medical or surgical condition on the date of termination of this *Certificate, you* will have continuation of *coverage* for *inpatient* services until the sooner of:
  - *Your* discharge from the *hospital*;
  - Sixty (60) days pass after the termination date of this *Certificate* ;
  - *You* obtain *coverage* from another *carrier* which includes *coverage* for *inpatient* services provided by this *Certificate* ;
  - Termination of *your Group's Group Service Agreement* by *ADVANTAGE*, as determined by:

- The *effective date* specified in written communication sent to *ADVANTAGE* by *your Group*, or
- Failure to pay a *premium* within the grace period permitted under the *Group Service Agreement*.

- Termination of *your coverage* and this *Certificate* by *ADVANTAGE* due to:
  - *You* knowingly providing false information to *ADVANTAGE*;
  - *Your* failure to comply with the rules stated in this *Certificate* ; or
  - *You* fail to pay *premium* within the grace period permitted in *your Group's Group Service Agreement*.

- **Exceptions to Continuation of *Coverage* and Conversion**

  Neither *you* nor *your eligible dependents* will be eligible for continuation of *coverage* under COBRA or for conversion to an *Individual Conversion Contract* if any of the following circumstances apply:

  - *You* do not meet the eligibility guidelines for an *Individual Conversion Contract* set forth in Indiana Code 27-8-15-31;
  - *Coverage* was terminated by *ADVANTAGE* or *your Group*; or
  - *You* have moved out of the geographic area in which *ADVANTAGE* is licensed to operate (Applies to individual conversion only).

In the event that *you* are deemed ineligible for conversion, *your eligible dependents* will also be deemed ineligible for conversion, unless otherwise required by law.

SECTION 12: OTHER IMPORTANT INFORMATION

Care Management
ADVANTAGE is committed to providing *members* with highest quality of care in the most cost-effective manner. In order to meet this endeavor, *ADVANTAGE* manages care using the following:

- Proper Referral Process –If services are not available within the *participating provider network*, *ADVANTAGE* will work with the *member* and *referring physician* to refer the *member* to the appropriate *provider* of service based on their condition.

- *Pre-Certification* – Pre-approval or certification of certain services (i.e. Physical Therapy, *Hospitali*zations, etc.). *Your referring physician* is responsible for obtaining any *pre-certifications* unless *you* are a Point of Service *member*, where this is *your* responsibility.

- Concurrent Review – A review conducted of all *inpatient* admissions to assess whether there is a need for a continued stay. This process ensures that *members* only stay as long as *medically necessary* and at the same time are not discharged prior to necessity.

- Discharge Planning – This process is in place to ensure appropriate and timely discharge from the *hospital* to a more appropriate level and setting of care such as home health care.

- Case Management – This program is designed to be used in cases of *members* who are in need of long term care. A nurse is assigned to the *member* to work with the *member's physicians* and the *member* about a treatment plan. The patient, *provider* and Case Manager must all agree on the most cost effective treatment method, while assuring quality medical care.

- Preventive Health – Each of *ADVANTAGE's* benefit plans offer preventative health benefits designed to promote wellness and early detection of potential health problems.

- Disease Management –*ADVANTAGE* empowers *members* who have conditions like Asthma, Hypertension, Cardiac Heart Failure, Depression, and Diabetes by providing them information on their condition to assist them with their conditions. *ADVANTAGE* provides them with newsletters and other materials on their conditions. Also, a member can choose to enroll and actively participate in *ADVANTAGE'*s Disease Management to receive discounted copays for certain disease-specific medications.

***Provider* Termination**
- Occasionally, a *physician* may no longer participate with *ADVANTAGE* due to retirement, death, relocation, termination, etc. If *your PCP* or *SCP* ceases to be an *ADVANTAGE participating provider*, *ADVANTAGE*'s Member Services Department will make good faith efforts to notify *you* within 30 days prior to the *effective date* of termination. *You* will receive instructions on how to select a new *physician*.

- If *you* are currently in active treatment with the terminating *physician*, or *you* are in *your* third trimester of pregnancy, please contact an *ADVANTAGE* Member Services Representative. *You* may be able to continue *your* care with the *physician* until the completion of *your* treatment or up to 90-days, whichever is shorter. A representative will assist *you* or direct *you* to *ADVANTAGE*'s Care Coordinator. *ADVANTAGE*'s goal is to ensure *you* have access to continuity of care until *your* current treatment plan has ended, or until *your* pregnancy has been delivered.

- If *you* need an updated *Provider Directory* or other assistance in selecting a *physician*, *ADVANTAGE*'s Member Services Department will help *you*.

- Upon termination of a contract with a *participating provider, ADVANTAGE* shall be liable for payment of *covered services* rendered by the *provider* to *you* under the care of the *provider* at the time of termination until services being rendered to *you* by the *provider* are completed, unless *ADVANTAGE* makes reasonable and medically appropriate provision for assumption for services by another *provider*.

Notice of Material *Provider* Change
ADVANTAGE will provide written notice to *you*, within a reasonable time, after learning of an action by a *participating provider* that has a material effect on the *Group* or *you*. Examples of such actions may include: leaving *ADVANTAGE*'s *participating provider network*; material breach of contract; or being unable to perform key contract terms, but only if any of those actions affects *you* in a material way.

Utilization Management (UM) Decision Maker
- UM decision making is based only on appropriateness of care and service and existence of *coverage*.
- *ADVANTAGE* does not specifically reward *provider*s or other individuals for issuing denials of *coverage* or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Medical Technology Assessment
- *ADVANTAGE* provides a process to evaluate new medical technologies, services and pharmacological treatment to assure appropriate access to such services by the *member* population. *ADVANTAGE* develops protocols for new technology proactively and reactively. As *ADVANTAGE* becomes aware of new technology, the new technology guidelines outlined in this process are followed to prepare *ADVANTAGE*'s position regarding the new technology in anticipation of a future request.
- The *member's physician* must request an approval, prior to the service date and in writing, regarding the recommended treatment or service that is a new medical technology, *experimental* or investigative treatments and services.
- *ADVANTAGE* has available participating specialists, sub-specialists, pharmacists, and a referral center (Hayes, Inc.) to assist with the review and determination regarding new medical technology.
- *ADVANTAGE* contracts with Hayes, Inc. to provide a database and access to research regarding various medical technologies, including new use of existing technologies and newly developed technologies. Elements of the Hayes technology assessment process include:
  - Application of rigorous methods of scientific inquiry which encompass a thorough search of the peer-reviewed scientific literature
  - Critical appraisal of the data reported with respect to study design and clinical significance of outcomes
  - Comparative analysis of alternatives

  There are many healthcare technologies assessed by Hayes, Inc. and accessible to *ADVANTAGE* including:
  - Medical and surgical procedures, including transplants
  - Drugs and pharmaceuticals
  - Diagnostic and screening tests
  - Alternative therapies
  - Behavioral Health procedures
  - Medical devices/equipment
- Requests for approval of new medical technology procedures/services that involve a *member* whose health situation is life threatening will be resolved and the *physician*/*member* notified within 72 hours of the request.
- Technology assessments for non-urgent situations should be submitted 5-7 days prior to the service date if possible to allow adequate time to investigate the proposed treatment or service. A response to a written request for non-urgent technology assessment is provided within 15 *calendar* days of receiving the request. Medical Management notifies the *PCP*, *SCP*, and facility by telephone of the recommendation to approve or deny *coverage* within one business day. Notification letters are mailed to the *PCP*, *SCP*, and *member* within two (2) business days of the determination to approve or deny new medical technology.
- If the Medical Director denies a request for a new technology service/procedure, a denial notification letter is sent to the *member*, *PCP*, and *SCP* outlining the principle reason for the denial, criteria utilized, and the appeals process.

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

Worker's Compensation
This *Certificate* is not in lieu of and does not affect any requirement or *coverage* by Worker's Compensation Insurance.

Rights to *Covered services* Not Transferable
No person other than *you* or *your eligible dependent* is entitled to receive health care services or other benefits to be furnished by *ADVANTAGE* under this *Certificate*. The right to health care services or other benefits is not transferable.

Right to Change Control when required by Law
ADVANTAGE will apply this *Certificate* in agreement with state and federal laws and regulations. If any part of this *Certificate* does not agree with state or federal laws or regulations, this *Certificate* is deemed amended and *ADVANTAGE* will change *ADVANTAGE*'s procedures to conform to the laws and regulations. *ADVANTAGE* reserves the right to terminate the C*ontract* and re-rate the C*ontract* based on the changes at the time of renewal of this *Certificate*.

Assignment of Benefits Payments
You are not permitted to assign benefits or payments for services covered under this *Certificate*.

Relationship Among Parties Affected by this *Certificate*

- The relationship between *ADVANTAGE* and participating *health professional*s and/or *provider networks* is that of independent contractors. *ADVANTAGE* is not a "professional" corporation and so does not practice medicine or direct the professional practice of medicine by any *health professional*. Neither participating *health professional*s nor *provider networks* are employees of *ADVANTAGE*, nor are they agents of *ADVANTAGE*. Nor is *ADVANTAGE* or any of *ADVANTAGE*'s employees an employee or agent of the *health professional*s or *provider networks* who participate in *ADVANTAGE*'s provider panel. *Health professional*s are responsible for maintaining professional-patient relationships with the *member*. *Health professional*s are solely responsible to the *member* for all medical services.

- *Participating providers* may receive a financial incentive from *ADVANTAGE* to appropriately manage the provision and cost of services rendered to *you*.

- Neither the *Group*, nor any *member*, is an agent or representative of *ADVANTAGE*. Neither the *Group,* nor any *member,* shall be liable for any acts or omissions of *ADVANTAGE*, *ADVANTAGE*'s agents or employees, or of any *participating health professional*, or *participating hospital*, or any other person or organization with which *ADVANTAGE*, *ADVANTAGE*'s agents or employee, has contracted for the performance of services under this *Certificate*.

- Certain *members* may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by an *ADVANTAGE participating health professional*. *Health professionals* shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the *member's* wishes, insofar as this can be done consistently with the *participating health professional's* judgment as to the requirements of proper medical practice. If a *member* refuses to follow a recommendation treatment or procedure, and a *participating health professional* believes that no professionally acceptable alternative exists, such *member* shall be so advised. The *member* will have the right to consultation (*second opinion*) from an appropriate *ADVANTAGE participating physician* regarding his or her medical condition. If both *participating physicians* agree as to the course of treatment, and the *member* still refuses to follow the recommendation, *ADVANTAGE* will cease to *provide covered services* or pay for treatment for such condition. At such time the *member* agrees to follow the recommended treatment or procedure, *covered services* will resume.

SECTION 13: NOTICE OF PRIVACY PRACTICES

ADVANTAGE is required by applicable federal and state laws to maintain the privacy of *your* health information. We are also required to give *you* this notice about our privacy practices, our legal duties, and *your* rights concerning *your* health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2005, and will remain in effect until we replace it.

ADVANTAGE reserves the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. *ADVANTAGE* reserves the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information *ADVANTAGE* created or received before we made the changes. Before we make significant change in our privacy practices, *ADVANTAGE* will change this notice and send the new notice to our health *subscribers* at the time of the change.

You may request a copy of our notice at any time. If *you* would like to request a copy or obtain additional information, please contact us using the contact information listed at the end of this notice.

Uses and Disclosures of Health Information
The sections below describe the ways *ADVANTAGE* uses and releases *your* health information. *Your* health information is not shared with anyone who does not have a "need to know" to perform one of the tasks listed below.

- **Treatment**: *ADVANTAGE* may use *your* health information or disclose it to third parties to coordinate and oversee *your* medical care. For example, we may use *your* health information to help *you* find a doctor or a *hospital* that can treat *your* specific health needs.

- **Payment**: *ADVANTAGE* may use *your* health information or disclose it to third parties to pay for *your* medical care. For example, we may use *your* health information when we receive a claim for payment. *Your* claims tell us what services *you* received and may include a diagnosis. *ADVANTAGE* may also disclose this information to another insurer if *you* are covered under more than one health plan.

NOTE: Non-English speaking *member*s can access Member Services, Utilization Management and Care Coordination, and other *ADVANTAGE* services for *member* treatment, payment or *ADVANTAGE* operations. *ADVANTAGE* contracts with Language Line Services to assist non-English speaking *member*s in accessing *ADVANTAGE* resources and getting answers to questions. The interpreters may communicate directly with the *member* and *ADVANTAGE* representatives to resolve *member* questions. The communication may include information related to *your* health care. As concepts familiar to English speakers often require explanation or elaboration in other languages and cultures, the interpreters will then convey the communications meaning-for-meaning not necessarily word-for-word.

- **Health Care Operations**: *ADVANTAGE* may use *your* health information and disclose it to third parties in order to assist in *ADVANTAGE*'s everyday work activities such as looking at the quality of *your* care, carrying out utilization review, and *ADVANTAGE*'s business planning. For example, *your* health information may be released to members of *ADVANTAGE* staff to review the quality of care and outcomes. *Your* health information may be released to doctors or doctor groups involved in *your* care to improve patient care. Additionally, *ADVANTAGE* publishes the Health Group Data Information Set (HEDIS) which is a report of *ADVANTAGE member*'s health care measurement data. *ADVANTAGE* also publishes the Commercial Adult Health Plan Survey (CAHPS) results, which measures *ADVANTAGE member* satisfaction. *ADVANTAGE*'s policy reflects that we utilize methodologies that protect the identity of individual *member*s, such as not connecting specific survey responses to individual *member*s, not providing any *member* specific data in the measurement data, etc.

  NOTE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to inform you of your right, our legal duties and our privacy practices. By enrolling in this Plan, *you* understand that *ADVANTAGE* has the right to utilize *your* personal medical information for future, known or routine needs for the purposes of treatment, payment, and health care operations. ***You* understand this consent is a condition of *your* enrollment in *ADVANTAGE* and *you* have the right to revoke this consent in writing at any time.**

- **To *You* and Upon *Your* Authorization**: *ADVANTAGE* must disclose *your* health information to *you*, as described in the Individual Rights section of this notice, below. *You* may give us written authorization to use *your* health information or to disclose it to anyone for any purpose. If *you* give us an authorization, *you* may revoke it in writing at any time. *Your* revocation will not affect any use or disclosure permitted by *your* authorization while it was in effect. Without *your* authorization, we may not use or disclose *your* health information for any reason except those described in this notice

- **To *Spouse* or Parent:** Unless *you* specifically request that *ADVANTAGE* not disclose such information, *ADVANTAGE* may disclose *your* health information to *your spouse* or parent, in compliance with applicable privacy laws, to help with *your* health care or payment for health care services. *Your* request to not disclose health information to a *spouse* or parent must be in writing, signed by the individual authorized to make such a request, and sent to the Contact Information listed at the end of this notice.

- **To Plan Sponsor (*Group*):** *ADVANTAGE* may disclose limited summary health information about *you* to *your* plan sponsor (*Group*). "Summary Health Information" is information that summarizes the claims history, claims expenses or types of claims experienced by *you* and other members of *your Group* health plan, from which specific identifiers have been deleted. However, *ADVANTAGE* may disclose *your* identifiable health information and the identifiable health information of others enrolled in *your Group* health plan to *your* plan sponsor (*Group*) only:
  1. If *you* authorize us to disclose the information by completing an authorization form; or
  2. If necessary for the *Group* to perform plan administration functions on behalf of the *Group* health plan, and *ADVANTAGE* receives a certification from the plan sponsor (*Group)* that satisfies all of the requirements of HIPAA, which allow for the release of identifiable health information.

- **To Family and Friends**: If *you* agree, or if *you* are unavailable to agree, when the situation, such as medical *emergency* or disaster relief, indicates that disclosure would be in *your* best interest, *ADVANTAGE* may disclose *your* health information to a family member, friend or other person to the extent necessary to help with *your* health care services.

- **Underwriting**: *ADVANTAGE* may receive *your* health information for underwriting, *premium* rating or other activities relating to the creation, renewal or replacement of a C*ontract* of health insurance or health benefits. We will not use or further disclose this health information for any other purpose, except as required by law, unless the *Contract* of health insurance or health benefits is placed with us. In that case, our use and disclosure of *your* health information will only be as described in this notice.

- **Marketing**: *ADVANTAGE* may use *your* health information to contact *you* with information about health-related benefits and services, including but not limited to, *ADVANTAGE*'s disease management programs and *quality improvement* activities that may be of interest to *you*. We may disclose *your* health information to a business associate to assist us in these activities. Unless the information is provided to *you* by a general newsletter, in person, or is for products or services of nominal value, *you* may opt-out of receiving further such information by telling us using the contact information listed at the end of this notice.

- **Research; Death; Organ Donation**: *ADVANTAGE* may use or disclose *your* health information for research purposes in limited circumstances. We may disclose the health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety**: *ADVANTAGE* may disclose *your* health information to the extent necessary to avert a serious and imminent threat to *your* health or safety or the health or safety of others. We may disclose *your* health information to a government agency authorized to oversee the health care system or government programs or its contractors, and public health authorities for public health purposes. We may disclose *your* health information to appropriate authorities if we reasonably believe that *you* are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law**: *ADVANTAGE* may use or disclose *your* health information when we are required to do so by law. For example, we must disclose *your* health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy law. We may disclose *your* health information when authorized by workers' compensation or similar laws.
- **Process and Proceedings**: *ADVANTAGE* may disclose *your* health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose *your* health information to law enforcement officials.
- **Law Enforcement**: *ADVANTAGE* may disclose limited information to a law enforcement official concerning the health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the health information of any inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security**: *ADVANTAGE* may disclose to Military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses of Health Information – By Authorization Only
Other uses and disclosures of health information not covered by this Notice or the law that apply to us will be made only with *your* written authorization. If *you* provide us with an authorization to use or release health information about *you*, *you* may end that authorization, in writing, at any time. If *you* end *your* authorization, we will no longer use or release health information about *you* for the reasons covered by our written authorization. *You* understand that we are unable to take back any disclosures we have already made with *your* authorization.

A parent, legal guardian, or properly named patient advocate may represent *you* if *you* cannot provide an authorization. Authorization is needed for certain release of information dealing with mental health issues, substance abuse issues, HIV/AIDS and *grievance*s. We can provide *you* with a sample authorization form. *You* may also end an authorization by writing to *ADVANTAGE* at the contact information list at the end of this Notice.

Confidentiality in All Settings
ADVANTAGE has policies and procedures in place that protect the privacy of *your* information.
- Every employee signs a statement when they are hired that they understand they are required to keep *member* information private. They also learn about the actions the company will take if the privacy policies are not followed.
- *ADVANTAGE* has strict control of access to electronic, and paper information specific to *member*s. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for *member*s.

ADVANTAGE tells all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours. In addition, *ADVANTAGE* will not share any *member* information with a *Group* without specific authorization from the *member*.

ADVANTAGE's Compliance Committee reviews our confidentiality policies and procedures every year. These committees also reviews how we collect, use, dispose of, and disclose *your* information. *Members* (or prospective *members)* and *providers* have the right to review *ADVANTAGE*'s privacy policies and procedures. *You* may get copies by contacting Member Services.

Changes to this Notice
ADVANTAGE has the right to change the terms of this Notice. We have the right to make these changes, which apply to health information we already have about *you* as well as any we receive in the future. We will always post a copy of the current Notice on *ADVANTAGE*'s web site. *You* will also receive materially revised Notices within 60 days of their effective date.

Individual Rights
- **Access**: *You* have the right to inspect or obtain copies of *your* health information, with limited exceptions. *You* may request that *ADVANTAGE* provide copies in a format other than photocopies (i.e. electronic). We will use the format *you* request unless we cannot practicably do so.

- **Disclosure Accounting**: *You* have the right to receive a list of instances in which *ADVANTAGE* or our business associates disclosed *your* health information obtained or created since April 14, 2003 for purposes other than treatment, payment or health care operations and certain other authorizations. We will provide *you* with the date(s) on which we made the disclosure, the name(s) of the person or entity (ies) to whom we disclosed *your* health information, a description of the health information disclosed, and certain other information. If *you* request this list more than once in 12-month period, we may charge *you* a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

- **Restriction Request:** *You* have the right to request that *ADVANTAGE* place additional restrictions on our use or disclosure of *your* health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our *Agreement* (except in an *emergency*). Any *Agreement ADVANTAGE* may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an *Agreement* on *your* behalf. *ADVANTAGE* will not be bound unless our *Agreement* is so memorialized in writing.

- **Confidential Communication**: *You* have the right to request that *ADVANTAGE* communicate with *you* in confidence about *your* health information by alternative means or to an alternative location. *You* must inform us that confidential communication by alternative means or to an alternative location is required to avoid endangering *you*. *You* must make *your* request in writing, and *you* must state that the information could endanger *you* if it is not communicated in confidence by the alternative means or to the alternative location *you* want. *ADVANTAGE* must accommodate *your* request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect *premiums* and pay claims under *your* health plan.

- **Amendment**: *You* have the right to request that *ADVANTAGE* amend *your* health information. *Your* request must be in writing, and it must explain why the information should be amended. *ADVANTAGE* may deny *your* request if we did not create the information *you* want amended or for certain other reasons. If we deny *your* request, we will provide *you* a written explanation. *You* may respond with a statement of disagreement to be appended to the information *you* wanted amended. If we accept *your* request to amend the information, we will make reasonable efforts to inform others, including people *you* name, of the amendment and to include the changes in any future disclosures of that information.

- **Electronic Notice**: If *you* receive this notice on our web site (www.advantageplan.com) or by electronic e-mail, *you* are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If *you* are concerned that we may have:

- Violated *your* privacy rights;
- *You* disagree with a decision we made about access to *your* health information;
- In response to a request *you* made to amend or restrict the use or disclosure of *your* health information; and/or
- In response to a request *you* made to have us communicate with *you* in confidence by an alternative means or at an alternative location

You may complain to *ADVANTAGE* using the contact information listed at the end of this notice. *You* also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide *you* with the address to file *your* complaint with the U.S. Department of Health and Human Services upon request.

ADVANTAGE supports *your* right to protect the privacy of *your* health information. We will not retaliate in any way if *you* choose to file a complaint with us or the U.S. Department of Health and Human Services. If *you* want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

ADVANTAGE Health Solutions, Inc.SM
Member Services Department
9045 River Road, Ste 200
Indianapolis, IN 46240
1-800-553-8933
1-800-743-3333 (TDD for hearing impaired)
Website: www.advantageplan.com

SECTION 14: ANTI-FRAUD POLICY STATEMENT

ADVANTAGE is committed to the fight against fraud and corruption. *ADVANTAGE* employees, management and Directors refrain from conduct that may violate the fraud and abuse laws. These laws prohibit:

- direct, indirect or disguised payments in exchange for the referral of patients;
- the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and

- making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

Employees, *members, providers* and contractors can provide valuable information to alert *ADVANTAGE* to possible fraud and abuse issues. Therefore, *ADVANTAGE* has established reporting mechanisms to ensure timely identification and resolution of issues or suspicions of fraud. We have contracted with FPV, Inc. to establish and manage an external hotline. The hotline will allow employees, *members, providers*, and contractors to report suspicion of fraud anonymously or in confidence and without fear of retaliation. Individuals who report problems and concerns in good faith via the hotline will be protected from any form of retaliation. All those who are employed in the external hotline operation are expected to act with utmost discretion and integrity in assuring that information received is acted upon in a reasonable and proper manner. Each FPV employee involved with the *ADVANTAGE* hotline will be required to sign a Confidentiality Agreement.

You may call the *ADVANTAGE* Hotline at **1-888-333-9576**. Our current call center hours are Monday – Friday from 8am – 9pm, and Saturday from 8am – 6pm. During off-hours *ADVANTAGE* has an automated voicemail system and returns all calls on that line.

SECTION 15: GLOSSARY OF TERMS

This section defines terms that have special meanings. The word or phrase is defined in this section or elsewhere in this *Certificate.*

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) - Corporation *authorized* to do business in Indiana, licensed under the Indiana Health Maintenance Organization law, which has a C*ontract* with *your* employer *group* (*Group*) to arrange for health care services for m*embers* as described in this *Certificate*.

AGREEMENT or GROUP SERVICE AGREEMENT or CONTRACT or GROUP CONTRACT - The *Contract*, including any *amendments* or riders agreed to by *ADVANTAGE* and *your Group* that expresses the rights and obligations of both parties. It also describes the costs, procedures, benefits, conditions, limitations, *non-covered services*, and other obligations to which *members* are subject to under *ADVANTAGE*'s health maintenance organization.

AMBULANCE – A specially designed and equipped vehicle or aircraft that is used for the purpose of responding to *emergency* life-threatening situations and providing *emergency* transportation services. An *ambulance* must be certified as such in the state(s) in which it operates.

ANNUAL BENEFIT MAXIMUM - A maximum number of visits, days, sessions, or specific dollar amount that will be provided per *covered service*, per *member*, and per *calendar year*.

AT HOME POST DELIVERY CARE - Health care services provided to a woman at her residence, including, but not limited to: parent education, assistance and training in breast or bottle feeding; and any maternal and neonatal tests routinely performed during the usual course of *inpatient* care for the woman or her newborn child, including collection of an adequate sample for the hereditary and metabolic newborn screening. Services may be provided by: a *physician*; a *RN*; or an advanced practice nurse whose scope of practice includes providing postpartum care in the area of maternal and child health care. The *At home post delivery care* visit must be provided within 48 hours after the mother and newborn child are discharged from the *hospital*. At the mother's discretion, the visit may occur in the *participating provider's* office.

AUTHORIZATION, AUTHORIZED SERVICES, PRIOR AUTHORIZATION, OR PRE-CERTIFICATION – A *covered service* which has been *authorized* in advance by *ADVANTAGE*.

BEHAVIORAL HEALTH NETWORK - A *participating behavioral health network* of mental health and substance abuse *providers* affiliated with a *member's* assigned *PCP*. The *participating provider network* is responsible for arranging behavioral health services, coordination of care, and case management.

BENEFIT PERIOD – A *benefit period* begins on the first day *you* go to a Medicare-covered *skilled nursing facility*. The *benefit period* ends when *you* have not been an *inpatient* at any *skilled nursing facility* for 60 days in a row. If *you* go to a *skilled nursing facility* after one *benefit period* has ended, a new *benefit period* begins. There is no limit to the number of *benefit period*s *you* can have. The type of care *you* actually receive during the stay determines whether *you* are considered to be an *inpatient* for *skilled nursing facility* stays.

BIOLOGICAL or BIOPHARMACEUTICAL DRUG means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. *Biological* or *biopharmaceutical products* typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct *physician* involvement, and significant *member* education. These services must be *authorized* by *ADVANTAGE*.

BRAND-NAME (DRUG) means a drug that has been manufactured under a patent and in accordance with the approval for the Food and Drug Administration (FDA).

CARRIER – An underwriter or insurer.

CALENDAR YEAR means the twelve-month period beginning on January 1 and ending on December 31.

CERTIFICATE OF COVERAGE (CERTIFICATE) - The document given to *you*, that describes both *your* and *ADVANTAGE*'s rights and duties. It includes the schedule of benefits and any *options*, amendments, riders or attachments to this document.

COINSURANCE and COPAYMENT – The amount a *member* must pay directly to a *participating provider* of *covered services* for those services and supplies. A *member* generally must pay this amount at the time *covered services* are received.

CONTRACT YEAR means the duration of *covered benefits* described in the A*greement* between *ADVANTAGE* and the *Group* and described on the cover page of this *Certificate*.

COORDINATION OF BENEFITS (COB) - An attempt by one of *ADVANTAGE*'s *participating provider's* and/or *ADVANTAGE* to recover the cost of care provided to a *member* from a third party. The third party may be another insurer, such as automobile, home, business, and/or renter, service plan, government third party payor, or other organization, which also provides *coverage* for a *member*'s health care needs. *Coordination of benefits* is subject to any limitations imposed by this *Certificate* or another applicable policy preventing such recovery.

COSMETIC – A service that involves physical appearance, but is not *medically necessary* and does not correct or materially improve a physiological function.

COVERED SERVICES or COVERAGE – Those services or supplies that a *member* is entitled to under this *Certificate,* if the services are *medically necessary* and *the member* has met all other requirements of this *Certificate.* The *Agreement* between *ADVANTAGE* and the *Group*, this *Certificate*, limit what *ADVANTAGE* will pay for some services and supplies. When *ADVANTAGE* says it will "Cover" a service or supply that means *ADVANTAGE* will treat the service as a *covered service*.

CUSTODIAL CARE - Care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. *Custodial care* is not covered under this *Certificate*.

DEDUCTIBLE - The specific dollar amount of charges for *covered services* that *you* must incur before certain *covered services* will be paid.

DURABLE MEDICAL EQUIPMENT (DME) - Rental or purchase of *DME* is covered only when *medically necessary* and *authorized* by ADVANTAGE. *DME* can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of *illness or injury* and is suitable for use in *member's* home. Examples of *DME* include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, *hospital* beds, monitoring devices, oxygen-breathing apparatus and insulin pumps.

EFFECTIVE DATE OF COVERAGE – The date when *your coverage* begins under this *Certificate*.

ELIGIBLE DEPENDENT or DEPENDENT - means a person of the *subscriber's* family: who meets the eligibility requirements of the *Group* and eligibility requirements listed in this *Certificate*; for whom the *subscriber* has applied for membership; and for whom *premiums* have been paid by *Group* and/or *subscriber*. To be an *eligible dependent*, a person must meet *ADVANTAGE*'s *service area* requirement, (see *Service Area* definition) and be either: the legal *spouse* of the *subscriber*; a natural or adopted unmarried *dependent* child of the *subscriber*; other individual determined to be eligible for enrollment by the *Group*; or an unmarried *dependent* child for whom the *subscriber* is the legal guardian or foster parent or has been ordered by a Court or administrative order to provide health care *coverage.;*

A *subscriber* and *spouse* working for the same *Group* cannot be both *subscriber* and *dependent.*

EMERGENCY SERVICES - Services provided due to a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a body organ or part of the individual.

EXPERIMENTAL or INVESTIGATIONAL - Any intervention (treatment, procedure, facility, equipment, drug device, service, or supply): that meets one or more of the following criteria:

- Intervention that is not generally and widely accepted in the practice of medicine in the U.S.; and whose effectiveness is not documented in peer-reviewed articles in medical journals published in the U.S. For interventions to be considered effective, journal articles should indicate that the intervention is more effective than other available, or, if not more effective, is safer or less costly.

- Interventions that are considered *experimental* or *investigational* by:
  - the U.S. Department of Health and Human Services;
  - the National Institute of Health; or

- any of their subsidiary agencies

• Drugs or medical devices *biological* products, or some combination thereof that the U.S. Food and Drug Administration (FDA) has not cleared or approved for commercial distribution, or that do not have other governmental agency approval as required by law.

• Use of an FDA cleared or approved drug, medical device, *biological* product or some combination thereof for a use: (1) that FDA has not cleared or approved and that would otherwise require such clearance or approval (i.e., an 'off-label' use); and (2) the effectiveness of which has not been documented in peer-reviewed articles in medical journals published in the U.S. For used of this type to be considered effective, such articles should indicate that using the drug, medical device, biological product, or some combination thereof for he particular use at issue is more effective than other products available for the proposed use, or, if not more effective, is safer or less costly.

FORMULARY - *ADVANTAGE* utilizes a prescription drug *formulary*. A *formulary* is a list of preferred *generic* and *brand name* prescription medications that have been approved by the Food and Drug Administration (FDA).

GENERIC (DRUG) means a copy of a *brand-name drug* for which the patent has expired. The *generic drug* may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the *brand-name drug*. The same quality and safety standards that apply to *brand-name drug*s also apply to the *generic* form. The FDA sets standards and reviews all *generic* medications before being marketed.

GRIEVANCE is a written or oral complaint submitted in accordance with the formal *grievance* procedure of *ADVANTAGE* by or on behalf of a *member* regarding any aspect of *ADVANTAGE* relative to the *member* that expresses dissatisfaction regarding the:

• Availability, delivery, appropriateness or quality of health care services
• Handling or payment of claims for health care services or;
• Matters pertaining to the contractual relationship between:
  i) a *member* and *ADVANTAGE*; or
  ii) a *Group* or individual C*ontract* holder and *ADVANTAGE*;
• Any concerns regarding confidentiality of information

and for which the *member* has a reasonable expectation that action will be taken to resolve or reconsider the matter that is subject of dissatisfaction.

GROUP means the *subscriber's* employer who has *contract*ed with *ADVANTAGE* to provide *member* and *eligible dependent*'s health benefits.

HEALTH PROFESSIONAL - A professional engaged in the delivery of health services who is licensed, where required, under the laws of the jurisdiction where services are delivered and operating within the scope of his/her license.

HOME HEALTH SERVICES - Health services delivered in a *member's* home setting and provided by an organization licensed by the State and operating with the scope of its license.

HOSPICE CARE OR FACILITY – a health care facility or a system of professional home visits and supervision, for supportive care of the *terminally ill*.

HOSPITAL - An acute care facility duly licensed in the jurisdiction where services are rendered.

ILLNESS - A sickness or disease and all related conditions and recurrences. The term *illness* includes pregnancy and all related conditions.

INJURY - An accident to the body that requires medical or surgical treatment.

INPATIENT - Confinement as a bed-patient for 24 hours or longer in a *hospital, SNF*, or *hospice facility.*

LATE ENROLLEE – As described in this *Certificate*, is a *subscriber* or *eligible dependent* who did not request enrollment with *ADVANTAGE*: during the initial enrollment period in which he/she was first entitled to enroll; or during any special enrollment period, and as described in this *Certificate*.

LICENSED PRACTICAL NURSE - Person who has been licensed by a State Board of Nurse Examiners or other state authority, and how is legally entitled to place the letters "LPN" after his name.

LOW PROTEIN MODIFIED FOOD PRODUCT means a food product that is (1) specially formulated to contain less than one (1) gram of protein per serving; and (2) intended to be used under the direction of a *physician* for dietary treatment of an *inherited metabolic disease*.

MAXIMUM ALLOWABLE AMOUNT – The amount that *ADVANTAGE* determines is the maximum payable for *Covered services you* receive, up to but not exceed charges actually billed. For a non-*participating provider* the *Maximum allowable amount* is the lesser of the actual charge or the standard rate under the contracted used with *participating providers.* The *Maximum allowable amount* is reduced by any penalties for which a *member* is responsible under the terms of this *Certificate.*

MEDICAL FOOD means a food that is (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by a medical evaluation; and (2) formulated to be consumed or administered internally under the direction of a *physician*.

MEDICALLY or *CLINICALLY NECESSARY* is defined as:

1. appropriate for the symptoms, diagnosis, or treatment of the medical condition; and
2. provided for the diagnosis or direct care and treatment of the medical condition; and
3. within standards of good medical practice within the organized medical community; and
4. not primarily for the convenience of the member's *physician* or another provider; and
5. not otherwise subject to *non-covered services* under this *Certificate* ; and
6. the most appropriate procedure, supply, equipment, or service that can safely be provided. The most appropriate procedures, supplies, equipment, or service must satisfy the following requirements:

   i. there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the member with the particular medical condition being treated than other alternatives; and
   ii. generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
   iii. for *hospital* stays, acute care as an *inpatient* is necessary due to the kind of services the member is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an *outpatient* or in a less intensified medical setting

The fact that a provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies *medically necessary*.

MEMBER (you, your) - An eligible person enrolled in *ADVANTAGE*'s health plan, as a *subscriber* or *eligible dependent*.

NON-COVERED SERVICES are those services not covered under this *Certificate* and are listed as *non-covered services* in this *Certificate.*

OPEN ENROLLMENT PERIOD - Period of time established by *ADVANTAGE* and the *Group* during which eligible employees and their *eligible dependents* may enroll as new *members*.

OPTION - An addition or amendment to the *Agreement* indicating any additional *covered services* and the corresponding *member copayment*, *coinsurance*, and maximum benefit limits (if applicable).

OUT-OF-POCKET MAXIMUM - Maximum *coinsurance* amount for *covered services*, per *member* and per family per *calendar year*.

OUTPATIENT - Member who receives medical services, but is not an *inpatient*.

PARTIAL HOSPITALIZATION - A structured mental health and/or substance abuse treatment program with sessions of three hours or longer.

PARTICIPATING or CONTRACTING HOSPITAL – A *hospital* that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHARMACY - A pharmacy or organization of pharmacies that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PHYSICIAN - A *physician* who contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PARTICIPATING or CONTRACTING PROVIDER - A *health professional* or other entity that contracts with *ADVANTAGE* to provide *covered services* to a *member*.

PCP or **PRIMARY CARE PHYSICIAN** – A *participating physician* selected by the *member* to be his/her primary health care *provider*. *Primary care physicians* may include Family or General *Physicians*, Internists, Pediatricians and OB-GYN's.

PHYSICIAN - An appropriately licensed *physician* or surgeon.

PHYSICIAN NETWORK, **PROVIDER NETWORK** means organized *group* of *physician*s, facilities and *health professionals* contracted with that has entered into *a* contract with *ADVANTAGE*. A *physician network* has as its primary purpose the delivery, or the arrangement for the delivery, of *covered services*.

POLICY MAXIMUM or CONTRACT MAXIMUM or AGREEMENT MAXIMUM – Total lifetime maximum dollar amount payable for *Covered services* the *member* receives under the *Agreement* issued to the *Group,* including any renewals, endorsements,

amendments or addendums thereto. If there is a lapse in *coverage*, the *policy maximum* applies to all benefits received both before or after the lapse.

PREMIUM – The total payment, including any contributions from *subscribers* or late charges, that the *Group* pays *ADVANTAGE* to maintain *coverage.*

PRE-EXISTING MEDICAL CONDITION – A physical or mental condition for which medical advice, diagnosis, care or treatment is recommended or received up to six (6) months prior to coverage *effective date*. Pregnancy is not considered a *pre-existing medical condition*. Genetic information may not be considered a *pre-existing medical condition* if there is no specific diagnosis of a current disease or medical problem related to the genetic test. A pre-existing medical condition may not apply to a newly born dependent child enrolled within 31 days of date of birth or a dependent child who is adopted by, or placed for adoption with, the subscriber and enrolled within the first 31 days of placement with the subscriber or within 31 days of the date of entry of the order granting the adopting parent custody of the child for purposes of adoption.

PRE-EXISTING MEDICAL CONDITION EXCLUSION PERIOD – The period of time during which services relating to *pre-existing medical conditions* are not considered *covered service*s under this *Certificate*. The *pre-existing exclusion period* is six (6) months from the effective date of coverage with *ADVANTAGE*, less the number of months exhausted under *prior creditable coverage*.

PRIOR CREDITABLE COVERAGE – C*reditable coverage you* had prior to *your effective date* with *ADVANTAGE* that was continuous. For the purpose of this section, "continuous" means *coverage* that was not interrupted by a break of 63 or more days in a row. There can be more than one break, but no single break can be 63 or more days in length. Proof of *prior creditable coverage* is determined by a Certificate of *Creditable Coverage*, which is a written Certificate of *your* prior *coverage* provided to *you* by *your* prior health *carrier*. The *Certificate* must identify *you* as the covered person, period of *coverage*, and waiting periods (if any).

PROPER REFERRALS - Process where a *member's physician* directs the *member* to seek or obtain *covered services* from another *participating or <u>non-</u>participating health professional* or *inpatient facility* subject to ADVANTAGE's *pre-certification* requirements.

PROVIDER - Any *hospital, physician,* pharmacy, *SNF*, individual, organization, or agency that is licensed to provide professional services within the scope of that license or certification.

PROVIDER DIRECTORY – A document listing *ADVANTAGE*'s *participating providers* available to *you* under this *Certificate* .

QUALITY IMPROVEMENT ("QI") COMMITTEE - Committee of *physicians and other health professionals* selected and approved by the *provider network* and/or *medical Group* to disseminate and maintain professional standards.

REGISTERED NURSE (RN) - A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "RN" after his name.

RENEWAL DATE - Date on which the *Agreement* will be renewed.

SECOND OPINION - Medical or surgical opinion that is provided by a *physician*, to reevaluate the condition. The *second opinion* is made with prior *authorization* from *ADVANTAGE*.

SERVICE AREA means the geographical area where the *member* must work or reside to be eligible to enroll, which **is 30 air** miles of the office of the *member's* assigned *PCP*.

SKILLED NURSING FACILITY or **SNF** - Institution, or a distinct part of an institution, which:

- is duly licensed in the state of Indiana; is regularly engaged in providing 24-hour skilled care under the regular supervision of a *physician* and the direct supervision of a *RN*;
- maintains a daily record on each patient; and
- provides each patient with active treatment of an *illness* or *injury*, or related rehabilitation, in accordance with existing standards of medical practice for that condition.

A *SNF* does not include any institution or portion of any institution that is primarily for rest, the aged, non-skilled care, or care of mental diseases or substance abuse.

SPECIALTY CARE PHYSICIAN (SCP) - A *physician* who has an identified specialty other than a family practice, internal medicine, or pediatrics; and who is not acting in the role of a *PCP* to the *member* at the time services are provided. Examples of *SCPs* would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc.

SPOUSE - *Subscriber*'s legal *spouse*.

SUBSCRIBER (you, your) - An employee of the *Group*, who resides and/or works in Indiana (the geographic area in which *ADVANTAGE* is licensed), who meets the eligibility requirements of the *Group*, who has enrolled for coverage with ADVANTAGE, and for whom *premiums* have been paid by the *Group*. A *subscriber* and *spouse* working for the same *Group* cannot be both *member* and *dependent.*

TERMINALLY ILL OR TERMINAL ILLNESS - A *physician* has given a prognosis that a *member* has six months or less to live.

URGENT CARE - Urgently needed services or *urgent care* services are instances when a *member* needs *covered services* urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen *illness* or *injury*;
- while outside of the *service area*;
- for which treatment cannot be delayed until the *member* returns to the *service area* without the *member's* condition growing much worse.

Urgently needed services are determined by medical condition not the place of treatment.

WELL CHILD CARE - A clinical check of a child for the purpose of assessing physical status and detecting abnormalities, in the absence of symptoms. *Well child care* includes pediatric immunizations including, but not limited to: diphtheria, pertusis, small pox, measles, mumps, rubella, poliomyelitis, and tetanus.

WOMAN AT RISK - A woman who meets at least one of the following descriptions:
- a woman who has personal history of breast cancer;
- a woman who has a personal history of breast disease that was proven benign by biopsy;
- a woman whose mother, sister, or daughter has had breast cancer; or

YOU or YOUR or MEMBER - An *eligible person* enrolled in *ADVANTAGE*'s health plan, as a *subscriber* or *eligible dependent.*

YOUNG ADULT – means a person who, regardless of marital status:

(1) between the ages of 19 and 24; and

(2) is not eligible for coverage as an eligible dependent under the subscriber contract; and

(3) meets one of the following criteria:

(A) is the natural or adopted child of a subscriber; or

(B) is the stepchild, grandchild, other blood relative of a subscriber and the subscriber pays more than 50% of the person's total support; or

(C) the subscriber is the persons' legal guardian and the subscriber pays more than 50% of the person's total support.

Family Planning Services Rider

The Certificate is amended as follows. If there is any conflict between the Certificate and this Rider, this Rider shall prevail. The effective date of this Rider is the date shown on the Contract.

Ethical and Religious Directives: ADVANTAGE Health Solutions, Inc.[sm] (ADVANTAGE) is an institution operated in accordance with The Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide, and no provision of a Policy shall be construed so as to require it to provide, services that are inconsistent with the medical ethics or precepts of the Catholic Church.

Family Planning Services means:

1. birth control drugs that require a prescription
2. birth control devices that require a prescription, including the removal of such devices; and
3. voluntary sterilization

FAMILY PLANNING SERVICES

ADVANTAGE is owned by Catholic organizations. Because of this, ADVANTAGE cannot provide services that are not in accord with the Ethical and Religious Directives. Coverage for Family Planning services will be provided and claims will be administered through a 100% reinsurance program through:

Cyrca Insurance Management
303 Congressional Blvd.
Carmel, IN 46032
1-800-510-0225

50% coinsurance up to $2,500 lifetime maximum for all Family Planning Services except for prescription drugs for birth control. Prescription drugs for birth control are excluded from the lifetime maximum. The applicable copayment for prescription drugs for birth control is equal to the amount of the outpatient prescription drug copayment stated in the Certificate if member is entitled to pharmacy benefits.

EXCLUSIONS

1. Abortion, except when the life of the mother would be endangered if the fetus were carried to term.

2. Birth control drugs or devices that do not require a prescription. For example:

   a. condoms; and

   b. foams, jellies, or creams used to kill sperm.

3. Oral and injectable drugs which are used primarily for the purpose of treating infertility. (For example, Clomid, Metrodin, and Pergonal.)
4. Cyropreservation of ova, sperm, or fertilized eggs.

5. Any procedure which involves destroying human embryos.

6. Artificial insemination, except by the covered person's spouse.

7. Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), or in-vitro or in-vivo fertilization.

8. Use of a surrogate for any reason.

9. Treatment for infertility.

10. Oral drugs for the treatment of impotence.