La Vie à l'Etranger 3000 Policy Terms and Conditions

WellAway

Keeping You Well, While You're Away.®

LVE3000-25-01
03/01/2025

For Individuals: Non-Group Policy – USA and Worldwide Coverage

Policyholder Name:

Policy Number:

Plan Type:

Effective Date:

This Policy is designed for those individuals that maintain active coverage with Caisse des Français de l'Etranger ("CFE"). The WellAway Limited ("WellAway") Premium only applies to your WellAway Policy. You are responsible to maintain your CFE membership active and paid in order to qualify for this Policy. . This Policy and any Endorsements to this Policy are designed to be top up plans to the CFE coverage.

This Policy provides ACA compliant health care coverage in the United States which has been approved under Title I of the Affordable Care Act and meets and exceeds minimum essential coverage, as applicable to non-grandfathered plans, pursuant to Section 5000A of the Internal Revenue Code and in the final regulations set forth in 45 CFR 156.604 pursuant to the authority granted to the Secretary of Health and Human Services under Section 5000A(f)(1)(E) and delegated to the Centers for Medicare & Medicaid Services. The benefits and services described in your Policy have an unlimited annual maximum, covers pre-existing conditions and include all Essential Health Benefits as outlined by the Affordable Care Act.

The general terms and conditions of this Policy contain all of the information you need regarding your benefits and requirements under this Policy. ConciergeCare Counselors are available to guide you through this Policy and your health care needs.

We encourage you to read this Policy in its entirety before you seek Health Care Services. Please refer to your Summary of Benefits and Coverage to determine your benefits, limitations and exclusions.

IMPORTANT NOTICE

In deciding to issue this Policy to you, we relied on the truthfulness and accuracy of the information provided on your Application Forms. Please read the information on your Application Forms carefully and notify us within ten (10) days if any of the information is incorrect or incomplete. Intentional fraudulent statements or Material Misrepresentations on your Application Forms could result in the cancellation or Rescission of your Policy. The description of coverage outlined in this document only refers to the benefits of this Policy.

During the term of this Policy, we agree to provide the health insurance coverage and benefits specifically provided herein to a Covered Person, subject to all applicable terms, conditions, limitations, and exclusions set forth in this Policy. This Policy contains provisions subject to participation with the CFE that will help you cover your Deductibles, Coinsurance and Copayments.

This Policy will stay in effect as long as you remain eligible for coverage and you pay your Premium on time. This Policy will be Rescinded or canceled if, at any time, you have made any intentional fraudulent statements or Material Misrepresentations. This Policy will also be canceled if we terminate this Policy for each and every individual covered by it.

If, after examining this Policy, you are not fully satisfied for any reason, your Premium will be refunded to you provided you notify us within ten (10) days from the delivery date of this Policy.

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Summary of Benefits

Cost Share Features	In-Network (INN)	Out-of-Network (ONN)	Worldwide
Annual limit	Unlimited	Unlimited	$1,000,000
Policy Year Deductible- Embedded Individual Deductible (The amount you pay)	$3,000 individual	$6,000 individual	No Deductible
Family Deductible (The amount your family pays)	$6,000 family	$12,000 family	$0
Coinsurance (This Summary of Benefits states the percentage of the Allowed Amount **your plan pays** for Covered Services)	80%	50%	80%
Out-of-pocket maximum Individual Out-of-Pocket maximum	$5,500 individual	$11,000 individual	$0
Family Out-of-Pocket maximum	$11,000 family	$22,000 family	$0

Medical Health Benefits

Payment for In-Network Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Services. Certain benefits indicated in this Summary of Benefits table require that you utilize an In-Network Provider.

Your Cost Share for Covered Services will vary based on In-Network Services or Out-of-Network Services. In-Network Premium Care or Select Providers will provide you with the least Out-of-Pocket costs. Non-Premium Care or Select Providers, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. You should always verify a Provider's participation status before you receive Health Care Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

Any Copayments listed in this Summary of Benefits table below apply per visit.

Wellness Care

These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility otherwise they will not be covered.

Adult Wellness Services (at all locations) Periodic routine health exams include: • routine gynecological exams including pap smears • immunizations • prostate specific antigen (age specific supported by the U.S. Preventive Services Task Force) • routine mammograms (age specific supported by the Health Resources and Services Administration) • measure your height, weight, blood pressure and take other routine measurements • review your medical and family history assess your risk factors and treatment options • review your health risk assessment questionnaire • update your list of providers and prescriptions • look for signs of cognitive impairment • set up a screening schedule for appropriate preventive services	100%	Not covered	80% Coinsurance

Wellness Care

	In-Network (INN)	Out-of-Network (ONN)	Worldwide
These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility otherwise they will not be covered.			
Child Wellness Services (at all locations) Periodic age specific physical examinations and developmental assessment in accordance with pediatric guidelines • office visit • health history • hearing examinations • age related diagnostic tests • vaccination and immunization necessary for prevention	100%	Not Covered	80% Coinsurance

Services that Require Hospitalization

Hospitalization* (Facility)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Emergency room (Facility)* (when your health is in jeopardy, your symptoms are severe, causing loss of life, limb or death (medically necessary))	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Physician Services (Primary Care Physicians and Specialist Physicians)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Rehabilitative services* (treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	Deductible then your plan pays 80% Coinsurance Limited to 45 days combined with Habilitative Services	Deductible then your plan pays 50% Coinsurance Limited to 45 days combined with Habilitative Services	80% Coinsurance Limited to 45 days combined with Habilitative Services
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	Deductible then your plan pays 80% Coinsurance Limited to 45 days combined with Rehabilitative Services	Deductible then your plan pays 50% Coinsurance Limited to 45 days combined with Rehabilitative Services	80% Coinsurance Limited to 45 days combined with Rehabilitative Services
Behavioral health services* (mental health such as psychotherapy and counseling & substance use disorder services)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Surgical procedures and surgeon fees * • refers to the fees charged by the main surgeon that performed the surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. • Services provided by an anesthesiologist during a covered surgical procedure.	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Oncology treatment* (includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance

** Prior Coverage Authorization required*

Services that Require Hospitalization

	In-Network (INN)	Out-of-Network (ONN)	Worldwide
Reconstructive surgery* (due to illness or injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve the ability in restoring normal life functions)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Organ transplant* (includes heart, lung, heart and lung, kidney, pancreas, kidney and pancreas, liver, cornea, allogenic and autologous bone marrow and peripheral stem cell transplants)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Emergency ambulance services (from emergency location to nearest facility, from one hospital to another, or from hospital to your home or skilled nursing facility)	Deductible then your plan pays 80% Coinsurance		80% Coinsurance

Outpatient Care

When Services are not performed in a Physician's office or in a free-standing non-hospital facility, a Site of Service Differential cost will apply.

Urgent care center	$55 Copayment	$105 Copayment	80% Coinsurance
Outpatient ambulatory surgical facility * (Free-standing non-hospital Facility only)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Outpatient Surgery Physician/Surgical Services • refers to the fees charged by the main surgeon that performed the surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. • Services provided by an anesthesiologist during a covered surgical procedure.	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Oncology treatment* (includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Reconstructive surgery* (due to illness or injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve the ability in restoring normal life functions)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Routine X-rays and Laboratory Tests	$95 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Advanced diagnostic and imaging services* (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance

** Prior Coverage Authorization required*

Outpatient Care

	In-Network (INN)	Out-of-Network (OON)	Worldwide
When Services are not performed in a Physician's office or in a free-standing non-hospital facility, a Site of Service Differential cost will apply.			
Rehabilitative services* (for treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	$45 Copayment (limited to 20 visits per benefit period)	Deductible then your plan pays 50% Coinsurance (limited to 20 visits per benefit period)	80% Coinsurance (limited to 20 visits per benefit period)
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	$45 Copayment (limited to 20 visits per benefit period)	Deductible then your plan pays 50% Coinsurance (limited to 20 visits per benefit period)	80% Coinsurance (limited to 20 visits per benefit period)
Outpatient physical therapy* (physical therapy for the purpose of aiding in the restoration of normal physical function lost due to a Condition or to attain age appropriate function for activities of daily living - treatment plan must be provided)	$45 Copayment (limited to 40 visits per benefit period)	Deductible then your plan pays 50% Coinsurance (limited to 40 visits per benefit period)	80% Coinsurance (limited to 40 visits per benefit period)
Outpatient Chiropractic Services (chiropractic services and spinal manipulation *(to correct a slight dislocation of a bone or joint that is demonstrated by x-ray*) when restoring function loss due to a medical condition or to attain age-appropriate function for activities of daily living - treatment plan must be provided)	Deductible then your plan pays 80% Coinsurance (limited to combined 15 visits per benefit period)	Deductible then your plan pays 50% Coinsurance (limited to combined 15 visits per benefit period)	80% Coinsurance (limited to combined 15 visits per benefit period)
Behavioral health services* (outpatient facility for mental health & substance use disorder services)	$45 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Emergency dental services (due to damage to natural sound teeth which is treated within 62 days of the accidental dental injury)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Vision services (for the treatment of aphakia, injury to or diseases of the eyes and glasses or lenses following cataract surgery)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance

Physician Services

Virtual Visits (for illnesses including cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	Your Plan pays 100%	Not covered	Not available
Primary Care (includes general consultation, primary care visit, check- ups, office visits, and gynecologist when designated as your primary care physician)	$25 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Specialist consultation (consultation or office visit for a specific condition or specialty)	$40 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Behavioral Health* (includes office visit, diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a physician, psychologist or mental health professional for the treatment of a mental health illness or substance use disorder)	$45 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Allergy testing & treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	$40 Copayment Maximum Benefit $1,500	Deductible then your plan pays 50% Coinsurance Maximum Benefit $1,500	80% Coinsurance Maximum Benefit $1,500

** Prior Coverage Authorization required*

Maternity Care	In-Network (INN)	Out-of-Network (OON)	Worldwide
Prenatal and postnatal physician consultations	Paid in Full	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Labor and delivery Hospital stay minimum 48 hours for normal delivery and 96 hours for c-section (includes hospital, obstetrician, midwife, anesthesiologist, pediatrician (well baby) for a normal delivery)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Complications of Pregnancy (mother only - miscarriage, pre-eclampsia, ectopic pregnancy and c-section)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Birthing center (includes a team of highly qualified professionals from midwifery, nursing, obstetrics, family medicine and childbirth)	$305 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Newborn care (a newborn child who is properly enrolled will be covered from the moment of birth for injury or illness, including routine care, and the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities and premature birth)	Deductible then your plan pays 80% Coinsurance	Not covered	80% Coinsurance
Infertility treatment	Not covered	Not covered	Not covered
Sterilization (surgical sterilizations, tubal ligations and vasectomies only)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance

Prescription Drugs	EHIM In-Network Pharmacy	Out-of-Network (OON)	Worldwide
Preventive	100%	Not covered	80% Coinsurance
Generic	$15 Copayment	Not covered	80% Coinsurance
Brand	$35 Copayment	Not covered	80% Coinsurance
Non-preferred brands	50% Coinsurance	Not covered	80% Coinsurance
Specialty	50% Coinsurance	Not covered	80% Coinsurance

Other Services

	In-Network (INN)	Out-of-Network (OON)	Worldwide
Skilled nursing facility* (following a hospital stay of no less than three (3) days and care must begin within 14 days following your hospital stay)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Home healthcare* (care must begin within 14 days following your hospital stay, prescribed by a physician and provided under the supervision of a registered nurse)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved and certified by a physician)	Deductible then your plan pays 80% Coinsurance	Not covered	80% Coinsurance
Dialysis* (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	$305 Copayment	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Durable medical equipment (helps to complete your daily activity and includes walker, wheelchair, crutches, canes, oxygen equipment, hearing aids or other equipment that can withstand repeated use which must be medically necessary and prescribed by a physician)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance
Prosthetic & Orthotics Devices (when prescribed by a Physician and designed and fitted by a Prosthetist or Orthotist as applicable)	Deductible then your plan pays 80% Coinsurance	Deductible then your plan pays 50% Coinsurance	80% Coinsurance

Evacuation & Repatriation

Medical evacuation*	Paid in full up to $100,000 limit per covered person, per benefit period
Repatriation of mortal remains*	Paid in full up to $25,000 lifetime limit per covered person

** Prior Coverage Authorization required*

Pediatric Dental Services

Pediatric Dental Services which exceed $500 are subject to Prior Coverage Authorization

	In-Network/ Out-of-Network and Worldwide
Preventive Dental Services • Oral Exam **-** *Once every 6 months in a Benefit Period* • Cleaning and fluoride treatments - *Once every 6 months in a Benefit Period* • Sealants – *Once per unrestored permanent molar every 36 months* • Space maintainers to replace prematurely lost teeth. • X-ray (bitewing – two films) – *Once every six months in a Benefit Period*	Your Plan pays 100% of UCR
Basic Dental Services • Anesthesia – general anesthesia and intravenous sedation is covered only when rendered in connection with a covered surgical procedure. • Endodontics – minor (such as pulpal therapy) • Extractions (removal of teeth-except extractions for orthodontics) • Palliative care (treatment to relieve pain or to keep an Accidental Dental Injury or dental Condition, such as an abscess from getting worse). • Periodontics – minor (such as deep cleaning) • Prosthodontics – minor (such as repair and relining of bridges, crowns and dentures) • Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold)	Deductible then your plan pays 80% Coinsurance of UCR
Major Dental Services • Endodontics – major (such as root canal treatment) • Periodontics – surgical (such as gingivectomy) • Prosthodontics – major (such as crowns and dentures - *limited to once every 60 months).* • Implants and orthodontia Services may be covered, when Medically Necessary, and with prior coverage authorization.	Deductible then your plan pays 80% Coinsurance of UCR

Pediatric Vision Benefits

Pediatric Vision Services are covered **only** when by rendered by an Optometrist. Pediatric Vision Services rendered by an Ophthalmologist are subject to applicable **Cost Share amounts** in your medical plan. Pediatric Vision Benefits are not covered when rendered by Out-of-Network Providers, except for Emergency Services. Pediatric Vision Benefits end on the last day of the calendar month of the Covered Person's 19th birthday.

Covered Service	**In-Network/ Out-of-Network and Worldwide**
Eye exam - one every 12 months • including dilation (when professionally indicated)	Your Plan pays 100% of UCR
Lenses one pair per member every 12 months (provided there were no benefits paid for contact lenses during the same benefit period).	Your Plan pays 100% of UCR
Frames one every 12 months from the Pediatric Frame Selection* * If you choose a frame that is not in the Pediatric Frame Selection you will be responsible for the difference in cost between the price of the frame selected and those available in the Pediatric Frame Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.	Your Plan pays 100% of UCR
Contact Lenses (instead of eye glasses) once every 12 months from the Pediatric Contact Lens Selection** including the evaluation, fitting and follow-up care (provided there were no benefits paid for contact lenses during the same benefit period). ** If you do not select contact lenses from the Pediatric Contact Lens Selection you will be responsible for the difference in cost between the contact lenses selected and those available in the Pediatric Contact Lens Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.	Your Plan pays 100% of UCR

Welcome to WellAway

CFE Complémentaire – What you need to know

Your WellAway Policy is a product designed to provide health coverage in the United States and worldwide. The CFE provides important coverage that allows you to receive reimbursements towards your Out-of-Pocket Costs related to the medical care you receive in the United States. It also allows you to return to France or its overseas territories for certain critical illnesses that may arise. The CFE alone will not provide sufficient coverage for you in the United States and is not compliant with the requirements of the Affordable Care Act for individuals living in the United States. Your WellAway policy complies with the Minimum Essential Coverage (MEC) required under the Affordable Care Act Law for expatriates living in the United States, effective January 1, 2014.

This Policy requires you to be enrolled in the CFE. If you do not wish to participate with the CFE, other coverage options exist that do not include the CFE participation requirement. However, the CFE program assists in covering items such as Cost Share amounts, pharmaceuticals, pharmacy network products or other medical care not covered by insurance coverage in the United States and worldwide. Your agent or a ConciergeCare Counselor can help you understand the differences in plans and premiums.

La Vie a l'Etranger – What you need to know

The La Vie a l'Etranger plan complies with the Minimum Essential Coverage (MEC) required under the Affordable Care Act requirements for expatriates living in the United States, effective January 1, 2014. This plan may also provide benefits outside the United States.

WellAway – What you need to know

We will provide services and answer your inquiries through your WellAway ConciergeCare Counselor. Emergency assistance and claim inquiries should also be directed to your ConciergeCare Counselor. Phone numbers to contact your ConciergeCare Counselor can be located within this Policy, on your ID Card, and your Summary of Benefits and Coverage ("Summary of Benefits").

In the United States, WellAway is contracted with PayerFusion Holdings, LLC ("PayerFusion"), a third-party administrator that is licensed in more than 35 states in the United States. PayerFusion will ensure the professional handling of your medical claims, and coordinate your case management and assistance anywhere in the United States. WellAway and/or PayerFusion will also assist you in the coordination of payments to the medical Providers that provide your medical benefits, and Premium payments due in any of the programs you participate.

Providers

In order to assist you in finding Providers in the United States, WellAway, through PayerFusion, has contracted with a robust national Network. Our Provider contracts allow a maximum cost effective use of your Policy benefits, and permit you to comply with the terms and conditions for utilizing In-Network Providers and In-Network Premium Care/Select Providers.

- **In-Network Providers**

  WellAway provides access to a PPO Network. In-Network Providers are available to you for your healthcare needs. Not all Providers in the Network are Premium Care or Select Providers. However, Premium Care or Select Providers will provide you with the least Out-of-Pocket costs. Non-Premium Care or Select Providers, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Using an In-Network Premium Care/Select Provider will reduce your costs and allow you to obtain significant savings but are still subject to certain requirements such as Prior Coverage Authorization and other requirements under this Policy. Prior Coverage Authorization may include the required use of designated Premium Care or Select Providers who have demonstrated high quality and cost-efficient care.

  Your ID Card is your key to accessing all of the Premium Care or Select Providers available to you as a Covered Person. Contact our ConciergeCare team via the telephone number on your ID Card. They are experienced in guiding you to the most appropriate Premium Care or Select Providers for you. Please present your ID Card to your Provider at the time of receiving Services to avoid being charged for Services rendered by your Provider. Your Identification Card will indicate the necessary details of the Network and your ConciergeCare Counselor will advise you of how to use the Network, find In-Network Providers and In-Network Premium Care/Select Providers, and assist you with your medical needs while residing in the United States.

- **Out-of-Network Providers**

Out-of-Network Providers are not contracted Providers with WellAway or the Network supporting your Policy. If you were to receive Services from Out-of-Network Providers, the payment will be sent or reimbursed directly to you. These amounts are based on Usual, Customary and Reasonable Charges ("UCR") as per the Policy terms and conditions and the Covered Person will be responsible for settling the claim with the Out-of-Network Provider. We are not contracted with Out-of-Network Providers and will not pay them directly. Out-of-Network Providers may bill the Covered Person for any amounts above UCR and are under no obligation to discount their services in any way and will bill you their full charges directly. We urge you to use In-Network Premium Care or Select Providers to minimize your Out-of-Pocket Costs. WellAway does not accept an assignment of benefits from a Covered Person to pay an Out-of-Network Provider directly. Coverage, if applicable, for Out-of-Network is subject to the Cost Share amounts indicated in the Summary of Benefits. Covered Persons will be responsible for Services which are not covered Out-of-Network.

Allowed Amount

In order to assist you in understanding how we determine the Allowed Amount under this Policy, please review the information provided below.

1. In the case of an In-Network Provider and In-Network Premium Care/Select Provider, this amount will be established in accordance with the applicable agreement between that Network Provider and WellAway via its third-party administrator, and its Network agreements. The Allowed Amount is the maximum amount the Company will pay for specific Health Care Services. You may also hear it referred to as "Eligible Expenses," "Payment Allowance" or "Negotiated Rate". When the Provider is an In-Network Premium Care or Select Provider you may not have to pay the difference between the billed amount and the Allowed Amount, however, you may be responsible for Cost Share amounts as outlined in your Summary of Benefits.

2. In the case of an Out-of-Network Provider that has not entered into an agreement with WellAway or its third-party administrator to provide access to its usual reduced fee from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by WellAway that may be based on several factors (UCR), including, but not limited to:

(i) WellAway will use UCR fees which are based on what Providers charge in a specific area for a specific service and they may be used to determine the Allowed Amount. An Allowed Amount is the maximum amount of money that a health insurance company will pay to a Provider for a specific Health Care Service.

(ii) In the case of an Out-of-Network Provider if you are unable to negotiate a price with the Out-of-Network Provider, the maximum amount paid by your Policy will be the UCR fees as determined by WellAway or our third-party administrator. The Provider may bill you for any amounts above the UCR at its discretion. Negotiating directly with your Out-of-Network Provider may reduce the amount they may bill you above the UCR payment made by WellAway.

(iii) Because WellAway and its third-party administrator are not contracted with Out-of-Network Providers, you should negotiate any balances above the allowed Out-of-Network payment as soon as possible with the Out-of-Network Provider that treated you.

(iv) In the case of an Out-of-Network Provider, WellAway will pay the Out-of-Network Covered Services to the Policyholder as outlined in the Summary of Benefits under the Out-of-Network column. These amounts are based on UCR as per the Policy terms and conditions and the Covered Person will be responsible for settling the claim with the Out-of-Network Provider for any balances above the UCR covered amount.

3. In no event will the Allowed Amount be greater than the amount the Provider actually charges.

4. You may obtain an estimate of the Allowed Amount for a particular Service by calling the ConciergeCare telephone number on your ID Card. Cost estimates may only be provided once we have determined that the service enquiry pertains to a Covered Service and that all Prior Coverage Authorization have been granted for the Procedure. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Policy apply. You should refer to the WHAT IS COVERED? section of this Policy and your Summary of Benefits to determine what is covered and how much we will pay.

Other Claim Information

Liability Calculation Method Per Claim

WellAway's Network may use various methods to determine a negotiated price of a claim, depending on the terms of the Provider agreement in the given geographic area where Services are rendered. The calculation of your liability on claims for Covered Services processed through the Policy will be based on the lesser amount of:

(i) the In-Network Provider's billed covered charges; or

(ii) the negotiated price made available to us by the Network. The negotiated price made available to us by the Network may reflect a payment negotiated with a health care Provider in which:

(a) the basis for determining your liability for Covered Services does not reflect the entire savings realized, or expected to be realized on a particular claim; or

(b) a surcharge amount is added as required by either federal or the laws of certain states.

Should either federal or state law in which the Health Care Services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require the payment of a surcharge, we would then calculate your liability in accordance with applicable law. Such negotiated payments may include, but are not limited to, anti-fraud and abuse recoveries. The third-party administrator processing claims on behalf of WellAway will perform these calculations upon receipt of the claims and when issuing payments to Providers.

How to Use Your Policy

Please read your entire Policy carefully before you need Health Care Services. It contains valuable information about:

- Your WellAway Policy as a top up plan to your CFE program;
- What is covered;
- What is not covered;
- Coverage and payment rules;
- Networks, In-Network facilities and Premium Care/Select Providers;
- How and when to file a claim and benefit limitations;
- Your share of your medical expenses;
- Important information including when benefits may change;
- How and when coverage stops;
- How to continue coverage if you are no longer eligible;
- How we will coordinate benefits with other policies or plans;
- Our subrogation rights; and
- Our right of reimbursement.

Refer to your Summary of Benefits to determine how much you have to pay for particular Health Care Services.

When reading your Policy, please remember:

1. You should read this Policy in its entirety in order to determine if a particular Health Care Service is covered. Sometimes it may be necessary to change the standard language in this Policy. If changes are needed, we will create an Endorsement to this Policy, which will either be inserted after the section that it modifies, or at the end of the Policy. Be sure to always check for these additional documents before making benefit decisions.

2. The headings of sections contained in this Policy are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.

3. References to “you” or “your” throughout refer to you as the Policyholder and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Policyholder or solely to your Covered Dependents will be noted as such.

4. References to “we”, “us”, “our” and “WellAway” throughout this Policy refer to WellAway Limited and any Company that may participate in the underwriting of this Policy which will be disclosed.

5. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the DEFINITIONS section or within the particular section where it is used.

6. The official language governing this Policy is USA English and shall remain the ruling language on coverage, benefits and definitions. This Policy may be available in other languages, but the translated document is provided for informational purposes only and does not constitute a legal document or your official policy.

7. Certain Health Care Services are subject to an In-Network Provider provision, which means those Services are only covered when provided by the Provider designated, solely by us, as the In-Network Provider, facility or Participating Pharmacy for such Services. Please refer to your Summary of Benefits and the WHAT IS COVERED? section of your Policy to determine which benefits are subject to this requirement.

8. This Policy is designed for a twelve (12) month commitment each Benefit Period. Any request from the Policyholder to cancel or make changes in plan options or coverage may only take place at the beginning of a new Benefit Period unless we specifically agree otherwise.

Locating Information

What is covered?
The WHAT IS COVERED? section.

What is not covered?
The WHAT IS NOT COVERED? section, along with the WHAT IS COVERED? section.

What is covered under my retail pharmacy plan?
The MEDICATION PROGRAM section.

Which Services are subject to an In-Network Provider Provision?
See your Summary of Benefits and the WHAT IS COVERED? section of your Policy.

How do I know what Providers I can use, and how the Providers I use will affect my Cost Share amount?
The HEALTHCARE PROVIDER OPTIONS section along with the current Provider Directory.

How much do I pay for Health Care Services?
The YOUR SHARE OF HEALTH CARE EXPENSES section along with the Summary of Benefits.

How do I add or remove a Covered Dependent? The ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and the TERMINATION OF COVERAGE section.

What if I am covered under WellAway and another health plan?
The COORDINATION OF BENEFITS section.

What happens when my coverage ends?
The TERMINATION OF COVERAGE section.

What do the terms used throughout this Policy mean?
The DEFINITIONS section.

Who do I call if I have questions or complaints?
Call your ConciergeCare Counselor at: + 1 (855) 773-7810 (this telephone number can also be found on your ID Card).

What is Covered?

Introduction

This section describes the Health Care Services that are covered under this Policy. For your convenience, we have indicated certain Services that are subject to your Cost Share amounts. However, all benefits for Covered Services are subject to: 1) your Cost Share amounts and the benefit maximums listed on your Summary of Benefits; 2) the applicable Allowed Amount; 3) any limitations and exclusions, as well as any other provisions contained in this Policy; and 4) our Medical Necessity guidelines then in effect (see the MEDICAL NECESSITY section).

Exclusions and limitations that are specific to a type of Service are included with the benefit description in this section. There are other exclusions and limitations listed in the WHAT IS NOT COVERED? section and, in some cases, separate Endorsements that are a part of this Policy. More than one limitation or exclusion may apply to a specific Service or a particular situation.

We will provide coverage for the Health Care Services listed in this section only if they are:

1. Authorized in advance by us, if Prior Coverage Authorization is required (see the ACCESS TO HEALTHCARE PROGRAMS section);

2. Within the Covered Services categories in this section;

3. Actually rendered to you (not just recommended) by an appropriately licensed health care Provider who is recognized by us for payment;

4. Billed to us on a claim form or itemized statement that lists the Services rendered to you. Claims and statements should include procedure codes, diagnosis codes and other information we require to process the claim;

5. Medically Necessary, as defined in this Policy and determined by us in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;

6. Within our benefit guidelines listed in this section;

7. Rendered while your coverage is in force; and

8. Not specifically or generally limited or excluded under this Policy.

We will determine what Services are Covered Services under this Policy after you have obtained them and we have received a claim for them. In some cases we may determine what Services are Covered Services under this Policy before they are rendered to you. For example, we may determine if a transplant would be a Covered Service under this Policy before you have the transplant.

We are not obligated to determine if a Service that has not been provided to you will be covered unless we have designated that the Service must be authorized in advance in the ACCESS TO HEALTHCARE PROGRAMS section. We are also not obligated to cover or pay for any Service that have not actually been rendered to you or your Covered Dependents.

In determining if Health Care Services are Covered Services under this Policy, no written or verbal representation by any employee or agent of WellAway or by any other person shall waive or modify the terms of this Policy and, therefore, neither you nor any health care Provider or other person should rely on any such written or verbal representation.

Our Benefit Guidelines

In providing benefits for Covered Services, we may apply the benefit guidelines listed below, as well as any other applicable payment rules specific to certain types of Services:

1. Our payment is based on our Allowed Amount and not necessarily the Provider’s billed charges.

2. Our payment for certain Health Care Services is included within the Allowed Amount for the primary procedure, and we will not pay additional amounts for any such Services.

3. Our payment is based on the Allowed Amount for the actual Service you received. Payment is not based on:

a. a Service that is more complex than the Service you actually received;

b. the method used to perform the Service; or

c. the day of the week or the time of day the Service is performed.

4. Some Services that have several components can be described by a single procedure code. In these cases, our payment for such Services includes all components of the Service under that one procedure code. This is also true when a Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

5. Services that are subject to an In-Network Provider Provision are only Covered Services when rendered by an In-Network Provider, for the particular Services, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition.

Covered Services Categories

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hypo-sensitization serum are covered. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses and subject to Medical Policy Guidelines. This benefit is subject to Prior Coverage Authorization and a benefit maximum amount.

Ambulance Services

Ambulance Services provided by a ground vehicle are covered when it is Medically Necessary to transport you from:

1. A Hospital that is unable to provide proper care to the nearest Hospital that can provide proper care;

2. A Hospital to your nearest home, or to a Skilled Nursing Facility; or

3. The place an Emergency Medical Condition occurs to the nearest Hospital that can provide proper care.

Medically Necessary expenses for Ambulance Services by boat, airplane, or helicopter are limited to the Allowed Amount for a ground vehicle unless:

1. The pick-up point is not accessible by ground vehicle;

2. Speed in excess of ground vehicle speed is critical; or

3. The travel distance involved in getting you to the nearest Hospital that can provide proper care is too far for medical safety, as determined by us.

Ambulatory Surgical Center

Services rendered at an Ambulatory Surgical Center are designated as Essential Health Benefits. These Services are covered and include:

1. Use of operating and recovery rooms;

2. Respiratory therapy such as oxygen;

3. Drugs and medicines administered at the Ambulatory Surgical Center (except for take-home drugs);

4. Intravenous solutions;

5. Dressings, including ordinary casts;

6. Anesthetics and their administration;

7. Administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the WHAT IS NOT COVERED? section);

8. Transfusion supplies and equipment;

9. Diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as an EKG;

10. Chemotherapy treatment for proven malignant disease; and

11. Other Medically Necessary Services.

This benefit is subject to Prior Coverage Authorization.

Anesthesia Administration Services

Anesthesia administered by a Physician or Certified Registered Nurse Anesthetist ("CRNA") are covered. When the CRNA is actively directed by a Physician, other than the Physician who performed the surgery, the Allowed Amount for Covered Services will include both the CRNA and the Physician's charges and will be based on the lower-directed Services Allowed Amount according to our payment program then in effect for such Covered Services.

Exclusion: Coverage does not include anesthesia Services by an operating Physician, his or her partner or associate.

Behavioral Health Services

Mental Health Services

Diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a Physician, Psychologist or Mental Health Professional for the treatment of a Mental and Nervous Disorder are covered as an Essential Health Benefit and include:

1. Office visits and E-visits (electronically through a computer via the internet) with a Physician, Psychologist or Mental Health Professional;

2. Outpatient treatment rendered in a facility; and

3. Inpatient hospitalization.

Note: Benefits stated in paragraphs 2 and 3 above are subject to Prior Coverage Authorization. All benefits are subject to applicable Cost Share amounts on your Summary of Benefits.

Exclusions:

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Policy, regardless of the underlying cause, or effect, of the disorder.

2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation.

3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation.

4. Services for educational purposes.

5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Policy, regardless of the underlying cause, or effect, of the disorder.

6. Services for pre-marital counseling.

7. Services for court-ordered care or testing, or required as a condition of parole or probation.

8. Services to test aptitude, ability, intelligence or interest.

9. Services required to maintain employment.

10. Services for cognitive remediation.

11. Inpatient stays that are primarily intended as a change of environment.

12. Inpatient (overnight) mental health Services received in a residential treatment facility.

Substance Use Disorder Services

Inpatient: Benefits will be provided based on the Allowable Amount including Physician or Professional Other Provider without an Inpatient hospital limit.

Outpatient or Office: Benefits will be provided at the Allowable Amount.

Note: Benefits are subject to Prior Coverage Authorization.

Limitations and Exclusions:

1. Diagnosis: Services must be for the diagnosis and/or treatment of manifest mental disorders. These disorders are described in two publications:

   a. The most current edition of the International Classification of Diseases Adapted (Public Health Service Publication No. 1693).

   b. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

2. Educational Credits: Benefits will not be paid for psychoanalysis or medical psychotherapy that can be used as credit towards earning a degree or furthering a Covered Person's education or training. (It makes no difference what the diagnosis is or what Symptoms are present.)

3. Marital Counseling: Benefits will not be paid for marital counseling or related services.

4. Professional Services: Professional services must be performed by a Physician or Professional Other Provider who is properly licensed or certified. A Professional Other Provider must be acting under the direct supervision of a Physician or a licensed clinical Psychologist. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their license.

5. Tobacco Dependency: Benefits will not be paid for Services, Supplies, or Drugs related to tobacco dependency except as described under the Preventive Care category of this section.

6. The Benefit Period maximums, if any, cited for Inpatient, intensive Outpatient, and other Outpatient and office Services include all Services provided for both Mental Health and Substance Use Disorder care.

7. Co-dependency Treatment: Services related to the treatment of the family of a person receiving treatment for nicotine, chemical, or alcohol dependence are not covered.

Definitions: Certain important terms applicable to this Behavioral Health Services category are set forth below. For additional applicable definitions, please refer to the DEFINITIONS section of this Policy.

Mental Health or Substance Use Disorder means a condition requiring specific treatment primarily because a Covered Person requires psychotherapeutic treatment, rehabilitation from a substance use disorder or both.

Mental Health Benefits means benefits with respect to services for mental health conditions as defined under the terms of this Policy and in accordance with any applicable federal and state laws.

Substance Use Disorder Benefits means benefits with respect to Services for Substance Use Disorders as defined under the terms of this Policy and in accordance with any applicable federal and state laws.

Inpatient Care Expenses means those billed by a Physician, Professional Other Provider, Hospital, or facility while a Covered Person is confined as an Inpatient.

Professional Other Provider means a Provider that must be acting under the direct supervision of a Physician or a Psychologist.

Outpatient Care Expenses means those services billed by a Physician, Professional Other Provider, Hospital, or facility, for Services provided in either the Physician's or Professional Other Provider's office, the Outpatient department of a Hospital, or facility, or a Covered Person's home.

Breast Reconstructive Surgery

Breast Reconstructive Surgery is a Covered Service only where the Covered Person's surgery is required as the result of a birth defect, Accidental injury, or a malignant disease process or its Treatment. Coverage for any reconstructive surgery will only be provided for the diseased body part; except that any Covered Person who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with federal law:

(1) Reconstruction of the breast on which the mastectomy has been performed.

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance.

(3) Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Note: This benefit is subject to Prior Coverage Authorization.

Child Cleft Lip and Palate Treatment

Health Care Services prescribed by your Physician, including medical, dental, Speech Therapy, audiology, and nutrition services for treatment of a Covered Dependent who has a cleft lip or cleft palate may be covered. In order to be covered, Services must be prescribed by a Provider who must certify in writing that the Services are Medically Necessary. Speech Therapy is subject to the limits stated in your Summary of Benefits for Outpatient Therapies and Spinal Manipulation Services.

Clinical Trials

Clinical trials are research studies in which Physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial.

If you are eligible to participate in an Approved Clinical Trial, routine patient care for Services furnished in connection with your participation in the Approved Clinical Trial are covered when:

1. An In-Network Provider has indicated such trial is appropriate for you; or

2. You provide us with medical and scientific information establishing and evidencing that your participation in such trial is appropriate.

Routine patient care includes all Medically Necessary Services that would otherwise be covered under this Policy, such as doctor visits, lab tests, x-rays and scans and Hospital stays related to treatment of your Condition.

Even though benefits may be available under this Policy for routine patient care related to an Approved Clinical Trial, you may not be eligible for inclusion in these trials or there may not be any trials available to treat your Condition at the time you want to be included in a clinical trial.

Exclusions:

1. Costs that are generally covered by the clinical trial, including, but not limited to:

   a. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

   b. The investigational item, device or Service itself.

   c. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. Services related to an Approved Clinical Trial received outside of the United States.

Concurrent Physician Care

Concurrent Care means care that is rendered to you by more than one Physician on the same date or during the same in-patient stay. Concurrent Care Services are only covered when documentation shows that:

1. The additional Physician actively participates in your treatment;

2. The Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and

3. The Physicians have different specialties or have the same specialty with different subspecialties Medically Necessary and indicated for your treatment.

Consultations

Consultations provided by a Physician are covered if your attending Physician requests the consultation and the consulting Physician prepares a written report.

Dental Services

Some types of dental Services are general dental Services; while most other dental Services are covered under the pediatric dental benefit. The only reason you need to know this is that some Services may have a different Cost Share depending on whether the Services are covered as a general dental Service or your pediatric dental benefits. This benefit is subject to Prior Coverage Authorization.

General Dental Services are limited to the following:

1. Care and stabilization Services for the treatment of damage to Sound Natural Teeth rendered within 90 days of an Accidental Dental Injury. This paragraph is not intended to exclude Services if the Accidental Dental Injury was present prior to the Effective

Date of the Policy, whether or not any medical advice, diagnosis, care, or Treatment was recommended or received prior to such date.

2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.

3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care rendered to you in a Hospital or Ambulatory Surgical Center if:

a. A Covered Dependent is under 8 years of age and the Dentist and the Covered Dependent's Physician determine that:

1) Dental treatment is necessary due to a dental Condition that is significantly complex; or

2) The Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective.

b. You have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center. Psychiatric reasons will not be considered significant or undue medical risk.

Exclusion: Dental Services, other than as described in the pediatric dental benefits section, rendered more than ninety (90) days after the date of an Accidental Dental Injury even if the Services could not have been rendered within ninety (90) days. This paragraph is not intended to exclude Services if the Accidental Dental Injury was present prior to the Effective Date of the Policy, whether or not any medical advice, diagnosis, care, or Treatment was recommended or received prior to such date.

Pediatric Dental Benefits

Pediatric dental benefits are covered as an Essential Health Benefits under this section only if they are:

1. Rendered to a Covered Person who has not reached the attained age of 19 and is extended through the end of the Benefit Period;

2. Not specifically or generally limited or excluded; and

3. Authorized for coverage by us, if Prior Coverage Authorization is required.

Note: If the estimated charges for Pediatric Dental Services exceed $500, you must obtain Prior Coverage Authorization from us.

Preventive Dental Services:

1. Oral exams, cleaning and fluoride treatments – once every six months in a Benefit Period.

2. Sealants – once per unrestored permanent molar every thirty-six (36) months.

3. Space maintainers to replace prematurely lost teeth.

4. X-rays (bitewing – two films) – once every six months in a Benefit Period.

Basic Dental Services:

1. Anesthesia – general anesthesia and intravenous sedation is covered only when rendered in connection with a covered surgical procedure.

2. Endodontics – minor (such as pulpal therapy).

3. Extractions (removal of teeth-except extractions for orthodontics).

4. Palliative care (treatment to relieve pain or to keep an Accidental Dental Injury or dental Condition, such as an abscess from getting worse). You may have to pay for the Services up front and then file a claim with us for reimbursement Claims must be filed within 90 days from the date of Service.

5. Periodontics – minor (such as deep cleaning).

6. Prosthodontics – minor (such as repair and relining of bridges, crowns and dentures).

7. Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold).

Major Services:

1. Endodontics – major (such as root canal treatment).

2. Periodontics – surgical (such as gingivectomy).

3. Prosthodontics – major (such as crowns and dentures, limited to once every sixty (60) months).

Implants and orthodontia Services are covered, when Medically Necessary, and with Prior Coverage Authorization.

Duplication of Dental Coverage and Exclusions

You cannot receive coverage under the Dental Services category for a Covered Service under both the General Dental Benefits and the Pediatric Dental Benefits. Dental Services covered under General Dental Benefits will not be covered under the Pediatric Dental Benefits and Dental Services covered under the Pediatric Dental Benefits will not be covered under the General Dental Benefits.

Exclusions: The dental exclusions below are applicable to all dental categories including, but not limited to, General Dental Benefits and Pediatric Dental Benefits.

1. Any dental Services not listed in this category as covered.

2. Cosmetic procedures, including, but not limited to, veneer restorations, tooth whitening, and orthodontia, except Medically Necessary orthodontia covered under Pediatric Dental Benefits.

3. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

4. Charges for nitrous oxide.

5. Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth reconstruction, restoration of tooth structure lost from attrition and restoration for crooked teeth.

6. Any additional treatment required because you do not follow instructions, or do not cooperate with the Dentist.

7. General anesthesia and intravenous sedation administered solely for patient management or comfort.

8. Services related to hereditary or developmental defects or cosmetic reasons, including, but not limited to, cleft palate (except as covered under Child Cleft Lip and Cleft Palate Treatment), upper or lower jaw defects, lack of development of enamel, discoloration of the teeth, and congenitally missing teeth.

9. Services rendered to a Covered Person after reaching the attained age of 19, including, but not limited to: care or treatment of the teeth or their supporting structures or gums, or dental procedures, including, but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral Prosthetic Devices, palatal expansion devices, bruxism appliances, and dental x-rays.

10. Restorations of the mouth, tooth or jaw, which are necessary due to an Accident are limited to those Services, Supplies and appliances appropriate for dental needs. Non-covered items include, but are not limited to, duplicate or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.

11. Benefits are not provided for mandibular staple implants, vestibuloplasty or skin grafts for atrophic mandible.

12. Replacement of lost or stolen Prosthetic Devices, extra set(s) of dentures or other Prosthetic Devices or appliances or temporary or treatment dentures.

13. Educational programs, such as training in plaque control or oral hygiene or for dietary instructions.

14. Myofunctional therapy and Services and Supplies related to temporomandibular joint dysfunctions and myofascial pain disorder.

Diabetes Treatment Services

Services related to the treatment and management of diabetes are covered when the treating Physician or a Physician who specializes in the treatment of diabetes certifies that such services are Medically Necessary and include the following:

1. Outpatient self-management training and educational Services when provided under the direct supervision of a certified In-Network Diabetes Educator or an In-Network board-certified Physician specializing in endocrinology;

2. Nutrition counseling provided by a licensed In-Network Dietitian;

3. Equipment and Supplies to treat diabetes, such as insulin pumps and tubing from an approved Provider (blood glucose meters, lancets and test strips are covered under your pharmacy benefit; refer to the MEDICATION PROGRAM section); and

4. Trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Exclusions:

1. Inpatient diabetes services are not covered.

2. Covered Outpatient self-management training and education are limited to a one-time evaluation and training program when Medically Necessary, within one (1) year of diagnosis. Any additional Medically Necessary self-management training shall be provided upon a significant change in symptoms, condition, or treatment. This additional training shall be limited to three (3) hours per year.

3. As otherwise limited or excluded by the Exclusions in the “What is Not Covered” section of your Policy.

Value-Based Diabetes Benefits

Managing a chronic condition, like diabetes, can be difficult. However, studies show you can help control your Symptoms by making lifestyle changes and by following your Physician’s advice. You can also delay, or even prevent, many of the complications of the disease.

Through the diabetes program, certain diabetes treatment Services are covered at no cost to you when you use In-Network Providers. Your Cost Share will be waived for the following diabetes treatment Services, up to the maximum amount listed below.

Note: The limits listed in the chart below apply only to the number of Services covered at no cost, but does not limit the number of Services covered on your plan, which will then be subject to your Cost Share amounts listed on your Summary of Benefits.

Type of Service	Limitations
Diabetic Retinal Exam	1 exam per year (no deductible applies)*
Podiatrist Exam	1 exam per year (no deductible applies)*
Insulin Pump	$0 Cost Share - limited to preferred brands/models** Note: Insulin pump supplies, such as tubing and infusion sets are subject to the Durable Medical Equipment Cost Share amount listed in your Summary of Benefits.
Diabetic Training	All Outpatient self-management training and educational Services are covered at $0 Cost Share when rendered by a certified Diabetes Educator or a board certified Physician specializing in endocrinology.
Lab Tests	HbA1c – 4 per year at $0* Lipid panel – 4 per year at $0* Urinalysis – 4 per year at $0*

*Medically Necessary Services rendered beyond the maximums listed above are subject to the Cost Share amounts listed on your Summary of Benefits and any applicable benefit limitations stated in your Policy.

**Insulin pumps require Prior Coverage Authorization. If, at the time the Prior Coverage Authorization is obtained, the $0 Cost Share is limited to certain brands or models, this information will be made available at the time of the Prior Coverage Authorization.

Diagnostic Services

Diagnostic Services are covered and include the following:

1. Radiology and ultrasound;

2. Advanced imaging Services such as nuclear medicine, CT/CAT Scans, MRAs, MRIs and PET Scans;

3. Laboratory Services (laboratory Services are considered Essential Health Benefits);

4. Pathology Services;

5. Approved machine testing such as electrocardiogram (EKG), electroencephalograph (EEG), and other electronic diagnostic medical procedures; and

6. Genetic testing for the purpose of explaining current signs and Symptoms of a possible hereditary disease and/or for other purposes in accordance with our Medical Necessity criteria then in effect.

Note:
1. We have the right to refer you to an Independent Clinical Laboratory or an Independent Diagnostic Testing Center if such Services are more appropriately rendered in such facility in accordance with applicable state and/or federal laws and regulations. When Diagnostic Services are not performed as indicated, a Site of Service Differential cost will apply.

2. Diagnostic Services require Prior Coverage Authorization from us, with the exception of routine x-rays and clinical laboratory Services when performed in an In-Network independent free-standing laboratory or a Physician's office.

Exclusion: Services which are not related to the Covered Person's Condition. Oversight of a medical laboratory by a Physician or other health care Provider, as described in the WHAT IS NOT COVERED? section.

Dialysis Services

Coverage includes equipment, training and medical Supplies, when rendered at any location by a Provider licensed to perform dialysis, including a Dialysis Center. This benefit is subject to Prior Coverage Authorization.

Durable Medical Equipment

Durable Medical Equipment are covered when provided by a Durable Medical Equipment Provider and when prescribed by a Physician and is limited to the most cost-effective equipment as determined by us. Replacement of Durable Medical Equipment due to growth of a Covered Dependent or significant change in functional status and repair of equipment you own or are buying are also Covered Services. Examples of Durable Medical Equipment include, but are not limited to: wheelchairs, crutches, canes, walkers, and oxygen equipment. Under certain circumstances, we may cover motorized wheelchairs which will be subject to medical necessity and Prior Coverage Authorization by us. If coverage is approved for a motorized wheelchair, the Covered Person's Coinsurance will be 50%.

Payment Rules for Durable Medical Equipment Benefits for Durable Medical Equipment will be based on the lowest of the following:

1. the purchase price;

2. the lease/purchase price;

3. the rental rate; or

4. our Allowed Amount. Our Allowed Amount for rental equipment will not exceed the total purchase price.

Note: Remember that your Cost Share is applied as claims are received and paid by us. This is important because if you are leasing to purchase Durable Medical Equipment, your Cost Share will apply throughout the lease period and continue until the equipment has been completely paid for in full. For example, after you have met your annual Deductible and Coinsurance, you may choose to lease or purchase a piece of equipment. If the lease continues into the next Benefit Period, you will have to meet your annual Deductible and Coinsurance again before any more payments are made by WellAway.

Exclusions:

1. Durable Medical Equipment that is primarily for convenience and/or comfort;

2. Modifications to motor vehicles and/or homes, including, but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools;

3. Exercise and Massage equipment, electric scooters, CPAP machines, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers; and

4. The replacement of Durable Medical Equipment just because it is old or used.

Emergency Services and Urgent Care Services

Emergency Services

Emergency Services for treatment of an Emergency Medical Condition are covered as Essential Health Benefits for both In-Network and Out-of-Network without the need for any Prior Coverage Authorization from us. *If you use an emergency room in the Hospital for a non-emergency service, the Services will not be covered*.

Payment Rules for Emergency Services

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will be the greater of:

1. The amount equal to the median amount negotiated with all In-Network Providers for the same Services;

2. The Allowed Amount as defined in this Policy; or

3. What Medicare would have paid for the Services rendered.

In no event will Out-of-Network Providers be paid more than their charges for the Services rendered.

Urgent Care Services
For non-critical but urgent care needs, you may be able to reduce your Out-of-Pocket Costs and, in many cases, your wait time for care by using an Urgent Care Center. All Urgent Care Centers maintain extended weekday and weekend hours. Urgent Care Centers treat non-emergency conditions such as:

- Animal bites
- Cuts, scrapes and minor wounds
- Minor burns
- Minor eye irritations, infections or irritations
- Rash, poison ivy
- Sprains, strains, dislocations and minor fractures

Enteral Formulas

Prescription and non-prescription enteral formulas for home use are covered when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism, as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Tubes and Supplies, if needed, are covered under the Durable Medical Equipment benefit.

Coverage to treat inherited diseases of amino acid and organic acids shall include food products modified to be low protein. This benefit is subject to Prior Coverage Authorization.

Eye Care and Vision Services

Some types of eye care and vision Services are covered under your medical benefits; some are covered under your vision benefits, if purchased (adults) or under the Pediatric Vision Services. The only reason you need to know this is that some Services may have a different Cost Share depending on whether the Services are covered under your medical benefits or your vision benefits. Exclusions that apply to all Services are listed under the section titled General Eye Care and Vision Exclusions.

Eye Care and Vision Services covered under the medical benefits are limited to the following:

1. Physician Services and/or soft lenses or sclera shells for the treatment of aphakic patients;

2. Initial glasses or contact lenses following cataract surgery; and

3. Physician Services to treat an injury to or disease of the eyes.

Pediatric Vision Services

Pediatric Vision Services are generally referred to as optometry care. This involves the process of vision testing and correction and is not covered under this Policy for adults. Pediatric Vision Services are covered as Essential Health Benefits under this section only if they are:

1. Rendered to a Covered Person who has not reached the attained age of 19, and is extended through the end of the Benefit Period; and

2. Not specifically or generally limited or excluded.

Pediatric Vision Services are limited to the following:

1. Vision Examinations: Benefits will be provided for one (1) vision exam for each Covered Person per Benefit Period.

2. Frames: Benefits will be provided for one (1) frame for each Covered Person per Benefit Period. Covered Services include, but are not limited, to facial measurements, determination of interpupillary distances, and assistance in frame selection, fitting and adjustment.

3. Lenses: Benefits will be provided for one (1) pair of lenses for each Covered Person per Benefit Period, provided there were no benefits paid for contact lenses during the same Benefit Period. Lenses include:

a. clear plastic single-vision lenses;

b. clear plastic lined bifocal, trifocal or lenticular lenses;

c. polycarbonate lenses;

d. standard progressive lenses;

e. plastic photosensitive lenses;

f. oversize lenses;

g. low-vision lenses;

h. blended-segment lenses;

i. intermediate vision lenses;

j. premium progressive lenses;

k. photochromic glass lenses;

l. polarized lenses;

m. high-indexed lenses;

n. scratch-resistant coating;

o. tinting of plastic lenses; and

p. ultraviolet coating.

4. Contact Lenses: Contact lenses are covered as a substitute for conventional lenses and frames as indicated above. Benefits will be provided for contact lenses for each Covered Person per Benefit Period, provided there were no benefits paid for contact lenses during the same Benefit Period.

Note: By utilizing an Optometrist, you maximize your benefit allowances and reduce your out-of-pocket payments to Providers. Pediatric Vision Services rendered by an Optometrist are covered at 100% of Usual, Customary and Reasonable Charges. Pediatric Vision Services rendered by an Ophthalmologist will be covered as a Specialist visit as stated in your Summary of Benefits.

Duplication of Vision Coverage and Exclusions

You cannot receive coverage under the Eye Care and Vision categories for a Covered Service under both the medical and pediatric vision benefits. Eye care and vision Services covered under medical benefits will not be covered under the pediatric vision benefits, and vision Services covered under the pediatric vision benefits will not be covered under medical benefits.

Exclusions (General Eye Care and Vision Exclusions):

1. Health Care Services to diagnose or treat vision problems for Covered Persons that are not a direct consequence of trauma or prior eye surgery, except as covered under pediatric vision benefits;

2. Vision examinations for a Covered Person who has reached the attained age of 19, and is extended through the end of the Benefit Period;

3. Eye exercises or visual training; and

4. Any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK.

Family Planning

Family Planning Services include:

1. Family planning counseling and Services, such as counseling and information on birth control; sex education, including prevention of venereal disease; and fitting of diaphragms;

2. Contraceptive medication by injection provided and administered by a Physician;

3. Intra-uterine devices indicated as covered in this Policy only under the MEDICATION PROGRAM section, including the insertion and removal of such devices; however, intra-uterine devices are limited to 1 insertion and 1 removal per Benefit Period;

4. Implants indicated as covered in this Policy only under the MEDICATION PROGRAM section, including the insertion and removal of such implants; however, implants are limited to 1 insertion and 1 removal per Benefit Period; and

5. Surgical sterilization (tubal ligations and vasectomies).

Note: Some family planning Services are covered under the Preventive Services category and will be paid in accordance with that category. Please refer to that category and your Summary of Benefits for more information. Contraceptive medications, devices and appliances may be covered under your pharmacy benefit. Please refer to the MEDICATION PROGRAM section for more information.

Exclusion: Elective abortions and the reversal of surgical sterilization procedures are not covered.

Home Health Care

Home Health Care Services are covered when all the following criteria are met:

1. You are unable to leave your home without considerable effort and assistance because you are bedridden or chair-bound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition;

2. The Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan to us;

3. The treatment plan has been reviewed and renewed by the prescribing Physician at least every thirty (30) days until benefits are exhausted. (We reserve the right to request a copy of any written treatment plan in order to determine whether such Services are covered under this Policy);

4. The Home Health Care Services are provided by or through a Home Health Agency; and

5. You are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

To obtain benefits, a Covered Person must meet all of the following conditions:

1. A Covered Person would have to be admitted to a Hospital or Skilled Nursing Facility if he or she did not receive Home Health Care Services;

2. The Home Health Care Services program must be directly related to the Condition for which hospitalization was required; and

3. The Home Health Care Services program must begin within fourteen (14) days of discharge from the Hospital or Skilled Nursing Facility. This paragraph is not intended to exclude Services if the medical condition was present prior to the Effective Date of the Policy, whether or not any medical advice, diagnosis, care, or Treatment was recommended or received prior to such date.

Home Health Care Services are limited to:

1. Part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse or a vocational nurse under the supervision of a Registered Nurse, and/or home health aide Services (part-time is defined as less than 8 hours per day and less than forty (40) hours per week and an intermittent visit will not exceed 2 hours per day);

2. Home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and provided under the supervision of a Registered Nurse;

3. Medical social Services;

4. Nutritional guidance;

5. Respiratory or inhalation therapy, such as oxygen; and

6. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist.

Exclusions:
1. Homemaker or domestic housekeeping services;

2. Sitter or companion services;

3. Services rendered by an employee or operator of an adult congregate living facility, an adult foster home, an adult day care center, or a nursing home facility;

4. Speech Therapy provided for diagnosis of developmental delay;

5. Custodial Care;

6. Food, housing and home-delivered meals; and

7. Services rendered in a Hospital, nursing home, or intermediate care Facility.

Note: This benefit is only available when you obtain Prior Coverage Authorization from us.

Hospice Services

Health Care Services provided in connection with a Hospice treatment program are Covered Services, provided the Hospice treatment program is:

1. Approved by your Physician; and

2. Certified to us in writing by your Physician that your life expectancy is 6 months or less.

Note:

1. This benefit is subject to Prior Coverage Authorization.

2. Inpatient Hospice Services must be approved by WellAway's Case Management Department.

Hospital Services

Covered Hospital Services include:

1. Room and board in a semi-private room when confined as an Inpatient, unless the Covered Person must be isolated from others for documented clinical reasons and not hospital convenience;

2. Intensive care units, including cardiac, progressive and neonatal care;

3. Use of operating and recovery rooms;

4. Use of emergency rooms;

5. Respiratory, pulmonary or inhalation therapy, such as oxygen;

6. Drugs and medicines administered by the Hospital (except for take-home drugs);

7. Intravenous solutions;

8. Administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion in the WHAT IS NOT COVERED? section);

9. Dressings, including ordinary casts;

10. Anesthetics and their administration;

11. Transfusion Supplies and equipment;

12. Diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as EKG;

13. Chemotherapy and radiation treatment for proven malignant disease;

14. Physical, Speech, Occupational and Cardiac Therapies;

15. Transplants as set forth in the Transplants Services category; and

16. Other Medically Necessary Services.

These Services are considered Essential Health Benefits.

Note: Hospitalization is subject to Prior Coverage Authorization.

Exclusions:

1. All expenses for Hospital Services (including the Hospital charges, Physician charges and any other charges related to an Inpatient stay) are excluded when Services could have been rendered without admitting you to the Hospital;

2. Gowns and slippers;

3. Shampoo, toothpaste, body lotions and hygiene packets;

4. Take-home drugs and medications;

5. Telephone and television charges;

6. Guest meals or gourmet menus; and

7. Admission kits.

Inpatient Rehabilitative & Habilitative Services Occupational Therapy, Physical Therapy and Speech Therapy are covered when provided as a Habilitative Service.

Inpatient Rehabilitative & Habilitative Services are covered as an Essential Health Benefit, and are each limited to a maximum of 45 days per Benefit Period per Covered Person, when all of the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation or habilitation program;

2. A plan of care must be developed and managed by a coordinated multi-disciplinary team;

3. Our Medical Necessity coverage criteria then in effect is met; and

4. The Rehabilitative or Habilitative Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

This benefit is subject to Prior Coverage Authorization.

Exclusions:
1. Inpatient rehabilitation is restricted to the treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery.

2. Cardiac Therapy, Massage Therapy, Pain Management and spinal manipulation Services are not covered as Habilitative Services.

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate state or federal regulatory agencies for diagnostic purposes or breast cancer screening are Covered Services. This benefit is only available when you utilize an In-Network Provider.

Mastectomy Services

Breast cancer treatment, including treatment for physical complications relating to a Mastectomy (including lymphedemas) and Outpatient post-surgical follow-up care for Mastectomy Services are covered when rendered by a Provider in accordance with prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, Outpatient center, or your home as determined by you and your Physician. This benefit is subject to Prior Coverage Authorization.

Maternity & Complications of Pregnancy

Health Care Services provided to you by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), Hospital, Birth Center, Midwife or Certified Nurse Midwife are Covered Services as an Essential Health Benefit and include the following:

1. Physician or Midwife Services provided to you for routine pregnancy, delivery, miscarriage or pregnancy complications. If your plan includes a Copayment for office Services, you will usually only have one Copayment, due on the first visit, for all prenatal care, the delivery and your follow-up visits to your obstetrician or Midwife. This Copayment applies only to Physician or Midwife Services relating to the pregnancy; any visits you have due to illness not related to the pregnancy may require a separate per visit Copayment.

2. Hospital or Birth Center Services for labor and delivery of the baby. This includes a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment and room and board for the mother and routine nursery care. Your Cost Share for these Services is listed on your Summary of Benefits and is in addition to your Cost Share for the obstetrician or Midwife. You may also choose to deliver your baby at home, in which case, the Hospital or Birth Center Cost Share would not apply. For a well mom and well-baby, both are discharged on the same day. One claim is filed by the Providers and no Prior Coverage Authorization or notification is required. The Providers are required to combine the baby's charges with the mother's charges in the same bill.

3. Routine nursery care for the newborn child during the covered portion of the mother's maternity stay is included under this benefit and the Hospital is required to file one claim which combines the baby's charges with the mother's charges. However, when an infant requires non-routine treatment during or after the mother's stay, the newborn is considered a patient in his or her own right and will be covered separately only if the newborn is properly enrolled. The newborn's hospital admission in this case is subject to separate Cost Share amounts. For a well mom and sick baby, the Providers will file two (2) claims, subject to separate Cost Share amounts. Notification is required for the baby.

Delivery Services include the following:

1. Normal delivery.

2. Caesarean section.

3. Spontaneous termination of pregnancy prior to full term.

4. Therapeutic termination of pregnancy prior to full term.

5. Ectopic pregnancies.

6. Pre and post-natal medical care – Physician visits only.

7. Laboratory, pathology, x-ray and radiology Services.

Complications of Pregnancy – Benefits for complications of pregnancy will be paid as any other illness, subject to the standard Deductible and Coinsurance requirements.

Complications of pregnancy are defined as:

1. Interruption of pregnancy (i.e. missed, spontaneous, or therapeutic abortions); and/or

2. Ectopic pregnancy; and/or

3. Placenta previa; and/or

4. Abruptio placenta; and/or

5. Eclampsia and toxemia; and/or

6. Hyperemesis gravidarum; and/or

7. Gestational diabetes; and/or

8. Cephalo-pelvic disproportion; and/or

9. Hydatiform mole.

Complications of Pregnancy do **NOT** include:

1. Fetal distress.

2. Previous caesarian section.

3. Pre-term labor.

4. Fetal position.

5. Conditions associated with the management of a difficult or high-risk pregnancy.

6. Prolonged or difficult labor.

7. All other conditions not specifically set forth in Complications of Pregnancy above.

Exclusions:
1. Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract. This exclusion applies to all Services related to such pregnancy (prenatal, labor and delivery and postpartum).

2. Infertility treatment and artificial conception: Benefits will not be provided for Artificial Insemination, In Vitro Fertilization, or other artificial methods of conception.

3. Genetic and chromosomal testing or counseling: Genetic molecular testing is not covered except when there are signs and/or Symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed. As used herein, “genetic molecular testing” means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.

Note: A plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, this does not prohibit the mother’s or newborn’s attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six 96 as applicable). In any case, a plan can only require that a Provider obtain authorization for prescribing an Inpatient Hospital stay that exceeds forty-eight 48 hours (or ninety-six 96 hours).

Medical Pharmacy

Prescription Drugs that are provided in a Physician’s office may have a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to the Prescription Drug but does not include the cost for the Services of the person who administers the Prescription Drug to you. Allergy injections and immunizations are not part of the Medical Pharmacy benefit.

You or your Physician must contact us to request coverage for a Prescription Drug covered under this category before administering it to you by following the process for Prior Coverage Authorization outlined in the Medication Program. Prescription Drugs covered under this category may be subject to the utilization review programs described in the MEDICATION PROGRAM section. This benefit is only available when you utilize an In-Network Provider.

Newborn Care

A newborn child who is properly enrolled will be covered from the moment of birth for injury or illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Care includes the following:

1. Routine nursery charges billed by a Hospital.

2. Routine Inpatient care of the newborn child and stand-by care of a pediatrician for a caesarean section.

Newborn Assessment
An assessment of the newborn child are covered when the Services are rendered at a Hospital, attending Physician's office, Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife. Covered Services include physical assessment of the child and any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Newborn Ambulance Services
Ambulance Services are covered when necessary to transport the newborn child to and from the nearest appropriate facility that is appropriately staffed and equipped to treat the child's Condition, as determined by us and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child.

Obesity & Weight Loss

Obesity in itself is not considered an illness or disease, and benefits are not allowed for the evaluation and treatment of obesity alone. Services and Supplies related to weight loss programs are not covered, with the exception of obesity screening & counseling for children and adults. The only situation under which benefits will be allowed for obesity is when a surgical procedure is required due to morbid obesity. Benefits will only be paid when the Covered Person meets the current NIH (National Institutes of Health) surgical criteria.

Note: The number of gastric bypass procedures covered under this Policy is limited to a lifetime maximum of one per Covered Person. This benefit is subject to Prior Coverage Authorization.

Orthotic Devices

Orthotic Devices including braces and trusses for the leg, arm, neck and back and special surgical corsets are covered when prescribed by a Physician and designed and fitted by an Orthotist.

Benefits are provided for necessary replacement of an Orthotic Device you own when due to irreparable damage, wear, a change in your Condition, or when necessary due to growth of a Covered Dependent.

Coverage for Orthotic Devices is based on the most cost-effective Orthotic Device that meets your medical needs as determined by us.

Exclusions:
1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/ appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

2. Expenses for orthotic appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding, such as dynamic orthotic cranioplasty or molding helmets; except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis.

3. Expenses for devices necessary to exercise, train or participate in sports, such as custom-made knee braces.

Osteoporosis Services

Screening, diagnosis and treatment of osteoporosis are covered for high-risk individuals, including, but not limited to, individuals who:

1. Are estrogen-deficient and at clinical risk for osteoporosis;

2. Have vertebral abnormalities;

3. Are receiving long-term glucocorticoid (steroid) therapy;

4. Have primary hyperparathyroidism; or

5. Have a family history of osteoporosis.

Outpatient Physical Therapy and Spinal Manipulation Services

Physical Therapy Services
Physical Therapy Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition. Your Policy will cover interventions/modalities/therapeutic procedures (therapeutic modalities) per visit as long as the therapeutic modalities are consistent with the Covered Person's plan of treatment for the same Condition. More than one (1) therapeutic modality may be billed as long it is identifiable by the type of treatment and consistent with the treatment plan. The therapeutic modalities must be electrical, thermal or mechanical energy that causes physiological changes, and a therapist must provide direct, one-on-one therapy for at least eight minutes to receive reimbursement for one unit of a time-based treatment code. Physical Therapy Services are limited to forty (40) visits in a Benefit Period per Covered Person. All Services must be Medically Necessary and relate specifically to the frequencies and duration of such therapy, long term and short-term goals.

Chiropractic & Spinal Manipulation Services
Chiropractic & Spinal manipulation Services rendered by a Physician for manipulation of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered. It is important that you understand the difference between a spinal manipulation and a visit in order to understand how the benefit limits work. During a visit, more than one Service can be rendered and billed. Spinal manipulation is a treatment modality or method and more than one spinal manipulation can occur and be billed during a single visit to a Provider. Coverage for chiropractic care and/or spinal manipulation is limited to 15 visits each Benefit Period.

Note: Outpatient Physical Therapy and Spinal Manipulation Services are subject to Prior Coverage Authorization.

Exclusions:

1. Application or use of the following or similar techniques or items for the purpose of aiding in the provision of Massage including, but not limited to: hot or cold packs, hydrotherapy, colonic irrigation, thermal therapy; chemical or herbal preparations, paraffin baths, infrared light, ultraviolet light, Hubbard tank, and/or contrast baths are not covered.

2. Cardiac Therapy, Pain Management and Massage Therapy Services are not covered in this category.

3. Benefits will not be provided for Occupational or Speech Therapy Services except as described in the Outpatient Rehabilitative & Habilitative Services category in this section.

Outpatient Rehabilitative & Habilitative Services

Rehabilitative Services
Services primarily for the purpose of therapeutic or rehabilitative treatment of the Covered Person (such as physical, occupational, speech, or oxygen therapy, etc.) are Covered Services.

Habilitative Services
Services primarily for the purpose of therapeutic or habilitative treatment of the Covered Person for conditions which have limited the normal age appropriate motor, sensory or communications development of the Covered Person are Covered Services if through the Habilitative Services, functional improvement and measurable progress is made toward achieving functional goals within a predictable period of time to reach the Covered Person's maximum potential development. Occupational Therapy, Physical Therapy and Speech Therapy are covered as Essential Health Benefits when provided as a Habilitative Service.

Outpatient Rehabilitative & Habilitative Services are covered, and are limited to a maximum of twenty (20) visits per Benefit Period per Covered Person, when all of the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation or habilitation program;

2. A plan of care must be developed and managed by a coordinated multi-disciplinary team;

3. Coverage is subject to our Medical Necessity coverage criteria then in effect; and

4. The Rehabilitative Therapies or habilitative therapies must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Limitations and Exclusions:

1. Outpatient rehabilitation is restricted to the treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery.

2. Cardiac Therapy, Massage Therapy, Pain Management and spinal manipulation Services are not covered as Habilitative Services.

3. This benefit is subject to Prior Coverage Authorization.

Oxygen

Coverage includes oxygen and the use of equipment for its administration.

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an Outpatient facility. Surgical Health Care Services provided by a Physician in the Physician's office are subject to your Deductible and Coinsurance, as indicated in the Hospital & Surgical Care section of your Summary of Benefits. All laboratory procedures, tests and imaging Services provided by a Physician or any licensed person within the Physician's office are subject to Deductible, Coinsurance or Copayments as indicated in the Outpatient Diagnostic Services section of your Summary of Benefits.

Physician E-Visits

Certain Physician Services can be rendered electronically through a computer via the internet (E-Visit). An E-Visit is covered when rendered in accordance with the rules below.*

Expenses for an E-Visit is covered only if:

1. You are an established patient (as defined below), of the Physician rendering the Services at the time the Services are provided;

2. The Services are provided in response to an online inquiry you sent to the Physician;

3. The E-Visit shall not exceed 1 in any consecutive seven day period;

4. The E-Visit includes at least a problem, focused history and straight forward medical decision making, as defined by the CPT manual;

5. The E-Visit is conducted over a secured channel, encrypted and compliant with the Health Insurance Portability and Accountability Act; and

6. An E-Visit is legally authorized in your state of residence. Physician E-Visits are limited to 1 per day per Physician even if they are performed for different Conditions but during the same day. The term "established patient" as used in this category shall

mean the Covered Person has previously received professional Services from the Physician who provided the E-Visit, or another Physician of the same specialty who belongs to the same group practice as that Physician, within the past 3 years.

*These rules do not apply to Physician E-visits for Mental Health Services.

Exclusions:
1. Expenses for failure to keep a scheduled appointment or scheduled E-Visit are not covered.

2. Telephone consultations are not covered.

3. E-Visits for the purpose of medication refill or for lab results, provision of educational material, registration or updating billing information or reminders are not covered.

4. Sleep studies including, but not limited to, simultaneous recording; heart rate; oxygen saturation; respiratory analysis e.g.; by airflow or peripheral arterial tone; sleep time; and sleep apnea studies at home.

Preventive Services

Preventive Services are covered as Essential Health Benefits for both adults and children based on prevailing medical standards and recommendations that are explained further below. Some examples of preventive Services include, but are not limited to, periodic routine health exams, routine gynecological exams, routine mammograms and pap smears, immunizations and related preventive Services such as prostate specific antigen (PSA).

Colonoscopies for colorectal cancer screenings (for adults aged 45 and older, every 10 years) is a screening colonoscopy done for the prevention of a medical condition and is considered a preventive Health Service. A screening colonoscopy will not have any Cost Shares to you, when performed within the frequency and age requirements established by ACA standards and guidelines. A diagnostic colonoscopy is done to explore or investigate abnormal symptoms, tests, prior medical conditions or family history. A diagnostic colonoscopy will be subject to applicable Cost Share amounts. If your treating Provider performs a screening colonoscopy that results in a diagnostic colonoscopy, it will be subject to medical review and applicable Cost Shares will apply if it is determined that the colonoscopy performed was a diagnostic colonoscopy and not a screening colonoscopy.

In order to be covered as a preventive Service, Services shall be provided in accordance with prevailing medical standards as follows:

1. Consistent with evidence-based items or Services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) established under the Public Health Service Act.

2. Consistent with immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved.

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

4. With respect to women, such additional preventive care and screenings not described in paragraph number one above, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Women’s preventive coverage under this paragraph includes:

a. Well-woman visits;

b. Screening for gestational diabetes;

c. Human papilloma virus testing;

d. Counseling for sexually transmitted infections;

e. Counseling and screening for human immune- deficiency virus;

f. Contraceptive methods and counseling except when indicated as covered under the MEDICATION PROGRAM section;

g. Screening and counseling for interpersonal and domestic violence;

h. Breastfeeding support, Supplies and counseling. Breastfeeding Supplies are limited to breast pumps. You must obtain Prior Coverage Authorization from us before you get a breast pump. Breast pumps must be obtained through a Durable Medical Equipment Provider who must be able to verify that you are either scheduled for delivery or have delivered within 9 months. In-Network benefits are only available through our preferred Durable Medical Equipment Provider. If you do not obtain Prior Coverage Authorization, we will not make any payment for such Service.

Note:

1. This benefit is only available when you utilize an In-Network Provider.

2. From time to time, medical standards that are based on the recommendations of the entities listed in numbers 1 through 4 above change. Services may be added to the recommendations and sometimes may be removed. It is important to understand that your coverage for these preventive Services is based on what is in effect on your Effective Date. If any of the recommendations or guidelines change after your Effective Date, your coverage will not change until the next Benefit Period. Routine vision and hearing examinations and screenings are not covered as preventive Services, except as required under paragraph number one and/or paragraph number three above.

For example, if the USPSTF adds a new recommendation for a preventive Service that we do not cover and you are already covered under this Policy; that new Service will not be a Covered Service under this category right away.

The coverage for the new Service will start at the beginning of your next Benefit Period.

Limitations:
1. Sterilization procedures covered under this category are limited to tubal ligations only.

2. Coverage for intra-uterine devices include insertion and removal.

3. Breast pumps are limited to:

a. one manual or electric breast pump per pregnancy, in connection with childbirth;

b. the most cost-effective pump as determined by us (please see the Durable Medical Equipment category in this section for additional information);

c. hospital-grade breast pumps are not covered except when Medically Necessary during an Inpatient stay, in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided.

Private Duty Nursing (Inpatient Only)

Benefits will be provided for Inpatient private duty nursing Services only when:

1. A Covered Person's Condition would ordinarily require that the Covered Person be placed in an intensive or coronary care unit, but the Hospital does not have such facilities, or the Hospital's intensive or coronary care unit cannot provide the level of care necessary for the Covered Person's Condition; and

2. The private duty nurse is not employed by the Hospital or Physician and is not a resident of the household or a relative of the Covered Person.

WellAway will review all Inpatient private duty nursing claims for appropriateness and Medical Necessity.

Exclusions:
1. Benefits will not be provided for private duty nursing Services that ordinarily would be provided by Hospital staff or its intensive care or coronary care units.

2. Benefits will not be provided for Outpatient private duty nursing.

3. Benefits will not be provided for Services, which are requested by, or for the convenience of a Covered Person or the Covered Person's family. (Examples: bathing, feeding, exercising, homemaking, moving the Covered Person, giving medication, or acting as a companion or sitter.) In other words, Services that do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not covered.

Prosthetic Devices

The following Prosthetic Devices are covered when prescribed by a Physician and designed and fitted by a Prosthetist:

1. Artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers, and Prosthetic Devices incident to a Mastectomy;

2. Appliances needed to effectively use artificial limbs or corrective braces; and

3. Penile prosthesis and surgery to insert penile prosthesis when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, and epispadias, and exstrophy.

Covered Prosthetic Devices (except cardiac pacemakers, and Prosthetic Devices incident to Mastectomy) are limited to the first permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition. Coverage for Prosthetic Devices is based on the most cost-effective Prosthetic Device that meets the Covered Person's medical needs as determined by us.

Benefits are provided for necessary replacement of a Prosthetic Device which is owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessary due to growth of a child.

Exclusions:
1. Expenses for microprocessor controlled or myoelectric artificial limbs, such as C-legs;

2. Expenses for performance enhancing Prosthetic Devices (such as carbon-fiber racing legs); and

3. Expenses for cosmetic enhancements to artificial limbs.

Self-Administered Prescription Drugs

Self-Administered Prescription Drugs are generally covered under the pharmacy benefit (MEDICATION PROGRAM section). However, there are times when these drugs would be covered under the medical benefits (i.e., when you are an Inpatient in a Hospital or Skilled Nursing Facility or when rendered to you by a Provider for immediate stabilization, such as anaphylaxis). Please refer to the following Covered Services categories for coverage limitations and exclusions: Ambulatory Surgical Centers, Hospital Services and Skilled Nursing Facilities.

Skilled Nursing Facilities

The following Health Care Services are Covered Services when you are an Inpatient in a Skilled Nursing Facility:

1. Room and board;

2. Respiratory, pulmonary or inhalation therapy, such as oxygen;

3. Drugs and medicines administered while an Inpatient (except take-home drugs);

4. Intravenous solutions;

5. Administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the WHAT IS NOT COVERED? section);

6. Dressings, including ordinary casts;

7. Transfusion Supplies and equipment;

8. Diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as an EKG;

9. Chemotherapy and radiation treatment for proven malignant disease;

10. Physical, Speech and Occupational Therapies; and

11. Other Medically Necessary Services.

Note:

1. Skilled Nursing Facility Services are subject to Prior Coverage Authorization.

2. Services must be provided within fourteen (14) days after discharge from the Hospital.

3. Care must begin immediately following your Hospital stay of no less than three (3) days. This is not intended to exclude Services if the Hospital stay was prior to the Effective Date of the Policy. Insurer has the right to review a Confinement, as it deems necessary, to determine if the stay is Medically Necessary. Insurer will reimburse one (1) Physician visit per day per specialty while the Covered Person is a patient in a Hospital or approved extended care Facility. Visits that are part of normal preoperative and postoperative care are covered under the Surgical fee and Insurer will not pay separate charges for such care.

Exclusion: Expenses for an Inpatient admission to a Skilled Nursing Facility for Custodial Care, convalescent care, or any other Service primarily for your convenience, or that of your family members or the Provider, are not covered.

Surgical Procedures

Surgical procedures rendered by a Physician, including surgical assistant Services rendered by a Physician, Registered Nurse First Assistant (RNFA) or a Physician Assistant acting as a surgical assistant when such assistance is Medically Necessary, include the following:

1. Surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects, Accidents, reconstructive surgery or prior therapeutic processes;

2. Oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth;

3. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery; and

4. The Assistant at Surgery is deemed needed for the surgery being performed according to medical standards.

Payment Rules for Surgical Procedures

1. When multiple surgical procedures are performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session, our payment will be based on 50 percent of the Allowed Amount for any secondary surgical procedure performed and is subject to the Cost Share amount (if any) indicated in your Summary of Benefits. This guideline applies to all bilateral procedures and all surgical procedures performed on the same date of Service.

2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An “incidental surgical procedure” includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure, which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (there is no payment for the removal of the normal appendix in this example).

3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, Unna Boot, and other related Health Care Services, is included in the Allowed Amount for the surgical procedure.

Note: Outpatient surgical procedures require Prior Coverage Authorization from us.

Transplant Services

Transplant Services include, but are not limited to, the procedures listed below. Transplant Services are covered when performed at a facility acceptable to us, subject to the limitations and exclusions set forth below. Transplant Services include pre-transplant, transplant and post-discharge Services and treatment of any complications after transplantation.

1. Autologous or Allogeneic Bone Marrow Transplant and/or Peripheral Stem Cell Transplant (HDC/ABMT). We will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. “Donor” is, in the case of an allogeneic transplant, the individual supplying the bone marrow and/or stem cells. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;

2. Corneal transplant;

3. Heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplant);

4. Heart-lung combination transplant;

5. Liver transplant;

6. Kidney transplant;

7. Pancreas transplant;

8. Pancreas transplant performed simultaneously with a kidney transplant;

9. Whole single or whole bilateral lung transplant. You may call the customer service phone number on your ID Card to determine which transplant Services are covered under this Policy; or

10. High dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support.

Note: This benefit requires that the Covered Person request a Prior Coverage Authorization from PayerFusion at least thirty (30) business days prior to the scheduled Service date, unless a greater time period is required as stated in this Policy.

Exclusions:

1. Experimental or Investigational transplant procedures.

2. Transplant procedures involving the transplantation of any non-human organ or tissue.

3. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.

4. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ.

5. Any organ, tissue, marrow, or stem cells that are sold rather than donated.

6. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.

7. Any non-medical costs, including, but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.

8. Any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Additional Benefits

Medical Evacuation

Medical Evacuation applies when the Covered Person is traveling outside the United States. In the event of an emergency where the necessary treatment for which the Covered Person is covered and the treatment is not available in the destination where the Covered Person is traveling, we will evacuate the Covered Person to the nearest appropriate medical facility up to the Maximum Benefit per Covered Person, per Benefit Period. The medical evacuation should be requested by the treating Physician and will be carried out in coordination between the Covered Person's treating Physician and WellAway's third-party administrator in the most cost effective way having regard to the Covered Person's medical Condition.

Following a Medical Evacuation, this Policy will cover the costs of transportation (economy class flight), to the Covered Person's Country of Origin or country of residence. The return journey must be made within fourteen (14) days after the Medical Evacuation and the treating Physician must provide a fit to fly certificate. The Plan Administrator will coordinate the transportation to return the Covered Person to the Country of Origin or country of residence.

Note:
1. We, and our agents, accept no liability in the event that such endeavors are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

2. Covered Person(s), or if unable, an individual acting on his/her behalf, must contact WellAway at the first indication that an evacuation is required. From this point onwards, WellAway's third-party administrator will organize and coordinate all stages of the evacuation until the Covered Person is safely received into care at his/her destination. This benefit is subject to Prior Coverage Authorization. In the event that all evacuation Services are not organized by us, we will deny all costs incurred.

Exclusions:
1. Where a Covered Person has been evacuated to the nearest appropriate medical facility and requires ongoing treatment, we will not cover the cost for the hotel accommodation or transportation to/from the nearest appropriate medical facility.

2. Medical Evacuation arising out of any Condition while on a cruise ship is excluded from coverage under this Policy.

3. Any expenses relating to search and rescue operations to find a Covered Person in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea are excluded from coverage under this Policy.

Repatriation of Mortal Remains

In the event the Covered Person dies outside the United States, WellAway's thrid-party administrator will arrange for the mortal remains to be returned to the Country of Origin as soon as reasonably possible, subject to airline requirements and restrictions.
In the event of death from a Condition, this Policy will provide coverage for:

- The cost of transportation of the body or ashes of a Covered Person to his/her Country of Origin, including all necessary documentation; or

- The cost of sending the urn to the Country of Origin.

Limitations: This benefit is subject to the following limitations:

1. Coverage is limited to expenses for embalming, a container legally appropriate for transportation, shipping costs and necessary government authorizations.

2. Funeral costs are not covered.

3. This benefit is subject to Prior Coverage Authorization.

4. The original death certificate must be provided along with copies of any payment of cremation Services of the Covered Person when a request for reimbursement is made. Additional documentation may be requested to be provided.

Worldwide Coverage

Expenses and Services provided outside the United States, excluding the Restricted Areas, are covered per Covered Person for a maximum of one hundred seventy-nine (179) days per Benefit Period. All covered Services must be Medically Necessary for the treatment of a Covered Person's Condition. All benefits are subject to Usual, Customary and Reasonable Charges. Please refer to your Summary of Benefits for applicable Cost Share amounts.

Note: We will attempt at all times to settle the costs directly with the Hospital and/or Provider; however, it is in the Hospital's and/or Provider's discretion to accept direct payment from us. In the event a direct settlement is not accepted by the Provider or Hospital, WellAway will:

(i) send the remittance to the Covered Person at the time Services are rendered or upon discharge via credit/debit card or other financial instrument; or

(ii) request the Covered Person to settle the invoices in full directly with the Hospital and/or Provider. Thereafter, the Covered Person may submit the invoices for reimbursement; provided, however, reimbursement will be in the amount of the Usual, Customary and Reasonable Charges for such Services. All reimbursement requests must be done in accordance with the Post-Service Claims section of this Policy.

Limitation: The Covered Person is covered worldwide under this Policy; however, if a treatment plan commences outside the United States, the treatment plan must be continued outside the United States, continuing the established treatment plan with the same Physician and protocols. The Policy will not cover treatment plans which commence outside the United States to be continued in the United States or another country of the Covered Person's choice. The Policy will also not cover treatment plans which commence inside the United States to be continued outside the United States or another country of the Covered Person's choice.

Exclusion: Telemedicine or Telehealth consultations outside the United States are not covered.

Return Home

We understand the importance of being medically treated by a Physician you trust or close to family when undergoing medical Services. Upon Prior Coverage Authorization, if the Covered Person chooses to obtain planned Services (which are Medically Necessary) at an accredited and approved Provider or Hospital located outside the United States, WellAway will coordinate care and waive applicable Cost Share amounts if the cost of such Services is less than the cost of such Services had they been rendered in the United States. The planned Services cannot exceed one hundred seventy-nine (179) days per Benefit Period.

We will require the following:

1. A letter from your Physician in the USA and medical records indicating that the Services you are seeking are medically necessary and that you are cleared for travel.
2. The identity of a Provider which will provide the necessary Services.
3. In the event of a Surgery, pre and post-surgical reports.
4. A cost estimate from your Provider(s) for the Services.
5. Medical records from your Provider(s) after the Services have been rendered.

Exclusions:

1. All Services must be a recognized medical Service and which are not Experimental or Investigational.
2. All Services are limited only to the Service itself and do not include diagnosis, second medical opinions, or peer reviews.
3. Lodging, meals, travel expenses, transportation or any other fees incurred while exercising Return Home are not included and will not be reimbursed under this Policy.
4. Any appointments, travel arrangements or Services utilized without receiving Prior Coverage Authorization will not be reimbursed.

We will attempt at all times to settle the costs directly with the Hospital and/or Provider; however, it is in the Hospital's and/or Provider's discretion to accept direct payment from us. In the event a direct settlement is not accepted by the Provider or Hospital, WellAway will:

(i) send the remittance to the Covered Person at the time Services are rendered or upon discharge via credit/debit card or other financial instrument; or

(ii) request the Covered Person to settle the invoices in full directly with the Hospital and/or Provider. Thereafter, the Covered Person may submit the invoices for reimbursement; provided, however, reimbursement will be in the amount of the Usual, Customary and Reasonable Charges for such Services. All reimbursement requests must be done in accordance with the Post-Service Claims section of this Policy.

Limitation: This coverage is not applicable to any Covered Person residing outside of the United States.

Medication Program

Introduction

Coverage for Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Participating Pharmacy is provided through the WellAway EHIM PBM Medication Program ("Medication Program") administered by EHIM PBM described in this section. This benefit is only available when you utilize an In-Network EHIM Participating Pharmacy and prescribed by a Physician or other health care professional. Some Health Care Services are available in a Pharmacy and in a medical office or facility however, we will only pay for them under one benefit (medical or pharmacy). For this reason, some items are excluded under this section, but covered under your medical benefits. In these cases, we will tell you what section to go to for more information. Certain important terms applicable to the Medication Program are set forth below. For additional applicable definitions, please refer to the DEFINITIONS section of this Policy.

In the Medication Guide you will find lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs, Covered OTC Drugs and Specialty Drugs. You may be able to reduce your Out-of-Pocket Costs by: (i) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; (ii) choosing Generic Prescription Drugs rather than Brand Name Prescription Drugs; and (iii) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs. Prescription Drugs and Supplies are only covered when you utilize a Participating Pharmacy. **Note**: The use of biosimilars (the preferred therapy based on step therapy requirements) must be exhausted first before a Brand medication is prescribed.

To verify if a Pharmacy is a Participating Pharmacy, contact your ConciergeCare Counselor using the telephone number on your ID Card. To view the Medication Guide you may access the Medication Guide on your member portal www.wellaway.com/account/login.

Covered Drugs & Supplies

A Prescription Drug, Covered OTC Drug or Self-Administered Injectable Prescription Drug is an Essential Health Benefit and covered under this section only if it is:

1. Prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license, except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;

2. Dispensed by a Pharmacist at a Participating Pharmacy;

3. Medically Necessary;

4. In the case of a Self-Administered injectable Prescription Drug, listed in the Medication Guide with a special symbol designating it as a covered Self-Administered injectable Prescription Drug;

5. In the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide;

6. A Prescription Drug contained in an anaphylactic kit, such as Epi-Pen, Epi-Pen Jr., or Ana-Kit;

7. Authorized for coverage by us, if Prior Coverage Authorization is required as indicated with a unique identifier in the Medication Guide, then in effect, or in your Summary of Benefits;

8. Not specifically or generally limited or excluded as stated in this section; and

9. Approved by the FDA and assigned a National Drug Code.

A Supply is covered under this section only if it is:

1. A Covered Prescription Supply;

2. Prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license;

3. Medically Necessary; and

4. Not specifically or generally limited or excluded as stated in this section.

Cost Share Tiers

All Drugs and Supplies covered under this section are assigned to a Cost Share tier. The Cost Share tiers that may apply to your plan are described below:

Tier 1: Preventive Prescription Drugs and Supplies

Tier 2: Condition Care Prescription Drugs and Supplies*

Tier 3: All other Generic Prescription Drugs and Supplies and Covered OTC Drugs (when applicable)

Tier 4: Condition Care Preferred Brand Name Prescription Drugs and Supplies*

Tier 5: Preferred Brand Name Prescription Drugs and Supplies

Tier 6: Non-Preferred Brand Name Prescription Drugs and Supplies

Tier 7: Specialty Generic and Brand Name Prescription Drugs and Supplies, as indicated in the Medication Guide.

*Condition care means certain medications used in the treatment of chronic conditions, which may be available to you at a lower Cost Share. If your plan includes a reduced Cost Share for these Drugs and Supplies, the Cost Share will be indicated in the Summary of Benefits.

Coverage & Benefit Guidelines

The benefits under this Medication Program have special benefit and payment rules in addition to rules that are specific to particular Covered Services listed in this Policy.

Contraceptive Coverage
Certain Prescription diaphragms, oral contraceptives, contraceptive patches, contraceptive implant(s), and intrauterine device(s) are covered under the Preventive Care Drugs of this Medication Program, subject to the limitations and exclusions listed in this section. Please refer to the Medication Guide for the covered contraceptives.

Preferred Generic Prescription oral contraceptives (including generic emergency contraceptives) and diaphragms indicated as covered in the Medication Guide, are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy.

Exceptions may be considered for Preferred Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Preferred Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, we must receive an “Exception Request Form” from your Physician.

You can obtain an Exception Request Form at www.ehimrx.com or you may call the EHIM customer service telephone number on your ID Card and it will be mailed to you upon request.

Note: Contraceptive injectable Prescription Drugs and most implants (unless stated above) and IUDs (unless stated above), inserted for any purpose, are not covered under this section. Some contraceptive methods are covered under the medical benefits; see the WHAT IS COVERED? section for more information.

Covered Over-the-Counter (OTC) Drugs
Certain OTC Drugs, listed in the Medication Guide, may be covered when you get a Prescription for the OTC Drug from your Physician. Only OTC Drugs that are listed in the Medication Guide are covered.

A list of Covered OTC Drugs is published in the most current Medication Guide and can be viewed on your member portal at www.wellaway.com/account/login or call your ConciergeCare Counselor using the telephone number on your ID Card.

Diabetic Coverage
All Prescription Drugs and Supplies used in the treatment of diabetes are covered subject to the limitations and exclusions listed in this section.

Insulin is only covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for injecting insulin are covered only when prescribed in conjunction with insulin.

The following Supplies and equipment used in the treatment of diabetes are covered under the Medication Program: blood glucose testing strips and tablets, lancets, blood glucose meters, acetone test tablets and syringes and needles.

Note: Other Supplies used in the treatment of diabetes are covered under the medical benefits, see the WHAT IS COVERED? section for more information.

Mineral Supplements, Fluoride or Vitamins
Unless noted below, the following Drugs are covered only when state or federal law requires a Prescription and when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license:

1. Prenatal vitamins;

2. Oral single-product fluoride (non-vitamin supplementation);

3. Sustained release niacin;

4. Folic acid;

5. Oral hematinic agents;

6. Dihydrotachysterol; or

7. Calcitriol.

Note: The Drugs set forth above and prescribed as set forth in this category may be available at no Cost Share if they are considered a Preventive Service as outlined in the WHAT IS COVERED? section.

Specialty Pharmacy Split Fill Option
Some types of medications may be difficult to tolerate for patients who are new to certain forms of treatment, such as oral oncology medication. To reduce waste and help avoid costs for medications that will go unused, the Specialty Pharmacy may split the first fill for certain medications identified in the Medication Guide. The Cost Share would also be split between the two fills.

Medication Program Limitations and Exclusions

Limitations:
Coverage and benefits for Covered Prescription Drugs and Supplies and Covered OTC Drugs are subject to the following limitations, in addition to all other provisions and exclusions in this Policy.

1. Prescription refills beyond the time limit specified by state and/or federal law are not covered.

2. Certain Prescription Drugs and Supplies and Covered OTC Drugs require Prior Coverage Authorization in order to be covered.

3. Retinoids such as Retin-A and their generic or therapeutic equivalents are excluded after age 26.

Exclusions:
1. Drugs that are covered and payable under the WHAT IS COVERED? section, such as Prescription Drugs that are dispensed and billed by a Hospital.

2. Except as covered in the Covered Drugs & Supplies category of this section, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.

3. Any Drug or Supply which can be purchased over-the-counter without a Prescription even when a written Prescription is provided (Drugs which do not require a Prescription), except for insulin, emergency contraceptives and Covered OTC Drugs listed in the Medication Guide.

4. All Supplies, other than Covered Prescription Supplies.

5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage of this Policy.

6. Therapeutic devices, appliances, medical or other Supplies and equipment, such as air and water purifiers, support garments, creams, gels, oils and waxes, regardless of the intended use (except for Covered Prescription Supplies).

7. Drugs and Supplies that are:

a. in excess of the limitations specified in this section or on your Summary of Benefits;

b. furnished to you without cost;

c. Experimental or Investigational;

d. indicated or used for the treatment of infertility;

e. used for cosmetic purposes including, but not limited, to Minoxidil, Rogaine or Renova;

f. prescribed by a Pharmacist, except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;

g. used for smoking cessation, unless such drug is indicated as covered in the Medication Guide;

h. listed in the Homeopathic Pharmacopoeia;

i. not Medically Necessary;

j. indicated or used for sexual dysfunction, such as Cialis, Levitra, Viagra and Caverject;

k. purchased from any source (including a Pharmacy) outside of the United States (except as covered in the Worldwide Coverage category of the Additional Benefits section);

l. prescribed by any health care professional not licensed in any state or territory of the United States of America, such as Puerto Rico, US Virgin Islands or Guam (except as covered in the Worldwide Coverage category of the Additional Benefits section);

m. OTC Drugs or Prescription Drugs not listed in the Medication Guide; and

n. Self-Administered Injectable Prescription Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 mg/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS. Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth hormone dependent peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses. Treatment is considered responsive in both adolescents with closed epiphyses and for adults, who continue to evidence growth hormone deficiency and the IGF-1 remains in the normal range for age and gender.

o. intentionally not disclosed on your Application Forms.

8. Mineral supplements, fluoride or vitamins except for those items listed in the Mineral Supplements, Fluoride or Vitamins category of this section.

9. Any appetite suppressant and/or other Drug indicated, or used, for purposes of weight reduction or control.

10. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Drugs & Supplies category of this section.

11. Drugs prescribed for uses other than the FDA approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for such treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of your particular cancer that have not been approved for any indication are also excluded.

12. Drugs that have not been approved by the FDA, as required by federal law, for distribution or delivery into interstate commerce.

13. Drugs that are compounded, even when one or more active ingredient is a Covered Prescription Drug under this section.

14. Drugs and Supplies purchased from an Out-of-Network Pharmacy, except for Emergency Services or when authorized in advance by us.

15. Any Drug prescribed in excess of the manufacturer’s recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer’s insert for such Drug. This exclusion does not apply if:

a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;

b. the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by the American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, or Agency for Health Care Policy and Research; or

c. we, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.

16. Any amount you are required to pay under the Medication Program as indicated on your Summary of Benefits.

17. Any penalty reductions.

18. Drugs or Supplies you prescribe to yourself or that are prescribed by any person related to you by blood or marriage.

19. Food or medical food products, whether prescribed or not.

20. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

a. the Drug is a Repackaged Drug;

b. the Drug is no longer marketed;

c. the Drug has been shown to have excessive adverse effects and/or safer alternatives;

d. the Drug is available as an OTC Drug;

e. the Drug has a preferred formulary alternative;

f. the Drug has a widely available/distributed AB rated generic equivalent formulation;

g. the Drug has shown limited effectiveness in relation to alternative Drugs on the formulary; or

h. the Drug is rarely used.

Please refer to the Medication Guide to determine if a particular Prescription Drug is excluded under this Medication Program.

Payment Rules

The amount you must pay for Covered Prescription Drugs and Supplies or Covered OTC Drugs may vary depending on:

1. The participation status of the Pharmacy where the Covered Prescription Drugs and Supplies or Covered OTC Drugs were purchased (i.e., Participating Pharmacy vs. Out-of-Network Pharmacy);

2. The terms of our agreement with the Pharmacy selected;

3. Whether you have satisfied any Deductible, Coinsurance and the amount of Copayment as set forth in your Summary of Benefits;

4. The assigned Cost Share tier;

5. Whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug; and

6. If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

a. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the Cost Share amount that applies to Non-Preferred Prescription Drug as indicated in your Summary of Benefits; and

b. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary. Note: The difference in cost described in this paragraph 6b. is a benefit penalty and therefore does not help to satisfy your Deductible or Out-of-Pocket Costs.

Note: A Brand Name Prescription Drug included on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug.

Pharmacy Participation Status

For purposes of this section, there are two types of Pharmacies: Participating Pharmacies and Out-of-Network Pharmacies.

Participating Pharmacies
The Pharmacy must be a Participating Pharmacy at the time Covered Prescription Drugs and Supplies and/or Covered OTC Drugs are purchased by you. Participating Pharmacies have agreed not to charge, or collect from you, more than the amount set forth in your Summary of Benefits for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug. To verify if a Pharmacy is a Participating Pharmacy, you may refer to the provider directory at www.ehimrx.com/pharmacylocator.php or call the EHIM customer service telephone number on your ID Card.

Prior to purchase, you must pay your Cost Share amount as listed in your Summary of Benefits and present your ID Card in order for the Pharmacy to verify that you are, in fact, covered by us.

When charges for Covered Prescription Drugs and Supplies or Covered OTC Drugs by a Participating Pharmacy are less than the required Copayment, the amount you pay will depend on the agreement then in effect between the Pharmacy and us, and will be one of the following:

1. The usual and customary charge of such Pharmacy as if it were not a Participating Pharmacy;

2. The charge under the Pharmacy's agreement with us; or

3. The Copayment, if less than the usual and customary charge of such Pharmacy.

Note: For Pharmacy charges outside the United States, the Covered Person must submit the Pharmacy invoices for reimbursement. All reimbursement requests must be done in accordance with the Post-Service Claims section of this Policy.

Specialty Pharmacy
Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical Conditions are typically more difficult to maintain, administer and monitor when compared to traditional Drugs. Specialty Drugs require Prior Coverage Authorization coverage from us and may require frequent dosage adjustments, special storage and handling and may not be readily available at local Pharmacies or routinely stocked by Physicians' offices, mostly due to the high cost and complex handling they require.

These Specialty Drugs can only be purchased from a Specialty Pharmacy. Specialty Pharmacies are a subset of Participating Pharmacies and are designated solely by us, as the Pharmacies where you can purchase Specialty Drugs under this Medication Program through EHIM PBM. For additional details on how to obtain covered Prescription Specialty Drugs from a Specialty Pharmacy, please refer to the Medication Guide.

Note: For Pharmacy charges outside the United States, the Covered Person must submit the Pharmacy invoices for reimbursement. All reimbursement requests must be done in accordance with the Post-Service Claims section of this Policy.

Out-of-Network Pharmacies
A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from an Out-of-Network Pharmacy is covered under this Medication Program only if for Emergency Services or authorized by us.

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from an Out-of-Network Pharmacy for Emergency Services or when authorized by us, you will have to pay the full cost of the Drug at the time of purchase. In order to be reimbursed for Covered Prescription Drugs and Supplies or Covered OTC Drugs purchased from an Out-of-Network Pharmacy, you must submit an itemized paid receipt to us at the address on your ID Card.

Note: For Pharmacy charges outside the United States, the Covered Person must submit the Pharmacy invoices for reimbursement. All reimbursement requests must be done in accordance with the Post-Service Claims section of this Policy.

Pharmacy Utilization Review Programs

Our pharmacy utilization review programs are intended to help educate and encourage the responsible use of Drugs and Supplies. Please review the following information so that you know what you may need to do in order to get the medication you need, without delays at the Pharmacy, and at a lower Cost Share.

We may, in our sole discretion, require that Prescriptions from your Provider for select Prescription Drugs and Supplies or OTC Drugs be reviewed under our pharmacy utilization review programs then in effect, in order for them to be covered. Under these programs, there may be limitations or conditions on coverage for select Prescription Drugs and Supplies and OTC Drugs, depending on the quantity, frequency, or type of Drug or Supply your Provider prescribed.

Note: If coverage is not available through these programs, or is limited, this does not mean that you cannot get the Drug or Supply from the Pharmacy. It only means that we will not cover or pay for the Drug or Supply. You are always free to purchase the Drug or Supply at your sole expense.

Our pharmacy utilization review programs include the following:

Prior Coverage Authorization Program

Certain Prescription Drugs and Supplies and OTC Drugs require Prior Coverage Authorization from us in order to be covered. If you do not obtain an authorization when one is required, we will deny coverage. Prescription Drugs and Supplies and OTC Drugs that require Prior Coverage Authorization are marked in the Medication Guide with a special symbol. Specialty Generic and Brand Name Prescription Drugs and Supplies over $400 require Prior Coverage Authorization. If your Provider prescribes a medication for you that requires Prior Coverage Authorization, ask him or her to get an authorization for you before you go to pick it up. When the Prior Coverage Authorization decision has been made, we will let you and your Provider know.

Responsible Quantity Program

Safety limits apply to certain Drugs based on the drug maker and FDA's guidelines. For example, your Physician may prescribe 12 tablets for a One-Month Supply and the prescribed Drug may have a 9-tablet limit for a One-Month Supply. Under this program, any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide may not be covered. If your Physician prescribes more than the Maximum quantity listed in the Medication Guide, you can either pay for the additional amount yourself or ask your Physician to request an authorization from us.

Responsible Steps Program

Many medical Conditions have several Drug treatment options that have been approved by the FDA, which means there may be a lower cost Drug that will effectively treat your Condition. Under the responsible steps program, certain Prescription Drugs and OTC Drugs are not be covered unless you have first tried one or more designated Drugs identified in the Medication Guide.

Your Physician must contact us to request coverage for a Prescription Drug that is part of the responsible steps program prior to prescribing the Drug. In order to be covered for such Prescription Drugs and OTC Drugs prescribed by your Physician, we must receive written documentation from your Physician that the designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Information on our pharmacy utilization review programs is published in the Medication Guide which can be accessed via your member portal or you may call your ConciergeCare Counselor or the EHIM customer service telephone number on your ID Card. Your Pharmacist may also tell you if a Prescription Drug or OTC Drug requires Prior Coverage Authorization.

Ultimate Responsibility for Medical Decisions

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs, Supplies and OTC Drugs will be provided under the terms of this Policy. Ultimately the final decision as to whether the Prescription Drug, Supply or OTC Drug should be prescribed must be made by you and the prescribing Physician. Decisions made by us in authorizing coverage are made only to determine whether coverage or benefits are available under this Medication Program and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for a Prescription Drug, Supply or OTC Drug, must be made solely by you and your treating Physician in accordance with the Physician/patient relationship. It is possible that you or your treating Physician may conclude that a particular Prescription Drug, Supply or OTC Drug is needed, appropriate, or desirable, even though such Prescription Drug, Supply or OTC Drug may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if we have indicated that we will not pay for such Prescription Drug, Supply or OTC Drug.

Medication Program Definitions

Brand Name Prescription Drug means a Prescription Drug that is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer Drug, or a Drug that is licensed to another company by the Brand Name Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other non-proprietary name.

Copayment or Copay means, when applicable, the amount you must pay to a Participating Pharmacy for each Covered Prescription Drug and Supply and/or Covered OTC Drug, at the time of purchase, as set forth in your Summary of Benefits.

Covered OTC Drug means an Over-the-Counter Drug that is designated in the Medication Guide as a Covered OTC Drug.

Covered Prescription Drug means a Drug, which, under federal or state law, requires a Prescription and which is covered under this Medication Program.

Covered Prescription Drug(s) and Supply(ies) means Covered Prescription Drugs and Covered Prescription Supplies.

Covered Prescription Supply(ies) means only the following Supplies:

1. Prescription diaphragms indicated as covered in the Medication Guide;

2. Syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage by us;

3. Syringes and needles prescribed with a Prescription Drug authorized for coverage by us;

4. Syringes and needles contained in anaphylactic kits (e.g., Epi-Pen, Epi-Pen, Jr., Ana Kit); and

5. Prescription Supplies used in the treatment of diabetes, limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets.

Day Supply means a Maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a twenty-four (24) hour period.

Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code.

Participating Pharmacy means a Pharmacy that is either:
1) participating in the WellAway EHIM PBM Medication Program and has signed a EHIM PBM Participating Pharmacy provider agreement; 2) a National Network Pharmacy; or 3) a Specialty Pharmacy.

Participating Pharmacy Allowance means the maximum amount allowed to be charged by a Participating Pharmacy per Prescription for a Covered Prescription Drug, Covered OTC Drug or Covered Prescription Supply under this EHIM PBM Pharmacy Program.

FDA means the United States Food and Drug Administration.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either 1) has been approved by the FDA for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355(j); or 2) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of WellAway, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic Prescription Drugs are identified by an "established name" under 21 U.S.C. 352(e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the Brand Name Prescription Drug.

Maximum means the amount designated in the Medication Guide as the Maximum, including, but not limited to, frequency, dosage and duration of therapy.

Medication Guide means the guide then in effect issued by us that designates the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Preferred Brand Name Prescription Drugs; and Non-Preferred Prescription Drugs. The Medication Guide does not list all Non-Preferred Prescription Drugs due to space limitations, but some Non-Preferred Prescription Drugs and potential alternatives are provided for your information. The Medication Guide is subject to change at any time. Please refer to your ConciergeCare Counselor or the EHIM PBM website www.ehimrx.com for the most current guide or you may call the customer service telephone number on your ID Card for current information.

National Drug Code (NDC) means the universal code that identifies the Drug dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

National Network Pharmacy means a Pharmacy located in the United States of America that is part of the national network of Pharmacies established by our EHIM Pharmacy Benefit Manager.

Non-Preferred Prescription Drug means a Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect.

One-Month Supply means a Maximum quantity per Prescription up to a thirty (30) Day Supply as defined by the Drug manufacturer's daily dosing recommendations. Certain Drugs (such as Specialty Drugs) may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

Out-of-Network Pharmacy means a Pharmacy that has not agreed to participate in our Medication Program and is not a National Network Pharmacy as established by EHIM Pharmacy Manager for this program, or a Specialty Pharmacy.

Over-the-Counter (OTC) Drug means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

Pharmacist means a person properly licensed to practice the profession of Pharmacy per state or federal law of your place of residence or a similar law of any state that regulates the profession of Pharmacy.

Pharmacy means an establishment licensed as a Pharmacy by state or federal law of your place of residence or a similar law of any state that regulates the profession of Pharmacies where a Pharmacist dispenses Prescription Drugs.

Pharmacy Benefit Manager means an organization that has established and manages a Pharmacy network and other Pharmacy management programs for third-party payers and employers, and which has entered into an arrangement with us to make such network and/or programs available to you.

Preferred Brand Name Prescription Drug means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect. The Preferred Medication List is contained in the Medication Guide. A Preferred Brand Name Prescription Drug on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug.

Preferred Generic Prescription Drug means a Generic Prescription Drug on the Preferred Medication List then in effect. The Preferred Medication List is contained in the Medication Guide.

Preferred Medication List means a list of Preferred Prescription Drugs then in effect, which have been designated by us as preferred and for which we provide coverage and benefits, subject to the limitations and exclusions set forth in this section. The Preferred Medication List is contained in the Medication Guide.

Preferred Prescription Drug means a Prescription Drug that appears on the Preferred Medication List then in effect. A Preferred Prescription Drug may be a Brand Name Prescription Drug or a Generic Prescription Drug. The Preferred Medication List is contained in the Medication Guide.

Prescription means an order for medications or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or Supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: “Caution: Federal law prohibits dispensing without a Prescription”. For purposes of the Medication Program, insulin and emergency contraceptives are considered Prescription Drugs because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

Repackaged Drug(s) means a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

Self-Administered Injectable Prescription Drug means an FDA approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, (except insulin). Covered Self-Administered Injectable Prescription Drugs are denoted with a special symbol in the Medication Guide.

Specialty Drug means an FDA approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of therapy. Specialty Drugs are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy provider agreement with us to participate in the Medication Program, to provide specific Specialty Drugs, as determined by EHIM PBM.

Supply(ies) means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, cotton swabs, and similar items and any birth control device.

What is Not Covered?

Introduction

The exclusions set forth in this section are in addition to any that are specified in the WHAT IS COVERED? and MEDICATION PROGRAM sections, including any Endorsement to this Policy. In addition, we will not pay for any of the Services or Supplies described in this section, even when recommended or prescribed by a Physician, or in the event it is the only available treatment for your Condition.

General Exclusions include, but are not limited to:

1. Any Health Care Service received prior to your Effective Date or after the date your coverage terminates.

2. Any Health Care Service not within the Covered Services categories described in the WHAT IS COVERED? or MEDICATION PROGRAM sections or any Endorsement to this Policy, unless such Services are specifically required to be covered by applicable law.

3. Any Health Care Service you render to yourself or those rendered by a Physician or other health care Provider related to you by blood or marriage.

4. Any Health Care Service that is not Medically Necessary as defined in this Policy and determined by us. The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service.

5. Any Health Care Service rendered at no charge.

6. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage.

7. Any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from, or is in connection with:

   a. war or an act of war, whether declared or not;

   b. your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted, or which constitutes riot, or rebellion;

   c. your engaging in an illegal occupation;

   d. Services received at military or government facilities;

   e. Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or

   f. Services received to treat you as a result of a criminal act unless such injury has not been paid or is not payable by a state crime victims compensation program or similar type of governmental program which reimburses victims for crime-related expenses.

8. Services that are not patient-specific, as determined solely by us, such as office infection control charges.

9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Policy.

10. Any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

11. Any Health Care Service subject to an In-Network Provider Provision rendered or supplied by or through any Provider other than the Provider designated solely by us, as the In-Network Provider, facility or Participating Pharmacy of such Services, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition. Please refer to your Summary of Benefits and the WHAT IS COVERED? section of your Policy to determine which Services are subject to an In-Network Provider Provision.

12. Expenses for completion of any form and/or medical information or for copies of your records or charts including any costs associated with forwarding or mailing copies of your records or charts.

Additional Exclusions:

Abortions that are elective.

Anesthesia administration Services rendered by an operating Physician who performed the surgery, his or her partner or associate.

Autopsy or postmortem examination Services, unless specifically requested by us.

Behavioral Health Services except as indicated in the WHAT IS COVERED? section, including:

1. Diagnosis: Services must be for the diagnosis and/or treatment of manifest mental disorders. These disorders are described in two publications:

   a. The most current edition of the International Classification of Diseases Adapted (Public Health Service Publication No. 1693).

   b. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

2. Educational Credits: Benefits will not be paid for psychoanalysis or medical psychotherapy that can be used as credit towards earning a degree or furthering a Covered Person's education or training. (It makes no difference what the diagnosis is or what Symptoms may be present.)

3. Marital Counseling: Benefits will not be paid for marital counseling or related services.

4. Professional Services: Professional services must be performed by a Physician or Professional Other Provider who is properly licensed or certified. A Professional Other Provider must be acting under the direct supervision of a Physician or a licensed clinical Psychologist. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their license.

5. Tobacco Dependency: Benefits will not be paid for Services, Supplies, or Drugs related to tobacco dependency except as described under the Preventive Care category of this section.

6. The Benefit Period maximums, if any, cited for Inpatient, intensive Outpatient, and other Outpatient and office Services include all Services provided for both Mental Health and Substance Use Disorder care.

7. Co-dependency Treatment: Services related to the treatment of the family of a person receiving treatment for nicotine, chemical, or alcohol dependence are not covered.

8. Services rendered for a Condition that is not a Mental and Nervous Disorder, regardless of the underlying cause or effect of the disorder.

9. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation.

10. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation.

11. Services for pre-marital counseling.

12. Services for court-ordered care or testing, or required as a condition of parole or probation.

13. Services to test aptitude, ability, intelligence or interest.

14. Services required to maintain employment.

15. Services for cognitive remediation.

16. Inpatient stays that are primarily intended as a change of environment.

17. Inpatient (overnight) mental health Services received in a residential treatment facility.

Clinical Trial expenses including:

1. Costs that are generally covered by the clinical trial, including, but not limited to:

   a. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

   b. The investigational item, device or Service itself.

   c. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. Services related to an Approved Clinical Trial received outside of the United States.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as transactional analysis, sensitivity training, assertiveness training, encounter groups, meditation, hypnosis, imagery, yoga, dance, and art therapy, Z therapy; biofeedback; prayer and mental healing; Massage Therapy except as listed in the WHAT IS COVERED? section; manual healing methods such as the Alexander technique, acupressure, aromatherapy, Ayurvedic Massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, primal scream therapy, Reichian therapy, reflexology, rolfing, shiatsu, Swedish Massage, traditional Chinese Massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition that arises as a complication of a non-Covered Service, such as treatment for a complication of cosmetic surgery.

Cost Share amounts you are required to pay, even when a Provider waives his or her portion of the Cost Share.

Cosmetic Services including any Service to improve the appearance or self-perception of an individual, including, but not limited to: cosmetic surgery and procedures or Supplies to correct alopecia or hair loss or skin wrinkling such as Minoxidil, Rogaine, Retin-A and hair implants/transplants.

Custodial Care as defined in the DEFINITIONS section of this Policy.

Dental Services except as indicated in the WHAT IS COVERED? section, including:

1. Dental Services other than as described in the pediatric dental benefits category rendered more than 90 days after the date of an Accidental Dental Injury even if the Services could not have been rendered within 90 days. This applies to Covered Persons

up to the attained age of 19 and is extended through the end of the Benefit Period. This exclusion is not intended to exclude Services if the Accidental Dental Injury was present prior to the Effective Date of the Policy, whether or not any medical advice, diagnosis, care, or Treatment was recommended or received prior to such date.

2. Orthodontia Services provided to a Covered Person who has not reached the attained age of 19.

3. Any dental Service not listed in the WHAT IS COVERED? section as covered.

4. Any dental Service listed under pediatric dental benefits that are rendered by a Provider who is not an In-Network Provider, except for Emergency Services.

5. Cosmetic procedures, including, but not limited to, veneer restorations, tooth whitening, and orthodontia, except Medically Necessary orthodontia covered under pediatric dental benefits.

6. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

7. Charges for nitrous oxide.

8. Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth reconstruction, restoration of tooth structure lost from attrition and restoration for crooked teeth.

9. Any additional treatment required because you do not follow instructions, or do not cooperate with the Dentist.

10. General anesthesia and intravenous sedation administered solely for patient management or comfort.

11. Services related to hereditary or developmental defects or cosmetic reasons, including but not limited to, cleft palate (except as covered under Child Cleft Lip and Palate Treatment category), upper or lower jaw defects, lack of development of enamel, discoloration of the teeth, and congenitally missing teeth.

12. Services rendered to a Covered Person after reaching the attained age of 19, including, but not limited to: care or treatment of the teeth or their supporting structures or gums, or dental procedures, including, but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral Prosthetic Devices, palatal expansion devices, bruxism appliances, and dental x-rays.

Diagnostic Admissions
If a Covered Person is admitted as an Inpatient to a Hospital for diagnostic procedures, and could have received these services as an Outpatient without danger to his or her health, benefits will not be provided for Hospital room charges or other charges that would not be paid if the Covered Person had received Diagnostic Services as an Outpatient.

Drugs
1. Drugs prescribed for uses other than the United States Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

2. Drugs dispensed to, or purchased by you from a Pharmacy, except as covered under the MEDICATION PROGRAM section. This exclusion does not apply to drugs dispensed to you when:

a. you are an Inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;

b. you are in the Outpatient department of a Hospital;

c. dispensed to your Physician for administration to you in the Physician's office and Prior Coverage Authorization has been obtained (if required); or

d. you are receiving Home Health Care according to a plan of treatment and the Home Health Agency bills us for such drugs.

The exceptions set forth in this subparagraph 2 above, do not apply to hemophilia drugs excluded under this subparagraph.

3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.

4. Any drug that is indicated or used for sexual dysfunction, such as Cialis, Levitra, Viagra and Caverject.

5. Any Self-Administered Prescription Drug except when indicated as covered in the WHAT IS COVERED? or MEDICATION PROGRAM sections of this Policy.

6. Any drug which requires Prior Coverage Authorization when Prior Coverage Authorization is not obtained.

7. Blood or blood products used to treat hemophilia, except when provided to you for:

a. emergency stabilization;

b. during a covered Inpatient stay; or

c. when proximately related to a surgical procedure.

Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including, but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and Massage equipment, biofeedback equipment, self-help devices, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, hospital beds, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, special braces, special equipment and the replacement of Durable Medical Equipment just because it is old or used.

Experimental or Investigational Services

Eye Care and Vision Services except as otherwise covered in the WHAT IS COVERED? section, including:

1. Health Care Services to diagnose or treat vision problems for a Covered Person after reaching the attained age of 19 that are not a direct consequence of trauma or prior eye surgery;

2. vision examinations for a Covered Person after reaching the attained age of 19;

3. eye exercises, visual training or visual therapy;

4. eye glasses and contact lenses and their fitting for a Covered Person after reaching the attained age of 19 except initial glasses or contact lenses following cataract surgery;

5. any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK;

6. Any vision Service, treatment or materials not specifically listed as a Covered Service;

7. Services and materials not meeting accepted standards of optometric practice;

8. Services and materials resulting from your failure to comply with professionally prescribed treatment;

9. State or territorial taxes on vision services performed;

10. Special lens designs or coatings except as indicated in the WHAT IS COVERED? section;

11. Replacement of lost or stolen eyewear;

12. Non-prescription (Plano) eyewear;

13. Two pairs of eyeglasses in lieu of bifocals;

14. Services not performed by licensed personnel; and

15. Prosthetic Devices, Services and contact lenses except as indicated in the medical benefits category of the WHAT IS COVERED? section.

Food and Food Products whether prescribed or not, except as covered in the Enteral Formulas category of the WHAT IS COVERED? section.

Foot care (routine), including any Service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions; flat feet; fallen arches; chronic foot strain; corns; hammer, claw and mallet toes; viral warts; or calluses unless determined by us to be Medically Necessary. This exclusion does not apply to Services otherwise covered under the Diabetes Treatment Services category in the WHAT IS COVERED? section.

Genetic Screening including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition, except as provided under the Diagnostic Testing and Preventive Services categories of the WHAT IS COVERED? section.

Hearing Services including routine hearing exams and screenings, except as provided under the Preventive Services category of the WHAT IS COVERED? section, and hearing aids (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries and repair costs.

Home Health Care Services that: (1) are rendered by an employee or operator of an adult congregate living facility, an adult foster home, an adult day care center, or a nursing home facility; (2) are rendered in a nursing home or intermediate care facility; or (3) is Speech Therapy provided for diagnosis of developmental delay.

Hospital Expenses including the Hospital charges, Physician charges and any other charges related to an Inpatient stay are not covered when Services could have been rendered without admitting you to the Hospital.

Immunizations except those covered under the Preventive Services category of the WHAT IS COVERED? section or the MEDICATION PROGRAM section.

Infertility Treatment including Services beyond what is necessary to determine the cause or reason for infertility and Services rendered to assist in achieving pregnancy are excluded. These Services include, but are not limited to:

1. Services provided to treat infertility;

2. Reversal of previous surgical sterilization procedures;

3. All infertility treatment medications;

4. Assisted reproductive therapy including, but not limited to, Artificial Insemination (AI); In Vitro Fertilization (IVF); Gamete Intrafallopian transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT); and any Services associated with these procedures; and

5. All Services associated with the donation or purchase of sperm.

Inpatient Rehabilitative & Habilitative Services
Inpatient rehabilitation is restricted only to the treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery. Cardiac Therapy, Massage Therapy, Pain Management and spinal manipulation Services are not covered as Habilitative Services.

Legal Payment Obligations Services for which a Covered Person legally does not have to pay, or charges that are made only because benefits are available under this Policy are not covered except as required by the federal, state, or local government. This includes Services provided by any person related to the Covered Person or residing in the Covered Person's household.

Massage Techniques such as application or use of the following or similar techniques or items for the purpose of aiding in the provision of Massage including, but not limited to: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; and/or contrast baths.

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all Services related to such pregnancy (prenatal, labor and delivery and postpartum).

Missed Appointment including any costs you incur for not going to a scheduled appointment, regardless of the reason for missing the appointment.

Obesity & Weight Loss Services Obesity in itself is not considered an illness or disease, and benefits are not allowed for the evaluation and treatment of obesity alone. Services and Supplies related to weight loss programs are not covered, with the exception of obesity screening and counseling for children and adults. The only situation under which benefits will be allowed for obesity is when a surgical procedure is required due to morbid obesity. Benefits will only be paid when the current NIH (National Institutes of Health) surgical criteria.

Note: The number of gastric bypass procedures covered under this Policy is limited to a lifetime maximum of one per Covered Person.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Orthognathic Surgery The following types of procedures are not covered except in the case of a congenital defect or restoration due to Accidental Dental injury:

1. Upper or lower jaw augmentation or reduction procedures;

2. Reconstructive procedures which correct deformities of the jaw; or

3. Procedures related to facial skeleton and associated soft tissues (surgical procedures include, but is not limited to, procedures involving repositioning and recontouring of the facial bones).

Orthotic Devices except as indicated in the WHAT IS COVERED? section, including:

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/ appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

2. Expenses for orthotic appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding, such as dynamic orthotic cranioplasty or molding helmets; except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis.

3. Expenses for devices necessary to exercise, train or participate in sports, e.g. custom-made knee braces.

Outpatient Rehabilitative & Habilitative Services Outpatient rehabilitation is restricted only to the treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery. Cardiac Therapy, Massage Therapy, Pain Management and spinal manipulation Services are not covered as Habilitative Services.

Outpatient Therapies Cardiac Therapy, Pain Management and Massage Therapy Services are not covered as Outpatient Therapies. In addition, application or use of the following or similar techniques or items for the purpose of aiding in the provision of Massage including, but not limited to: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; and/or contrast baths are not covered.

Oversight of a medical laboratory by a Physician or other health care Provider. "Oversight" as used in this exclusion shall include, but is not limited to, the oversight of:

1. The laboratory to assure timeliness, reliability, and/or usefulness of test results;

2. The calibration of laboratory machines or testing of laboratory equipment;

3. The preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and

4. Laboratory equipment or laboratory personnel for any reason.

Personal Comfort, Hygiene or Convenience Items and Services deemed to be not Medically Necessary and not directly related to your treatment, including, but not limited to:

1. Homemaker or domestic housekeeping services;

2. Sitter or companion services;

3. Food, housing and home-delivered meals;

4. Beauty and barber services;

5. Personal hygiene Supplies such as shampoo, toothpaste, body lotions and hygiene packets;

6. Clothing, including support hose;

7. Radio and television;

8. Guest meals and accommodations;

9. Telephone charges;

10. Take-home Supplies or drugs, including, but not limited to, first aid items, adhesive tape, bandages, gauze and antiseptics;

11. Travel expenses (other than Medically Necessary Ambulance Services);

12. Motel/hotel accommodations;

13. Air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;

14. Hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;

15. Heating pads, hot water bottles, or ice packs;

16. Physical fitness equipment;

17. Hand rails and grab bars; and

18. Massage except as set forth in the WHAT IS COVERED? section.

Private Duty Nursing

1. Benefits will not be provided for nursing services that ordinarily would be provided by Hospital staff or its intensive care or coronary care units.

2. Benefits will not be provided for Services, which are requested by, or for the convenience of the Covered Person or the Covered Person's family. (Examples: bathing, feeding, exercising, homemaking, moving the Covered Person, giving medication, or acting as a companion or sitter.) In other words, Services that do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such Services, are not covered.

3. Benefits will not be provided for Outpatient private duty nursing.

Prosthetic Devices except as indicated in the WHAT IS COVERED? section including:

1. Expenses for microprocessor controlled or myoelectric artificial limbs, such as C-legs;

2. Expenses for performance enhancing Prosthetic Devices (such as carbon-fiber racing legs);

3. Expenses for cosmetic enhancements to artificial limbs; and

4. Penile prosthesis and surgery to insert penile prosthesis except when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, and epispadias, and exstrophy.

Prophylaxis/prophylactic medicine except as explicitly described elsewhere in this Policy, medical benefits and treatment that are of a preventive or prophylactic nature are not Covered Services under this Policy. Preventive or prophylactic treatments and services are those which are rendered to a person for purposes other than treating a present and existing medical condition in that person including, but not limited to, immunizations or Surgery on otherwise healthy body organs and/or parts.

Routine Hearing Examinations except as indicated in the Preventive Services category of the WHAT IS COVERED? section. Services will not be covered for the testing of hearing acuity, and for the prescription or fitting of a hearing aid, or any Services related to the prescription or fitting.

Routine Physicals Services connected with routine physical or screening exams and immunizations are not covered except as described in the Preventive Services category of the WHAT IS COVERED? section (examples of services not covered: yearly physicals, screening examinations for school or sports, camp or other activities).

Sexual Reassignment, or modification Services, including, but not limited to, any Service or Supply related to such treatment, such as psychiatric Services.

Skilled Nursing Facilities expenses for an Inpatient admission to a Skilled Nursing Facility for Custodial Care, convalescent care, or any other Service primarily for your convenience or that of your family members or the Provider.

Smoking Cessation Programs, including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, except as provided under the Preventive Services category of the WHAT IS COVERED? section or the MEDICATION PROGRAM section.

Sports-Related Devices and Services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation are not covered.

Telephone Consultations except as covered under Physician Services in the WHAT IS COVERED? section.

Training and Educational Programs or materials, including, but not limited to, programs or materials for Pain Management and vocational rehabilitation, except as provided under the Diabetes Treatment Services category of the WHAT IS COVERED? section.

Transplant Services except as indicated in the WHAT IS COVERED? section, including:

1. Transplant procedures not included in the Transplant Services category of the WHAT IS COVERED? section, or otherwise excluded under this Policy, such as Experimental or Investigational transplant procedures.

2. Transplant procedures involving the transplantation of any non-human organ or tissue.

3. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.

4. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ.

5. Any organ, tissue, marrow, or stem cells that are sold rather than donated.

6. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.

7. Any non-medical costs, including, but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.

8. Any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Travel or vacation expenses even if prescribed or ordered by a Provider.

Volunteer Services or Services which would normally be provided free of charge.

Weight Control Services and Supplies related to weight loss programs are not covered, except as specified in the WHAT IS COVERED? section. In addition, will not pay for the following:

1. Laboratory or x-ray services related to weight loss programs;

2. Prescription Drugs and medicines related to weight loss programs; and

3. Surgery required as the result of obesity (unless specified in the WHAT IS COVERED? section.

War Services or Supplies required as the result of disease or injuries due to war, civil war, insurrection, rebellion, or revolution are not covered.

Wigs and/or cranial prosthesis.

Workers' Compensation Services or Supplies resulting from a work-related illness or injury, compensation for which is available, in whole or in part, under the provisions of any legislation of any governmental unit, are not covered.

Medical Necessity

In order for Health Care Services to be covered under this Policy, the Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as determined by us and defined in this Policy.

It is important to remember that any time we review Services for Medical Necessity it is solely for the purpose of determining coverage, benefits or payment under the terms of this Policy and not for the purpose of recommending or providing medical care. When we review for Medical Necessity, we will review specific medical facts or information about you. Any such review, however, is strictly for the purpose of determining whether the Service provided or proposed meets the definition of Medical Necessity in this Policy as determined by us. In applying the definition of Medical Necessity to a specific Service, we may determine that the Health Care Service was/is:

1. In accordance with Generally Accepted Standards of Medical Practice;

2. Clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury, disease or Symptoms;

3. Not primarily for your convenience, your family's convenience, your caregiver's convenience or that of your Physician or other health care Provider; and

4. Not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. Inpatient), and/or an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or Symptoms.

When determining whether a Service is not more costly than the same or similar Service as referenced in paragraph 4 above, we may, but are not required to, take into consideration various factors including, but not limited to, the following:

a. the Allowed Amount for the Service at the location for the delivery of the Service versus an alternate setting;

b. the amount we have to pay to the proposed particular Provider versus the Allowed Amount for a Service by another Provider including Providers of the same and/or different licensure and/or specialty; and/or

c. an analysis of the therapeutic and/or diagnostic outcomes of an alternate treatment versus the recommended or performed procedure including a comparison to no treatment. Any such analysis may include the short and/or long-term health outcomes of the recommended or performed treatment versus alternate treatments including an analysis of such outcomes as the ability of the proposed procedure to treat comorbidities, time to disease recurrence, the likelihood of additional Services in the future, etc.

Note: The distance you have to travel to receive a Health Care Service, time off from work, overall recovery time, etc. are not factors that we are required to consider when evaluating whether or not a Health Care Service is not more costly than an alternative Service or sequence of Services.

In addition, we will apply our coverage and payment guidelines then in effect. Reviews we perform of Medical Necessity may be based on comparative effectiveness research, where available, or on evidence showing lack of superiority of a particular Service or lack of difference in outcomes with respect to a particular Service. In performing Medical Necessity reviews, we may take into consideration and use cost data which may be proprietary, as well as any duplication of previous Services provided (i.e., laboratory, diagnostic services, and other medical tests). We encourage you, when medically appropriate to provide your Physician with the results of any previously provided medical Services in order to reduce your Cost Share amounts.

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and that of your treating Providers. You and your Providers are responsible for deciding what medical care you should have and when that care should be provided. We are solely responsible for determining whether

expenses incurred for that medical care are covered under this Policy. In making coverage decisions, we will not be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

The following are a few examples of hospitalization and other Services that are not Medically Necessary:

1. staying in the Hospital because arrangements for discharge have not been completed;

2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment;

3. staying in the Hospital because supervision in the home, or care in the home, is not available or is inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., Hospital Outpatient department or at home with Home Health Care Services); or

4. Inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other Service primarily for the convenience of the Covered Person or his or her family members or a Provider.

Note: Whether or not a Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Service does not mean that the Service is Medically Necessary (as determined by us and defined in this Policy) or a Covered Service. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service. Please refer to the DEFINITIONS section for the definition of “Medically Necessary or Medical Necessity”.

Your Share of Healthcare Expenses

This section explains what your share of the health care expenses may be for Covered Services you receive. Since not all plans include all the different types of Cost Shares explained in this section, it is important that you look at your Summary of Benefits to see your share of the cost for specific Covered Services.

Deductibles

There are different types of Deductibles; some that apply to most Covered Services on your plan and some that apply only to a specific type of Service. Listed below are the different types of Deductibles and a brief explanation of how they work. You will need to look at your Summary of Benefits to find out what types of Deductibles (if any) apply to your plan.

Rules for applying charges to Deductibles:

- We can only apply charges for claims we actually receive;
- Only charges for Covered Services will be applied; and
- We will only apply the amount of charges up to our Allowed Amount.

Overall Deductible (DED)

This Deductible applies to most of the Covered Services in your Policy before we begin to pay for Covered Services. Some Covered Services, such as Preventive Services, do not apply the Deductible when you use In-Network Providers, so be sure to look at your Summary of Benefits. After the individual or family Deductible has been met, neither you nor your Covered Dependents (if any) will have any additional Deductible amount for the rest of the applicable Benefit Period. A new Deductible amount will apply at the beginning of each Benefit Period. There are individual and family Deductibles, both of which apply each Benefit Period.

Individual Benefit Period Deductible

If you are the only person on your plan, you only have to reach the individual Deductible and the family Deductible listed on your Summary of Benefits does not apply to you. This amount, when applicable, must be satisfied by you each Benefit Period before any payment will be made by us. If more than one person is on your plan, the amount each person has to reach depends on the type of family Deductible described below.

Family Benefit Period Deductible

If you have one or more family members on your plan, the family Deductible can be satisfied by any one Covered Person or a combination of Covered Persons as follows:

If your Summary of Benefits indicates that the Deductible is embedded, each Covered Person only needs to satisfy the individual Deductible and not the entire family Deductible, prior to us paying for Covered Services for that Covered Person. We will not begin to pay for Covered Services for the other family members until they either satisfy the individual Deductible or until the family Deductible is met. The family Deductible is met when any combination of family members' costs for Covered Services meets the family Deductible limit. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward that person's individual Deductible.

Copayments

A Copayment is a fixed dollar amount you must pay when you receive certain Covered Services. Listed below are the different types of Copayments and a brief explanation of how they work. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you will pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service. Not all plans have Copayments, so be sure to look at your Summary of Benefits.

Copayments:

- must be paid at the time you receive the Services;
- apply before any payment will be made by us;
- apply regardless of the reason for the Service; and
- usually apply to all Services rendered during the visit but there are exceptions to this rule, so be sure to check your Summary of Benefits and the brief explanations below.

Office Services Copayment

An office Services Copayment applies to each office visit and applies to all Covered Services rendered during that visit, except for Durable Medical Equipment, Medical Pharmacy, and Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Copayment.

Inpatient Facility Services Copayment

The Inpatient facility Copayment applies to the use of an Emergency Room and will be waived if admitted at an Inpatient facility (e.g. Hospital). Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while you are an Inpatient.

Outpatient Facility Services Copayment

The Outpatient facility Copayment only applies to an Outpatient facility and you must pay it for each Outpatient visit. Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while using these facilities.

Note: Copayments for Outpatient facility Services may vary depending on the type of facility chosen and the Services received. Please see your Summary of Benefits for more information. If your plan includes a Copayment for emergency room Services and you are admitted to the Hospital as an Inpatient at the time of the emergency room visit, this Copayment will be waived, and you will pay the Cost Share that applies to Inpatient facility Services.

Coinsurance

Coinsurance is a percentage of our Allowed Amount that you must pay before we will pay our portion of the Allowed Amount for Covered Services. The Coinsurance percentage is calculated after all other Cost Share amounts for a given Service, such as your Deductible.

Note: If a particular Covered Service is not available from any In-Network Provider, the Coinsurance percentage that we will base payment on for that Covered Service will not be less than ten (10%) percentage points lower than the Coinsurance percentage we would have based payment on had the Covered Services been available from an In-Network Provider. For example, if the In-Network Coinsurance for your plan was 80%, the Coinsurance percentage that would be used as a base for Covered Services as described above would be between 70% and 80% of the Allowed Amount. In this example, the Coinsurance percentage used as the basis for payment would not be less than 70% of the Allowed Amount.

Out-of-Pocket Maximums

An out-of-pocket maximum is the Benefit Period limit on Cost Share amounts that you have to pay for a given Benefit Period for Health Care Services that are Covered Services under this Policy. After you have paid this dollar amount in Cost Share, you will have no additional Cost Share for the rest of that Benefit Period and we will pay 100% of our Allowed Amount for Covered Services rendered during the rest of that Benefit Period.

Individual Benefit Period Out-of-Pocket Maximum

If you are the only person on your Policy, only the individual out-of-pocket maximum applies to you and the family out-of-pocket maximum listed on your Summary of Benefits does not apply to you. After you have reached the individual out-of-pocket maximum, you will have no additional Cost Share for the rest of that Benefit Period and we will pay 100% of our Allowed Amount for Covered Services rendered during the rest of that Benefit Period. If more than one person is on your Policy the amount each person has to reach depends on the type of out-of-pocket maximum described below.

Family Benefit Period Out-of-Pocket Maximum

If you have one or more family members on your plan, the family out-of-pocket maximum can be satisfied by any one Covered Person or a combination of Covered Persons depending on the type of out-of-pocket maximum described below.

Embedded Out-of-Pocket Maximum

If your Summary of Benefits indicates that the out-of-pocket maximum is embedded, when any one Covered Person meets the individual out-of-pocket maximum, that Covered Person will have no additional Cost Share for the rest of the Benefit Period. The rest of the family must continue satisfying their out-of-pocket maximum until the family out-of-pocket maximum is met. The maximum amount that any one Covered Person in your family can contribute toward the family out-of-pocket maximum is the amount applied toward that person's individual out-of-pocket maximum.

All Cost Share amounts you pay toward the Covered Services explained in this Policy will apply to the out-of-pocket maximum, such as Deductibles, Coinsurance and Copayments. The following charges will not apply to the out-of-pocket maximums and when you have reached the out-of-pocket maximum, you will still have to pay these charges:

- Premium amounts you must pay for this Policy and the CFE;
- charges for Services that are not covered;
- charges that are in excess of our Allowed Amount; and
- any benefit penalties.

How We Will Credit Benefit Maximums

We will only credit the amounts we actually pay for Covered Services to any benefit maximums on your Policy. The amounts we pay are based on our Allowed Amount for the Covered Services provided. You will need to look at your Summary of Benefits to find out if any benefit maximums apply to your Policy.

Additional Expenses You Must Pay

In addition to your share of the expenses described above, you are also responsible for:

1. Charges in excess of any maximum benefit limitation listed in your Summary of Benefits;

2. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;

3. Charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept our Allowed Amount as payment in full;

4. Any benefit reductions and benefit penalties;

5. Charges for Health Care Services which are non-Covered Services or excluded;

6. The Premium applicable to your Policy which is payable to WellAway and the premium applicable to your CFE coverage which is directly payable to the CFE; and

7. Charges incurred for Services you receive that are rendered by or through any Provider other than the Provider designated solely by us as the In-Network Provider or Participating Pharmacy for such Services, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition.

Healthcare Provider Options in the United States

Introduction

This Policy was designed to help make health care more affordable by offering access to a robust network of medical Providers which includes In-Network Providers for certain types of Health Care Services. It is important that you understand how the Providers you choose to use for medical care and the type of Services you receive will affect how much you have to pay for medical Services. This section explains payment rules when receiving Covered Services from different types of Providers under this Policy. This section does not include the specific Cost Share amounts under your plan; as you read this section, please keep in mind that you will have to check your Summary of Benefits for those details. For information on Pharmacy Provider options, please refer to the MEDICATION PROGRAM section.

Note: For Hospitals and/or Providers outside the United States, costs will be settled via reimbursement. Please refer to the "How to File a Post-Service Claim" category in the CLAIMS PROCESSING section.

Provider Participation Status

In order to help control health care costs, we have entered into contracts with certain Providers to participate in the Network or we may access certain Providers for your Policy through our third-party administrator or by the use of a Network. We, or our representatives or contractors, negotiate with these Providers to establish maximum allowances and payment rules for Covered Services as one way to control health care costs. The allowances we establish are called our Allowed Amounts. Your Out-of-Pocket Costs for a particular Covered Service is based on our Allowed Amount for that Covered Service. We do this in accordance with any required laws or guidelines governing Network contracts and the leasing of Networks. Your ID Card will clearly display the Network your plan will access upon receipt of your Policy and ID Cards. We may, from time to time, revise or change our Networks and will issue you a new ID Card if this situation occurs.

In-Network Providers

You should use In-Network Providers whenever possible in order to reduce your Out-of-Pocket Costs and obtain significant savings. In order to be covered, certain Health Care Services must be rendered by an In-Network Provider designated solely by us, except when such Services are required for Emergency Services for the treatment of an Emergency Medical Condition. Please refer to your Summary of Benefits and this Policy terms and conditions to determine which Services are subject to an In-Network Provider Provision.

We encourage you to select and develop a relationship with an In-Network Primary Care Physician. There are several advantages to selecting a Primary Care Physician (family practitioners, general practitioners, internal medicine doctors and pediatricians):

- Primary Care Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs.
- Developing and continuing a relationship with a Primary Care Physician allows the Physician to become knowledgeable about you and your family's health history.
- A Primary Care Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific health care needs.
- Care rendered by Primary Care Physicians usually results in lower Cost Share amounts for you.

WellAway provides access to a PPO Network. In-Network Providers are available to you for your healthcare needs. Not all Providers in the Network are Premium Care or Select Providers. However, Premium Care or Select Providers will provide you with the least Out-of-Pocket costs. Non-Premium Care or Select Providers, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Using an In-Network Premium Care/Select Provider will reduce your costs and allow you to obtain significant savings but are still subject to certain requirements such as Prior Coverage Authorization and other requirements under this Policy. Prior Coverage Authorization may include the required use of designated Premium Care or Select Providers who have demonstrated high quality and cost-efficient care.

Your ID Card is your key to accessing all of the Providers available to you as a member. Please present your ID Card to your Provider at the time of receiving Services.

What is a Premium Care/Select Provider? Premium Care/Select Providers are those Primary Care Physicians and certain Specialists who meet certain quality and cost-efficient care criteria. Using a Premium Care/Select Provider will reduce your costs and allow you to obtain significant savings. You may find that certain specialties do not have any Premium Care/Select Providers i.e., dermatology. For those specialists, an excess differential is not applicable if you visit the Specialist in his/her office and not in a hospital setting. Currently there are 16 Premium Care/Select Providers and Specialists (this is subject to change):

- Allergy
- Cardiology
- Ear, Nose and Throat
- Endocrinology
- Family Medicine
- Gastroenterology
- General Surgery
- Internal Medicine
- Nephrology
- Neurology
- Neurosurgery, Orthopedics and Spine
- Obstetrics and Gynecology
- Pediatrics
- Pulmonology
- Rheumatology
- Urology

In the event you decide not to utilize a Premium Care/Select Provider (Primary Care or one of the designated Specialists above), you will be responsible for any excess or differentials in addition to your Cost Share amounts. However, if there are no Premium Care/Select Providers within a 50-mile radius of your home, an excess differential is not applicable if you visit the Physician in his/her office and not in a hospital setting.

In order to minimize your costs, (i) certain Services require Prior Coverage Authorization; (ii) must be rendered by an In-Network Provider (except when such Services are Medical Emergency Services); and/or (iii) be performed in a physician's office or in a free-standing diagnostic center. Our In-Network free-standing facilities are conveniently located and provide Basic Diagnostic Services, Advanced Imaging/Diagnostic Testing and other Outpatient Services. For laboratory tests, visit Quest Diagnostics. **Contact our ConciergeCare team via the telephone number on your ID Card. We are experienced in guiding you to the most appropriate providers for you.**

You are responsible for checking to see if a Provider is a Premium Care/Select Provider and an In-Network facility for your plan prior to receiving Services. To find out if a Provider is a Premium Care/Select Provider and an In-Network facility you should contact a ConciergeCare Counselor via the telephone number on your ID Card.

Note: Covered Person will be responsible for the excess or differentials above the Allowed Amount. This amount is not a covered amount and is not applied to satisfy your Deductible or Out-of-Pocket Costs.

Out-of-Network Providers

When you use Out-of-Network Providers your Cost Share for Covered Services will be higher. We will base our payment on the Allowed Amount at the Coinsurance percentage listed in your Summary of Benefits. If your Provider directory does not include a Provider as In-Network under your Policy, the Provider is considered Out-of-Network. WellAway does not accept an assignment of benefits from a Covered Person to pay an Out-of-Network Provider directly.

Out-of-Area Providers

If there is no Premium Care/Select Provider or In-Network Provider located within a 50-mile radius of your local residence, the claim will be paid as In-Network subject to Allowable Charges or at the Rate of a similarly situated In-Network Provider, after applicable Cost Share amounts have been applied. In the event the Covered Person travels outside the state of local residence, the claim will be paid based on the Provider's status in the Network in such location (i.e., Premium Care/Select Provider, In-Network or Out-of-Network), subject to Allowable Charges and after applicable Cost Share amounts have been applied.

Understanding Your Provider Options

Provider Type	What benefit level is applied?	Who will file your claims?	Who is responsible for admission notification?	Will I have to pay the difference between the billed amount and the Allowed Amount?
In-Network Provider	The highest level of coverage	The Provider will file claims for you	Provider (unless Provider located outside of your domiciled state)	If the provider is not an In-Network Provider, when required, benefits are not covered
Out-of-Network Provider	The lowest level of coverage; you will share more of the cost	You will have to file your claims	You should notify us of your Inpatient admissions	Yes

Location of Service

The location or setting where you receive Services can also affect the amount you pay. For example, the amount you must pay will vary whether you receive Services in a Hospital, a Provider's office, or an Ambulatory Surgical Center. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the WHAT IS COVERED? Section and your Summary of Benefits to find out if the Services are covered and how much you will have to pay. You should also consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

Physicians

When you receive Covered Services from a Physician, several factors will determine your Cost Share, including whether the Physician is In-Network or Out-of-Network, the location of service, the type of Service rendered and the Physician's specialty (as determined by us).

Hospitals

Each time you receive Inpatient or Outpatient Covered Services at a Hospital, in addition to any Cost Share for Physician Services, you will have to pay the Cost Share related to Hospital Services. Remember your Cost Share amount is also different for Out-of-Network Hospitals. Since not all Physicians admit patients to every Hospital, it is important when choosing a Physician that you find out the Hospitals where your Physician has admitting privileges. You can find out what Hospitals your Physician admits to by contacting the Physician's office. This information will help you figure out what your Cost Share may be in the event you are hospitalized.

Specialty Pharmacy

Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical Conditions are typically more difficult to maintain, administer and monitor when compared to traditional drugs. Specialty Drugs may require frequent dosage adjustments, special storage and handling and may not be readily available at local pharmacies or routinely stocked by Physicians' offices, mostly due to the high cost and complex handling they require. Using the Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications. Please refer to the MEDICATION PROGRAM section to learn how to locate Specialty Pharmacies.

Other Providers

With WellAway you have access to other Providers in addition to the ones described in this section. Other Providers include facilities that provide alternative Outpatient settings or other persons and entities that specialize in specific Services. While these Providers may be recognized for payment, they may not be In-Network Providers for your plan. Also, all of the Services that are within the scope of certain Providers' licenses may not be Covered Services under this Policy. Please refer to the WHAT IS

COVERED? And WHAT IS NOT COVERED? sections of this Policy and your Summary of Benefits to find out what your Cost Share may be for Covered Services rendered by these Providers.

You may be able to receive certain Outpatient Services at a location other than a Hospital. Your Cost Share for Services rendered at some alternative facilities is generally less than if you had received those same Services at a Hospital.

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, we will not honor any of the following assignments, or attempted assignments, by you to any Provider, including, and without limitation, any of the following:

1. an assignment of the benefits due you under this Policy;

2. an assignment of the right to receive payments due under this Policy; or

3. an assignment of a claim for damages resulting from a breach, or an alleged breach, of any promise or obligation set forth in this Policy, or any promise or obligation set forth in any plan.

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who:

1. is an In-Network Provider under your Policy; or

2. is a Network Provider even if that Provider is not in the panel for your Policy, if applicable.

A written attestation of the assignment of benefits will be required.

ConciergeCare and your Welcome Package

Upon enrolling in a WellAway Policy you will receive a welcome package containing details about your Policy. Your ConciergeCare Counselor will assist you in navigating the details of your Policy and the complexities of the United States' healthcare system. Your ConciergeCare Counselor will also assist you in finding In-Network Providers or even assist you with appointments, bills you may receive, or filing for reimbursements or claims for any other products or plans purchased from WellAway and your coordination of benefits with the CFE coverage.

Quality Assurance

Quality assurance is a formal methodology and set of activities designed to assess the quality of Health Care Services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy identified deficiencies and evaluation of actions taken. We have a quality assurance program in place to assess the Services of In-Network Providers.

Access to Healthcare Programs

Introduction

We have established (and from time to time will continue to establish) various customer-focused health education and information programs and benefit utilization management and utilization review programs. We call these programs our Access to Healthcare Programs. The Access to Healthcare Programs are designed to:

- provide you with information that will help you make more informed decisions about your health;
- help us facilitate the management and review of coverage and benefits provided under our policies; and
- present opportunities, as explained below, for you and us to agree upon alternative benefits or payments for cost-effective medically appropriate Health Care Services.

Admission Notification

Our admission notification rules vary depending on whether you are admitted to a Hospital, Psychiatric, Substance Abuse, Hospice, Inpatient rehabilitation, long term acute care (LTAC) or Skilled Nursing Facility which is In-Network or Out-of-Network. To find out if a Provider is in our network, you can:

1. access the current WellAway Provider directory, visit www.wellaway.com and click/tap the Provider Search link on our menu located at the top right hand corner of the page; or

2. call the customer service telephone number on your ID Card or your ConciergeCare Counselor.

In-Network

We must be notified of all Inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospitals, Psychiatric, Substance Abuse, Hospice, Inpatient rehabilitation, LTAC and Skilled Nursing Facilities.

In-Network Providers located in the USA have agreed to notify us of your admission; however, you should ask the facility if we have been notified of your admission. For an admission outside of the USA, you or the facility should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Access to Healthcare Programs available to you. You or the facility may notify us of your admission by calling the customer service telephone number on your ID card or your ConciergeCare Counselor.

Out-of-Network

For admissions to an Out-of-Network Hospital, Psychiatric, Substance Abuse, Hospice, Inpatient rehabilitation, LTAC or Skilled Nursing Facility, you or the facility should notify us of the admission. Notifying us of your admission will enable us to provide you information about the Access to Healthcare Programs available to you. You or the facility may notify us of your admission by calling the customer service telephone number on your ID card or your ConciergeCare Counselor.

Inpatient Facility Program

We will review Hospital stays, Hospice, Inpatient rehabilitation, LTAC and Skilled Nursing Facility Services, and other Health Care Services rendered during the course of an Inpatient stay or treatment program. We may conduct this review while you are Inpatient, after your discharge, or as part of a review of an episode of care when you are transferred from one level of Inpatient care to another for ongoing treatment. This review is conducted solely to determine whether a particular admission or Health Care Service rendered during that admission is covered under this Policy. Using our established criteria then in effect, a concurrent review of the Inpatient stay may occur at regular intervals, including before a transfer from one Inpatient facility to another. We will let your Physician know when Inpatient coverage criteria are no longer met. As a part of this program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an Inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Policy and not for the purpose of recommending or providing medical care.

In anticipation of your needs following an Inpatient stay, we may provide you and your Physician with information about other WellAway Access to Healthcare Programs which may be beneficial to you, and help you and your Physician identify health care resources which may be available in your community. Upon request, we will answer questions your Physician has regarding your coverage or benefits following discharge from the Hospital.

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for you to understand our Prior Coverage Authorization programs and how the Provider you select and the type of Service you receive affects these rules and ultimately how much you will have to pay under this Policy.

Prior Coverage Authorization/Pre-Service Notification is a process by which a Covered Person obtains approval for certain Services (non-Emergency Services) prior to the commencement of the proposed Services. This requires that the Covered Person request a Prior Coverage Authorization from PayerFusion at least five (5) business days prior to the scheduled Service date, unless a greater time period is required as stated in this Policy.

With the exception of an Outpatient Physician office visit (not in a hospital setting) for the Services listed below, you or your Physician will be required to obtain prior coverage authorization from us for certain Services including:

1. Allergy Testing and Treatment;
2. Diagnostic Services with the exception of routine x-rays and clinical laboratory Services when performed in an In-Network independent free-standing laboratory or a Physician's office;
3. Behavioral Health Services (Inpatient facility and Outpatient facility);
4. Breast Reconstructive Surgery;
5. Dental-related Services;
6. Dialysis;
7. Enteral nutrition;
8. Evacuation, Repatriation and Return Home;
9. High-cost Prescription Drugs;
10. High-dose chemotherapy and/or radiation therapy with Bone Marrow Transplant and/or peripheral stem cell support;
11. Home Health Care/IV home therapy;
12. Hospice care;
13. Hospitalization
14. Human organ Transplants;
15. Obesity and weight loss services;
16. Oncology Services (Inpatient and Outpatient);
17. Orthognathic surgery;
18. Outpatient physical therapy;
19. Outpatient spinal manipulation;

20. Prescription Drugs, as denoted with a special symbol in the Medication Guide;

21. Reconstructive surgery;

22. Rehabilitative and Habilitative Services (Inpatient and Outpatient);

23. Skilled Nursing;

24. Surgical procedures (Inpatient and Outpatient);

25. Insulin pumps;

26. Breast pumps;

27. Pediatric Dental Services which exceed $500;

28. Medically Necessary implants and orthodontia services in the Pediatric Dental Services category of the WHAT IS COVERED? section; and

29. Other Health Care Services that are or may become subject to a Prior Coverage Authorization program or a Pre-Service Notification program as then defined and administered by us.

You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

1. In the case of Prescription Drugs, it is your sole responsibility to obtain Prior Coverage Authorization when you use a Provider before the drug is purchased or administered. If you do not obtain Prior Coverage Authorization, we will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration. All Prescription Drugs covered under the Medical Pharmacy category in the WHAT IS COVERED? section, require Prior Coverage Authorization. For a list of other medications that require Prior Coverage Authorization and details on how to get an authorization, please refer to the Medication Guide.

2. In the case of advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, you must obtain an authorization when rendered or referred by a Provider before the advanced diagnostic imaging Services are provided. If you do not obtain Prior Coverage Authorization we will deny coverage for the Services and not make any payment for such Services. For details on how to obtain Prior Coverage Authorization for advanced diagnostic imaging Services, please call the customer service telephone number on your ID Card or your ConciergeCare Counselor.

3. Other than an Outpatient Physician office visit (not in a hospital setting), in the case of Behavioral Health Services, you must obtain an authorization when rendered or referred by a Provider before Behavioral Health Services are provided. If you do not obtain Prior Coverage Authorization we will not make any payment for such Services. For details on how to obtain Prior Coverage Authorization for Behavioral Health Services, please call the customer service telephone number on your ID Card or your ConciergeCare Counselor.

4. In the case of other Health Care Services under a Prior Coverage Authorization or Pre-Service Notification program, you must obtain an authorization or comply with any Pre-Service Notification requirements when rendered or referred by a Provider before the Services are provided. For details on how to obtain Prior Coverage Authorization for other Health Care Services, please call the customer service telephone number on your ID Card or your ConciergeCare Counselor.

If you do not obtain Prior Coverage Authorization or provide Pre-Service Notification, we will:

1. Deny payment of the claim; or

2. Apply a benefit penalty when the claim is presented to us for payment consisting of one of the following:

a. $500;

b. 20% of the total Allowed Amount of the claim; or

c. The lesser of $500 or 20% of the total Allowed Amount of the claim.

The decision to apply a penalty or deny the claim will be made uniformly and the applicable denial/penalty will be identified in the notice describing the Prior Coverage Authorization and Pre-Service Notification programs.

We will inform you of any Health Care Service that is or will become subject to a Prior Coverage Authorization or Pre-Service Notification program, including how you can obtain Prior Coverage Authorization and/or provide the Pre-Service Notification for such Service. This information will be provided to you upon enrollment, or at least thirty (30) days prior to such Services becoming subject to a Prior Coverage Authorization or Pre-Service Notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require Prior Coverage Authorization shall occur no more frequently than twice in a Benefit Period.

Once the necessary medical documentation has been received from you and/or the Provider, WellAway, or a designated vendor, will review the information and make a Prior Coverage Authorization decision, based on our established criteria then in effect. You will be notified of the Prior Coverage Authorization decision.

Note: Prior Coverage Authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition. Prior Coverage Authorization is also not required for an Outpatient Physician office visit (not in a hospital setting).

Please refer to the APPEAL AND GRIEVANCE PROCESS section for information on what you can do if Prior Coverage Authorization is denied.

Personal Case Management

In the event a Covered Person suffers from a catastrophic illness or injury, WellAway has the right, in its sole discretion, to designate a personal case manager to you to help you coordinate coverage, benefits, or payment for Health Care Services you receive.

We may elect to offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available by us on a case-by-case basis when you meet our case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, your personal case manager, and your Physician agree to in writing.

The fact that we have paid or may offer to pay for certain Health Care Services in no way obligates us to continue to provide or pay for the same or similar Services. Nothing contained in this category shall be deemed a waiver of our right to enforce this Policy in strict accordance with its terms. The terms of this Policy will continue to apply, except as specifically modified in writing by us in accordance with the personal case management rules then in effect.

Important Information Relating to Your Health

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and the responsibility of your health care Providers. You and your Providers are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. We are solely responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Policy. In fulfilling this responsibility, we will not be deemed to participate in, or override, the medical decisions of your health care Provider. Please note that certain benefits require the Covered Person to obtain Services from an In-Network Provider.

Payment of Premiums

This Policy is not enforceable, and your coverage is not effective until we receive and accept the Policyholder's Application Forms and the first Premium payment, in full. All future Premium payments are due, in full, in advance or within the Grace Period. The amount of your initial Premium payment is printed on the first page of this Policy. If we do not, for any reason, provide you with a notice of payment due, you, as the Policyholder, are still obligated under this Policy to pay Premiums on time, even if you do not receive a bill from us. You, as the Policyholder, are solely responsible for submitting the Premium by the end of the Grace Period.

If we accept Premium for a Covered Dependent for a period of time after such dependent no longer meets the eligibility rules, coverage for such dependent will continue during the Grace Period for which an identifiable Premium was accepted, unless such acceptance resulted from a misstatement of age or residence. All Premiums are payable monthly, quarterly, or on an annual basis.

Premium payments are payable to:

WellAway Limited
Victoria Place
31 Victoria Street
5th Floor
PO Box HM 1624
Hamilton HM GX
Bermuda

We may provide you with options for direct pay, bank wires, credit card payments, and online payments to facilitate keeping the Policy in force. Your broker will discuss these options with you at the time of discussing the products that may be available to you.

Note: Your premium payments to the CFE are not included in your WellAway Premium and must be paid separately as they become due, directly to the CFE.

Premium Payment Due Date

The first Premium payment is due before the Effective Date of this Policy. The Premium must be paid monthly, quarterly, or annually. In the event that the initial Premium payment is dishonored, your coverage will not be effective and we will not enroll you in coverage. Each recurring Premium payment, following the initial Premium payment, is due in full on or before the due date as stated on your bill (monthly, quarterly, or annual bill).

Grace Period

This Policy has a Premium payment Grace Period which begins on the date the Premium payment is due. If any required Premium payment is not received by us on or before the due date, it may be paid during this Grace Period. The Grace Period is thirty-one (31) days. Coverage will stay in force during the Grace Period, however; if Premium payments are not received by the end of the Grace Period, coverage will terminate as of the Premium due date.

Partial Payments

When we bill you for different kinds of coverage, products and/or services on the same bill (such as health insurance and dental insurance) and you pay less than the total amount of the bill, the way we credit your partial payment will affect your coverage. We have established the order in which your partial payment will be applied to the different kinds of coverage, products and/or services, which is outlined on your bill. By accepting this coverage, you agree that partial payments will be applied in the order indicated on your bill.

Changes in Premiums

The Premium may be modified each year at the end of each Benefit Period due to changes in the Rates. In addition, the Premium may be modified due to a change in age of the Policyholder or any Covered Dependents from one age group/class to another effective as of July 1st of the current Benefit Period. We will provide at least forty-five (45) days prior written notice to the

Policyholder. If you send us any payments after you receive the notice of change to your Premium, this means you, as the Policyholder, agree to the Premium changes.

Your Premium may also change if the Risk Class of the Policyholder or any Covered Dependent changes, or if the number of individuals covered under this Policy changes. For example, the Premium may change once you establish a permanent domicile in the United States or if you move to another geographic location including your relocation outside of the United States. This change may result in an increase or decrease of the Premium depending on the healthcare inflation factors of the area where you relocate.

Defaults in Payments

If all Premiums required under this Policy are not paid in full when they are due, this Policy will terminate as described in this section. However, even if your coverage is terminated for non-payment, you, as the Policyholder are still obligated under this Policy to pay us any prorated portion of the Premium for the period of time during which we provided benefits, or for any amounts otherwise due to us.

Eligibility and Enrollment for Coverage

Any person who meets and continues to meet the eligibility rules described in this Policy, is entitled to apply for coverage with us under this Policy. These eligibility rules are binding upon you and your Eligible Dependents. We will require acceptable documents proving that a person meets and continues to meet the eligibility requirements, such as a court order naming the Policyholder as the legal guardian or appropriate Adoption documents described in this section.

Policyholder Eligibility

In order to be eligible to apply for coverage as a Policyholder, you must:

1. Be over the attained age of 18 and residing outside of your Country of Origin. Policyholders between the ages of 18-21 require prior approval from WellAway before coverage is effective;

2. Plan to live in the United States for more than 11 months;

3. Apply for coverage under, and be named on, the Application Forms for this Policy;

4. Be under the attained age of 64; and

5. Pay the required Premiums.

Dependent Eligibility

A person who meets the standards required by the Affordable Care Act and meets the eligibility criteria specified below is eligible to apply for coverage under this Policy as an Eligible Dependent only if the person: (i) was named on the initial Application Forms for, or properly enrolled under, this Policy; (ii) pays the required Premium; and is:

1. The Policyholder's spouse under a legally valid existing marriage;

2. The Policyholder's or covered Domestic Partner's natural, newborn, Adopted, or step child (or a child for whom the Policyholder or covered Domestic Partner has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Benefit Period in which he or she reaches age 26, regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan; or

3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: You are solely responsible, as the Policyholder, to establish that a child meets the eligibility rules. Eligibility will end when the child no longer meets the eligibility rules required to be an Eligible Dependent described above.

Handicapped Children

In the case of a handicapped dependent child, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 26, if the child is otherwise eligible for coverage under the Policy. This eligibility will end on the last day of the month in which the dependent child no longer meets these requirements.

Other Eligibility Rules

1. No person whose coverage with us has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll with us.

2. No person shall be refused enrollment or re-enrollment because of race, color, national origin, disability, sex, age, creed, marital status, gender, gender identity or sexual orientation (except as provided in this section).

3. The Policyholder must notify us as soon as a Covered Dependent fails to continue to meet each of the eligibility requirements; if the Policyholder does not provide timely notification we shall have the right to:

a. retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met; and

b. recover an amount equal to the Allowed Amount for Health Care Services and/or Supplies provided after such date, less any Premium we received for such dependent for coverage after such date.

Upon our request, the Policyholder shall provide proof, which is acceptable to us, of a Covered Dependent's continuing eligibility for coverage.

4. Upon reaching age 65, if the Covered Person is eligible for any plans offered by the government for retirees or any other plan of similar circumstance, WellAway reserves the right to terminate or no longer offer this plan to such Covered Person.

General Rules for Enrollment

1. Any person who is not properly enrolled with us through a WellAway representative or licensed agent will not be covered under this Policy. We will have no obligation whatsoever to any person who is not properly enrolled.

2. All factual representations made by you to WellAway in writing in connection with the issuance of this Policy and enrollment hereunder must be accurate and complete. Any intentional false, incomplete or misleading information provided during the enrollment process, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right we may have, we may terminate or Rescind your coverage.

3. We will not provide coverage or benefits to any person who would not have been eligible to enroll with us, had accurate and complete information been provided to us on a timely basis. In such cases, we may require you or a person legally responsible for you, to reimburse us for any payments we made on your behalf.

4. Eligibility for coverage under this Policy is determined by the Risk Class applicable to you and your dependents. In determining eligibility for coverage under this Policy, we rely on the information provided by you prior to your enrollment.

5. If, in applying for this Policy, or in enrolling yourself or your dependents, you commit fraud or make an intentional misrepresentation of a material fact, we will Rescind your coverage. After five (5) years from your Effective Date, your Policy may only be Rescinded for intentional fraudulent misstatements. If, in applying for this Policy or in enrolling yourself or dependents, you make an intentional fraudulent statement or misrepresentation of a material fact including, but not limited to, your demographic information including your geographical area, age, or the age of your dependents, we may elect to cancel the Policy within forty-five (45) days prior written notice. We may also elect to continue this Policy provided that the Policyholder pays us for the full amount of the Premium that would have been in effect if you had stated the true facts.

Enrollment & Effective Date
To enroll in coverage, you must:

1. Complete and submit the required Application Forms, including for all Eligible Dependents, through your broker, your broker's website, WellAway's website, or a representative assigned by WellAway;

2. Provide any other information that WellAway may need to determine eligibility at our request; and

3. Agree to pay the required Premium.

Your Effective Date is stated on your Certificate of Coverage.

Note: Your CFE coverage will begin once your CFE application has been processed and approved by the CFE.

Special Enrollment Periods
A special enrollment period is the thirty (30) day period of time immediately following one of these special events, during which you may apply for coverage. If you apply for coverage during a special enrollment period the effective date of your new coverage will depend on what type of special event occurred as explained below.

To apply for coverage, you must complete the applicable Application Forms and submit them within the thirty (30) day period.

Special Event	Effective Date
1. You gain a dependent or become a dependent through marriage or a dependent child up to age 26 relocates to the United States.	First day of the following month.
2. You gain a dependent or become a dependent through birth, Adoption or placement for Adoption.	Date of birth, Adoption, or placement for Adoption. Additional rules apply for dependent enrollments as explained below.
3. In the event you relocate from the United States, you are no longer permanently domiciled in the United States and no longer eligible for this coverage.	As determined by us.

Additional Rules for Dependent Enrollment

A person may be added upon becoming an Eligible Dependent during a special enrollment period. Below are special rules for certain Eligible Dependents.

Newborn Children – To enroll a newborn child who is an Eligible Dependent, you must complete and submit any required Application Forms. The Effective Date of coverage for a newborn child is usually the date of birth as long as you have enrolled the newborn child in time (as indicated below). We must be notified, in writing, when you are adding a newborn and the rules for Effective Date and Premiums charged for the newborn may vary depending on when the notification is received. The special enrollment period to add a newborn is only thirty (30) days from the date the child is born. If you do not add a newborn within the thirty (30) day period, you will need to wait until the next Benefit Period of your Policy to add the child. Coverage will only be in effect once the required Premium has been paid.

Additional Rules for Adopted Newborn Children

In addition to the requirement above, in order for an Adopted newborn's Effective Date to be the date of birth, a written agreement to Adopt such child must have been entered into by the Policyholder prior to the birth of such child, whether or not such an agreement is enforceable. We will require the Policyholder to provide any information and/or documents that we deem necessary in order to administer this provision. Proof of final Adoption must be submitted to us. If the Adopted newborn child is not ultimately placed in your residence, there shall be no coverage for the Adopted newborn child. It is your responsibility as the Policyholder to notify us that the Adopted newborn child is not placed in your residence.

Note: The guidelines above only apply to newborns born after the Effective Date of this Policy. If a child is born before the Effective Date of this Policy, the newborn must be added during the application process.

Adopted Children – To enroll an Adopted child, you must complete and submit any required Application Forms prior to, or within thirty (30) days after the date of placement and pay the additional Premium due, if any. The Effective Date will be the date the Adopted child is placed in the residence. We may need you to provide additional information and/or documents deemed necessary by us in order to properly administer this provision. If you do not add an Adopted child within the thirty (30) day period, you will need to wait until the next Benefit Period of your Policy to add the child. Coverage will only be in effect once the required Premium has been paid.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for such Adopted child. As the Policyholder, you are solely responsible for notifying us the Adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

Other Dependents - If other Eligible Dependents were not named on the Application Forms for this Policy (such as a new spouse or a new court order to provide coverage for a minor child), you may still apply for coverage for such dependents during a special enrollment period. An Eligible Dependent can become covered when you submit the required Application Forms and pay the required Premiums. The Effective Date of coverage for such dependents will be determined by WellAway.

Continuing Coverage on Termination of Eligibility

If you lose coverage or coverage ceases because of termination of eligibility under this Policy, you may contact WellAway to provide you with temporary level of health insurance coverage most suitable for your needs. You may request other coverage depending on your country of residence and you will be required to pay a Premium where limitations in coverage and benefits may apply.

For more information, please contact WellAway or a ConciergeCare Counselor.

Termination of Coverage

Introduction

This section describes the rules for termination of coverage. We have divided this section into two subsections: Termination of an Individual and Termination of the Policy.

Termination of an Individual

If your coverage is terminated by us for any reason we will provide you with written notice at least thirty (30) days prior to your last day of coverage under this Policy.

Policyholder
A Policyholder's coverage will automatically end at 12:01 a.m. on the termination date provided in your termination notice. A Policyholder's coverage will end for the following reasons:

1. The Policy terminates in accordance with Termination of the Policy subsection;

2. The Policyholder's coverage is terminated for cause (see Termination for Cause below); and/or

3. The Policyholder changes permanent residence from the United States to another country of residence where the eligibility requirements will change.

Covered Dependent
A Covered Dependent's coverage will automatically end at 12:01 a.m. on the termination date provided in your termination notice. A Covered Dependent's coverage will end for the following reasons:

1. The Policyholder's coverage terminates for any reason;

2. The Covered Dependent no longer meets any of the eligibility requirements;

3. Eighteen (18) months after the birth of a newborn child who is the child of a Covered Dependent child; and/or

4. The Covered Dependent's coverage is terminated by us for cause.

If you, as the Policyholder, wish to terminate coverage of a Covered Dependent, you must provide at least fifteen (15) days' notice of the requested termination date to WellAway.

Domestic Partner's Dependent Child
In addition to the requirements set forth above under Covered Dependent, a Covered Dependent child's coverage under this Policy will end at 12:01 a.m. on the date that the Domestic Partnership ends or the date of death of the Domestic Partner.

Termination of a Covered Person for Cause
If, in our opinion, any of the following events occur, we will terminate a Covered Person's coverage for cause. For purposes of this Policy, cause shall be defined as follows:

1. Disruptive, unruly, abusive, unlawful, and intentional fraudulent or uncooperative behavior to the extent that your continued coverage with us impairs our ability to provide coverage and/or benefits or to arrange for the delivery of Health Care Services to you or any other Covered Person. Prior to terminating your coverage for any of these reasons, we will:

   a. make a reasonable effort to resolve the problem presented by you, including the use or attempted use of our Appeal and Grievance Process;

b. ascertain, to the extent possible, that your behavior is not related to the use of medical Services or mental illness; and

c. document the problems encountered, efforts made to resolve the problems, and any of your medical Conditions involved.

2. You intentionally misrepresent, omit or give false information on your Application Forms or other forms completed for us for the purpose of obtaining coverage under this Policy, by you or on your behalf;

3. You fail to comply with a material provision of this Policy;

4. You no longer live in the United States; or

5. Any act of Fraud with respect to this Policy. For purposes of this Policy, “Fraud” means deception by a person with the intent to wrongly benefit him/her. It includes any act that is defined as fraud under federal or state laws, and includes, but is not limited to:

(i) Using another person’s name as your own;

(ii) Using an ID Card that does not belong to you;

(iii) Giving your ID card to someone else;

(iv) Misuse of Services;

(v) Billing for Services that were not provided;

(vi) Giving false information on your records. This includes records that relate to your Eligibility;

(vii) Giving statements on the Application Form which are found to be misrepresentations or are incomplete or incorrect;

(viii) Knowingly claiming benefits for any purpose other than as provided for under this Policy;

(ix) Agreeing to any attempt by a third party action or omission to obtain an unreasonable pecuniary advantage to our detriment; or

(x) Purchasing this Policy with the intent of receiving a planned medical Service.

If we decide to terminate the Policy based on one or more of the actions listed above, your Policy will be terminated effective immediately. We will provide written notice of such termination. Any termination made for the reasons stated above is subject to review in accordance with the Appeal and Grievance Process described in this Policy.

Rescission of Coverage
We reserve the right to Rescind coverage of this Policy or coverage for any Covered Person under this Policy as permitted by law while you reside in the United States. We may only Rescind the Policy or coverage of a Covered Person under the Policy if you or another person on your behalf commits fraud or you make an intentional misrepresentation of a material fact in applying for coverage or benefits. Only intentional fraudulent misstatements on the Application Forms may be used by us to void coverage or deny any claim for loss incurred or disability, if discovered at any time during the Policy.

Notice of Ineligible Dependent
If a Covered Dependent no longer meets all of the applicable eligibility requirements specified in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section of this Policy, the Policyholder must notify us in writing immediately and no later than thirty (30) days after the date the Covered Dependent ceases to be eligible for coverage. If we receive notification after the thirty (30) day period, the change will be effective as of the current date and we will not refund any Premiums.

Our Responsibilities Upon Termination of Your Coverage Upon termination of coverage for you or any of your Covered Dependents for any reason, we will have no further liability or responsibility with respect to such person, except as otherwise specifically described in this Policy.

Certification of Creditable Coverage
Upon request, in the event coverage ends for any reason, we will issue a written certification of Creditable Coverage to you. The certification of Creditable Coverage will indicate the period of time you were enrolled with us. You may call the customer service

telephone number on your ID Card or your ConciergeCare Counselor to request the certification. The succeeding carrier will be responsible for determining if our coverage meets their qualifying Creditable Coverage guidelines.

Termination of the Policy

Discontinuation of Form
We may decide to discontinue this form of Policy, but may do so only if:

1. We provide notice to each Policyholder under this Policy form at least forty-five (45) days before the date the coverage under this Policy form will end;

2. We offer the option to each Covered Person to purchase any other health care coverage we currently offer to individuals where you live; and

3. We act uniformly without regard to any health status related factor of Covered Persons or individuals who may become eligible for such coverage.

Discontinuation of all Policies in Individual Product
We may decide to discontinue all of the policies that we have issued to other persons (including this Policy), residing or domiciled in the same or similar geographic area as you may be, but may do so only if:

1. We provide notice to each Policyholder at least ninety (90) days before the date the coverage under such policies will end; and

2. We return any unused Premium to the Policyholder, except certain reserves for unpaid claims, if needed.

Defaults in Payments
If all Premiums required under this Policy are not paid in full when they are due, this Policy will terminate at the end of the Grace Period, as described in the PAYMENT OF PREMIUMS section of this Policy.

2. If the CFE premiums are not paid, you are no longer eligible for this Policy. Any applicable discounts will be forfeited and a new premium amount will be billed on your next payment period.

Reinstatement of Coverage
If any Premium is not paid within the time granted the Policyholder for payment [Premium due date plus Grace Period], a subsequent acceptance of Premium by us or by any broker duly authorized by us to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if we or such broker require an application for reinstatement and issue a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of the application by us or, lacking such approval, upon the forty-fifth (45th) day following the date of the conditional receipt unless we have previously notified you in writing of our disapproval of the application. The reinstated Policy shall cover only losses resulting from such Accident as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after that date. In all other respects, the Policyholder and WellAway shall have the same rights as we had under the Policy immediately before the due date of the defaulted Premium, subject to the provisions of any rider which may be attached to the Policy in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Notice of Termination
A written notice of any termination of this entire Policy will be mailed to the Policyholder in accordance with the terms set forth herein. This notice will state the reason the Policy is being terminated.

Conditions of Renewal and Termination

This Policy is a continuous policy while you are domiciled or living in the United States and you may fall under the requirements of the Affordable Care Act (ACA). This means that the Policy does not need to be renewed each year. However, this Policy may be terminated earlier in accordance with the terms and conditions of this Policy.

Claims Processing

Introduction

This section is intended to:

1. Help you understand what your treating Providers must do, under the terms of this Policy, in order to obtain payment for Covered Services that have been rendered or will be rendered to you; and

2. Provide you with a general description of the applicable procedures we will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying you when we deny benefits.

Types of Claims

For purposes of this Policy, there are three types of claims: (1) Post-Service Claims; (2) Pre-Service Claims; and (3) Claims Involving Urgent Care. It is important that you become familiar with the types of claims that can be submitted to us and the timeframes and other requirements that apply.

Post-Service Claims

How to File a Post-Service Claim
Experience shows that the most common type of claim we will receive from you or your treating Providers will likely be Post-Service Claims. In-Network Providers have agreed to file Post-Service Claims with us for Health Care Services they render to you. In the event a Provider who renders Services to you does not file a Post-Service Claim for such Services, it is your responsibility to submit claims by Providers within the United States in CMS 1500 formats, or UB04 CMS formats. This is because of the standardized claim forms used industry wide in the United States. We will reimburse you in accordance with the terms of the Provider contract, if one exists. In the event that you utilize a Non-Network Provider that has chosen to “opt-out” of billing an insurance company and did not provide you with a medical claim in CMS 1500 formats, or UB04 CMS formats, your claim will be deemed a non-reimbursable claim.

For Post-Service Claims for medical services rendered outside the United States, we must receive an itemized statement containing the following information, filed in a claim form provided by us containing:

1. Name of Physician or Hospital on letterhead which includes the address, telephone number and e-mail address, if applicable;

2. Physician’s Tax Identification Number (TIN) or NPI number;

3. Date of Service when the treatment was incurred or provided;

4. Procedure code or (CPT code) description of the Service that was provided;

5. Itemization or fee of each Service charged by the Provider;

6. Description of the diagnosis, including any applicable diagnosis codes;

7. Valid proof of payment such as a cancelled check or credit card receipt; and

8. Policyholder’s name and Policy number as they appear on the ID card.

We must receive a Post-Service Claim within ninety (90) days of the date the Health Care Service was rendered, unless you are legally incapacitated.

Note: Please refer to the Medication Program section for information on the processing of Prescription Drug claims.

Processing Post-Service Claims
We will use our best efforts to pay, contest, or deny all Post-Service Claims for which we have all of the necessary information, as determined by us, within the time frames described below.

Payment for Post-Service Claims

When payment is due under the terms of this Policy, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within twenty (20) days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within forty (40) days of receipt. You may receive notice of payment for paper claims within thirty (30) days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more information, we may contest or deny the claim within the timeframes set forth below.

Contested Post-Service Claims

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within twenty (20) days of receipt, that the claim or a portion of the claim is contested. In the event we contest a paper Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within thirty (30) days of receipt, that the claim or a portion of the claim is contested. The notice may identify: (1) the contested portion or portions of the claim; (2) the reasons for contesting the claim or a portion of the claim; and (3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether more information is needed in order to complete processing of the claim. If we request additional information, we must receive it within forty-five (45) days of the request for the information. If we do not receive the requested information, the claim or a portion of the claim will be processed based on the information in our possession at the time and may be denied. Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within fifteen (15) days of receipt of the requested information.

Denial of Post-Service Claims:

In the event we deny a Post-Service Claim submitted electronically, we will use our best efforts to provide notice, within twenty (20) days of receipt that the claim or a portion of the claim is denied. In the event we deny a paper Post-Service Claim, we will use our best efforts to provide notice, within thirty (30) days of receipt of the claim, that the claim or a portion of the claim is denied. The notice may identify the denied portions of the claim and the reasons for denial. It is your responsibility to ensure that we receive all information that we determine is necessary to adjudicate a Post-Service Claim. If we do not receive the necessary information, the claim or a portion of the claim may be denied. A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this section.

In any event, we will use our best efforts to pay or deny all (1) electronic Post-Service Claims within ninety (90) days of receipt of the completed claim; and (2) paper Post-Service Claims within one hundred twenty (120) days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by us or otherwise electronically transmitted.

We will investigate any allegation of improper billing by a Provider upon receipt of written notification from you. If we determine that you were billed for a Service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due solely due to the notification from you, we will pay you twenty (20) percent of the amount of the reduction, up to an amount not to exceed $500.

Pre-Service Claims

How to file a Pre-Service Claim
This Policy may condition coverage, benefits, or payment (in whole or in part) for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the WHAT IS COVERED? section, the ACCESS TO HEALTHCARE PROGRAMS section and other applicable sections of this Policy. You may also call the customer service telephone number on your ID Card for assistance or your ConciergeCare Counselor.

We are not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to you unless the terms of this Policy require approval by us (or condition payment) for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim from an Urgent Care Center, we will use our best efforts to provide notice of the determination (whether adverse or not) as soon as possible, but not later than seventy-two (72) hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, we will use our best efforts to provide notice within twenty-four (24) hours of: (1) the need for additional information; (2) the specific information that you or the Provider may need to provide; and (3) the date that we reasonably expect to provide notice of the decision. If we request additional information, we must receive it within forty-eight (48) hours of the request. We will use our best efforts to provide notice of the decision on the Pre-Service Claim within forty-eight (48) hours after the earlier of: (1) receipt of the requested information; or (2) the end of the period you were afforded to provide the specified additional information as described above.

Benefit Determinations on Pre-Service Claims that Do Not Involve Urgent Care

We will use our best efforts to provide notice of a decision of a Pre-Service Claim not involving urgent care Services within fifteen (15) days of receipt, provided additional information is not required for a coverage decision. This fifteen (15) day determination period may be extended by us one (1) time for up to an additional fifteen (15) days. If such an extension is necessary, we will use our best efforts to provide notice of the extension and the reasons for such extension. We will use our best efforts to provide notification of the decision on your Pre-Service Claim within a total of thirty (30) days of the initial receipt of the claim, if an extension of time was taken by us.

If additional information is necessary to make a determination, we will use our best efforts to: (1) provide notice of the need for additional information, prior to the expiration of the initial fifteen (15) day period; (2) identify the specific information that you or the Provider may need to provide; and (3) inform you of the date that we reasonably expect to notify you of the decision. If we request additional information, we must receive it within forty-five (45) days of the request for the information. We will use our best efforts to provide notice of the decision on the Pre-Service Claim within fifteen (15) days of receipt of the requested information. A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

Concurrent care exists where more than one physician renders services more extensive than consultative services during a period of time.

A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. Your coverage for the Service or Supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as Copayments, Coinsurance and Deductibles that apply to the Service or Supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the Service or Supply received during the continuation period.

A reduction or termination of coverage or benefits for Services will be considered an Adverse Benefit Determination when:

1. We have approved, in writing, coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and

2. The reduction or termination occurs before the end of such previously approved time or number of Services; and

3. The reduction or termination of coverage or benefits by us was not due to an amendment to the Policy or termination of your coverage as provided by this Policy.

We will use our best efforts to notify you of such reduction or termination in advance so that you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determinations described below. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within twenty-four (24) hours after receipt of the request, provided it is received at least twenty-four (24) hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within twenty-four (24) hours if: (1) we need additional information; or (2) you or your ConciergeCare Counselor did not follow proper procedures in the request for an extension. If we request additional information, you will have forty-eight (48) hours to provide the requested information. We may notify you orally and in writing, unless you or your ConciergeCare Counselor specifically request that it be in writing. A denial of a request for an extension of Services is considered an Adverse Benefit Determination and is subject to the procedures described below.

Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

1. The date the Service or Supply was provided;

2. The Provider’s name;

3. The dollar amount of the claim, if applicable;

4. The diagnosis codes included on the claim (e.g., ICD-9, ICD-10, DSM-IV), and upon request, a description of such codes;

5. The standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a Concurrent Care Decision description of such codes;

6. The specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;

7. A description of the specific Policy provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

8. A description of any additional information that might change the determination and why that information is necessary;

9. A description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and

10. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how to obtain the specific explanation of the scientific or clinical judgment for the determination.

If the claim is a Claim Involving Urgent Care, we may notify you orally within the proper timeframes, provided we follow up with a written or electronic notification meeting the requirements of this subsection no later than two (2) working days or three (3) calendar days after the oral notification.

Excess Coverage Provision

The Allowed Amount otherwise payable for Covered Services will be reduced by the total amount of benefits provided by any Other Plan (as defined below). The amount of benefits provided by Other Plans:

1. will be determined without reference to any:

    a) coordination of benefits provision;

    b) non-duplication of benefits provisions; or

    c) other similar provision;

2. will include any amount to which the Covered Person is entitled, regardless of whether claim is made for the benefits; and

3. will include the reasonable value of any Services provided under the Policy.

Other Plan means:

a) group, blanket or franchise insurance;

b) group Hospital, medical services, or pre-payment plan;

c) labor-management trustee, union welfare, employer organization, or employee benefit organization plan;

d) governmental, social security or other similar programs or coverage provided by any applicable law or regulation;

e) automobile insurance medical payments benefit or automobile reparations insurance (no fault); or

f) Worker's Compensation or similar law.

Additional Claims Processing Provisions

Release of Information/Cooperation
In order to process claims, we will need certain information, including information regarding other health care coverage you may have and/or medical information from Providers who render Services to you. You must cooperate with us in our effort to obtain this information, including signing any release of information form at our request. If you do not fully cooperate with us, we will deny the claim and we will have no liability for such claim.

Physical Examination and Autopsy
In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. If you do not fully cooperate with such examination, we may deny the claim and we shall have no liability for such claim. We also reserve the right, if the law permits, to have an autopsy performed on you in case of death.

Legal Actions
No legal action arising out of or in connection with coverage under this Policy may be brought against us within the sixty (60) day period following our receipt of the completed claim as required herein. Additionally, action may only be brought against us within six (6) months after the final determination of any claim, appeal or external review, as applicable.

Fraud, Misrepresentation or Omission in Applying for Benefits
We rely on the information provided on the itemized statement when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any intentional fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information will result, in addition to any other legal remedy we may have, in denial of the claim or cancellation or Rescission of your coverage.

Communication of Claims Decisions
All claims decisions, including denial and claims review decisions, will be communicated to you in writing such as through your monthly member health statement. This written correspondence may indicate:

1. The specific reason or reasons the claim was denied.

2. Reference to the specific Policy provisions upon which the denial is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination.

3. A description of any additional information that would change the initial determination and why that information is necessary.

4. An explanation of the steps to be taken if you wish to have a claim denial reviewed.

5. A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures.

6. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

Circumstances Beyond Our Control
To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we will make a good faith effort to make payment for such Services, taking into account the impact of the event. For purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Appeal & Grievance Process

Introduction

This section is intended to help you understand what you need to do to appeal a claims decision.

How to Appeal an Adverse Benefit

Except as described below, only you, or a person designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the process described below. Your appeal must be submitted to us in writing for an internal appeal within sixty (60) days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a thirty (30) day period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

1. You must cooperate fully with us in our effort to promptly review and resolve an appeal. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the appeal processed within the time frames set forth in this section.

2. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The expedited appeal process only applies to Pre-Service Claims or requests for extension of Concurrent Care Services made within twenty-four (24) hours before the authorization for such Services expires. An expedited appeal will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.

3. You may review pertinent documents upon request and free of charge, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.

4. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Policy to your medical circumstances. This information is provided free of charge.

5. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.

6. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.

7. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request.

8. If the claim is a Claim Involving Urgent Care, you may request an expedited review orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method.

9. If your request for expedited review arises out of a concurrent review determination by us that a continued hospitalization is not Medically Necessary, coverage for the hospitalization will continue until you have been notified of the determination.

10. We will review the appeal and may make a decision based on medical records, additional information and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review. The Plan Administrator will attempt to retrieve the medical records on behalf of the Covered Person; however, if these are not provided to us, it will be the responsibility of the Covered Person to provide the information in order to validate the claim. The claim will be closed with non-payment until the required information is provided to us. Expenses Incurred for such records will be at the sole expense of the Covered Person. The Covered Person has sixty (60) days from the date he/she received Notification in writing requesting additional information to authenticate and validate a claim. If the information is not provided to the Plan Administrator within the allotted timeframe, the claim will be denied.

11. We will advise you of all appeal decisions in writing, as outlined in the Timing of Our Appeal Review on Adverse Benefit Determinations subsection.

12. If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed appointment of a representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An appointment of a representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of a representative forms are available at www.wellaway.com or by calling the telephone number on your ID Card.

13. If you are not satisfied with our decision, you have the right to an independent external review through an external review organization for certain appeals, as described in the How to Request External Review of our Appeal Decisions subsection below.

How to Submit a Grievance Related to an In-Network Provider Provision

The following guidelines are applicable to reviews of Grievances:

1. We must receive your Grievance in writing; and

2. We may consult with appropriate Physicians, as necessary. Appeals and Grievances must be sent to the address below or the address on your ID card.

ATTN: Member Appeals
WellAway Limited
Victoria Place
31 Victoria Street
5th Floor
PO Box HM 1624
Hamilton HM GX
Bermuda

Timing of Our Appeal Review on Adverse Benefit Determinations

We will use our best efforts to review your appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

1. Pre-Service Claims: within thirty (30) days of the receipt of your appeal;

2. Post-Service Claims: within sixty (60) days of the receipt of your appeal; or

3. Claims Involving Urgent Care (and requests to extend concurrent care Services made within twenty-four (24) hours prior to the termination of the Services) within seventy-two (72) hours of receipt of your request.

If additional information is necessary, we will notify you within twenty-four (24) hours and we must receive the requested additional information within forty-eight (48) hours of our request. After we receive the additional information, we will have an additional forty-eight (48) hours to make a final determination.

Note: The nature of a claim for Services (i.e., whether it is “urgent care” or not) is judged as of the time of the benefit determination on review, not as of the time the Service was initially reviewed or provided.

Timing of Our Review on Grievances

We will use our best efforts to review your Grievance and communicate the decision within sixty (60) days of receipt of your Grievance. You, or a Provider acting on your behalf, who has had a claim denied as not Medically Necessary has the opportunity to appeal the claim denial. The appeal may be directed to WellAway Claims Department. The Claims Department will respond to you, within a reasonable time, not to exceed fifteen (15) business days.

How to Request External Review of our Appeal Decision

If we deny your appeal and our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational, you are entitled to request an independent, external review of our decision. Your request will be reviewed by an independent third party with clinical knowledge. You may submit additional written comments to the external reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the external review request form within four (4) months after receipt of your denial to the address below:

WellAway Limited
Victoria Place
31 Victoria Street
5th Floor
PO Box HM 1624
Hamilton HM GX
Bermuda

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. Moreover, expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Services for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this type of request. If you have any questions or concerns during the external review process, please contact us at the telephone number listed on your ID card. You may submit additional written comments to the external reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above. If the external reviewer decides to overturn our decision, we will provide coverage or payment for your Health Care Service or Supply.

You, or someone you name to act for you, may file a request for external review. To appoint someone to act on your behalf, please complete an appointment of personal representative form.

You are entitled to receive, upon written request and free of charge, reasonable access to, and copies of all documents relevant to your appeal, including a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.

You may request, and we will provide the diagnosis and treatment codes, as well as their corresponding meanings, applicable to this notice, if available.

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided by WellAway. It is designed to avoid duplication of payment for Covered Services and/or Supplies. We shall coordinate payment of Covered Services to the maximum extent allowed by law. Policies that may be subject to Coordination of Benefits include, but are not limited to, the following, which will be referred to as “plan(s)” for purposes of this section:

1. Any group or non-group insurance, group-type self-insurance, or HMO plan; foreign plans, temporary or travel insurance that may pay while you are away or traveling;

2. Any group plan issued in coordination with any other WellAway product(s);

3. Any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision; and

4. To the extent permitted by law, any other government sponsored health insurance program or national health plans from your country of origin that will be able to pay in part, of the medical care expenses incurred.

The amount of payment by us, if any, is based on whether or not we are the primary payer. When we are primary, we will pay for Covered Services without regard to your coverage under other plans. When we are not primary, our payment will be reduced so that total benefits under all plans will not exceed 100% of the total reasonable expenses actually incurred for the Covered Services. In the event the Covered Services were rendered by an In-Network Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount we are obligated to pay such In-Network Provider based on this Policy.

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. When we cover you as a dependent and establish the order in which benefits under the respective plans will be determined; the other plan covers you as other than a dependent, we will be secondary.

2. When we cover you as a dependent child and your parents are married (not separated or divorced):

   a. the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;

   b. if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, we will be secondary.

3. When we cover you as a dependent child whose parents are not married, or are separated or divorced:

   a. if the parent with custody is not remarried, the plan of the parent with custody is primary;

   b. if the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent’s plan is secondary; and the plan of the parent without custody pays last;

   c. regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child’s health care expenses, the plan of that parent is always primary.

4. When we cover you as a dependent child and the other plan covers you as a dependent child:

   a. the plan of the parent who is neither laid off nor retired will be primary;

   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

5. If you have continuation of coverage under COBRA, Continuation Act, COBRA would be primary.

6. When rules 1, 2, 3, 4 and 5 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary, unless you are age 65 or older and covered under Medicare Parts A and B. In that case, this Policy will be secondary to Medicare.

7. If the other plan does not have rules that establish the same order of benefits as under this Policy, the benefits under the other plan will be determined primary to the benefits under this Policy.

Note:

1. We will not coordinate benefits against an indemnity type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or Accidents, or a Medicare Supplement policy.

2. If you have purchased other coverage, please refer to the benefits outlined under that policy as different terms and conditions may apply.

Subrogation

If you are injured or become ill as a result of another party's intentional act, negligence or fault, you must notify us concerning the circumstances under which you were injured or became ill. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. If you recover money to compensate for the cost/expense of Health Care Services to treat your illness or injury, we are legally entitled to be reimbursed for payments we made on your behalf to the Physicians, Hospitals, or other Providers who treated you. Our legal right to be repaid in such cases is called "subrogation." We will recover the amount of any payments we made on your behalf minus our pro rata share for any costs and attorney's fees incurred by you in pursuing and recovering damages. We will "subrogate" against all money recovered regardless of the source of the money including, but not limited to, uninsured motorist coverage and workers' compensation.

Although we may, but are not required to, take into consideration any special factors relating to your specific case in resolving our subrogation claim, we will have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of the recovery or settlement. You must not do anything to prejudice our right of subrogation hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

In the United States, the Insurer pays secondary to any and all personal insurance protection (PIP), medical payment to others (Med-Pay), no-fault coverage or governmental reimbursement programs, including, but not limited to, state crime victim compensation programs, which reimburse victims for crime-related expenses. The Insurer has no duty or obligation to pay any claims until PIP, Med-Pay, no-fault coverage, or reimbursement to the Covered Person is exhausted. In the event that the Plan Administrator pays claims that should have been paid by PIP, Med-Pay, no-fault coverage or a state compensation program, the Insurer has a right of recovery from the insurance carrier or Covered Person, as applicable.

Excess Coverage

No benefits are payable for any expense incurred for an accident or illness which has been paid or is payable by other valid and collectible insurance or governmental reimbursement programs. Benefits will only be paid under this Policy on the unpaid balances after the other insurance has paid or the allowable reimbursement has been made.

Facility of Payment

Whenever payments which should have been made by us are made by any other person, plan, or organization, we shall have the right, exercisable alone and in our sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts we shall determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Policy and, to the extent of such payments, we shall be fully discharged from liability.

General Provisions

Access to Information

We shall have the right to receive, from any health care Provider rendering Services to you, information that is reasonably necessary, as determined by us, in order to administer the coverage and/or benefits we provide, subject to all applicable confidentiality requirements set forth in this section. By accepting coverage under this Policy, you authorize every health care Provider who renders Services or furnishes Supplies to you, to disclose to us or to entities affiliated with us, upon request, all facts, records, and reports pertaining to your care, treatment, and physical or mental Condition, and to permit us to copy any such records and reports so obtained.

Amendment

The terms of coverage and benefits to be provided by us under this Policy may be amended, without your consent or that of any other person, upon sixty (60) days prior written notice to the Policyholder. In the event the amendment is unacceptable to the Policyholder, the Policyholder may terminate this Policy upon prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to benefits and coverage under this Policy prior to the date of such amendment. No agent or other person, except our duly authorized officer, has the authority to modify the terms of this Policy, or to bind us in any manner not expressly set forth herein, including, but not limited to, the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us under this Policy may not be amended by the Policyholder unless such amendment is evidenced in writing and signed by our duly authorized officer.

Assignment and Delegation

The obligations arising hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however, that we may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without your consent, at any time.

Keeping your health information private is extremely important, so your medical information will not include certain health information that pertains to “sensitive” medical conditions, for which the law provides special protection.

In addition, we will ensure safe and secure transmission of claim information. Only authorized health care Providers or authorized members of the Provider’s staff will have access to your information. Remember, this will help your Physician in obtaining important information concerning your health history.

In order to assist you with your coverage and benefits, you hereby authorize us to coordinate care amongst your authorized treating health care Providers. However, if for some reason you, or any of your Covered Dependents, choose not to provide your treating Physician access to your claim history, the use of this information may be restricted. Please notify us by calling the telephone number on your ID Card and inform your ConciergeCare Counselor of your decision.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and/or benefits under this Policy, specific medical information concerning you received by/from a Provider shall be kept confidential by us. Such information shall not be disclosed to third parties without your written consent, except for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and/or benefits under this Policy, including our quality assurance and utilization review activities. Additionally, we may disclose such information to entities affiliated with us. However, any documents or information which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

Our financial arrangements with In-Network Providers may require that we release certain claims and medical information about you even if you have not sought treatment by or through that Provider. By accepting coverage, you hereby authorize us to release to In-Network Providers claims information, including related medical information, pertaining to you, in order for the In-Network Provider to evaluate financial responsibility under their contracts with us.

Cooperation Required of Covered Persons

You must cooperate with us, and must execute and submit to us such consents, releases, assignments, and other documents as may be requested by us in order to administer and exercise our rights under this Policy. Failure to do so may result in the denial of claims.

Customer Rewards Program

From time to time, we may offer you rewards for participating in Access to Healthcare Programs. We will tell you about any available rewards programs through mailings or newsletters or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Policy.

We reserve the right to offer rewards in excess of $25 USD per year, as well as the right to discontinue or modify the features of any reward program or promotional offer at any time without your consent.

Enrollment Records

Reporting Changes

You, as the Policyholder, must provide any information required for the purpose of recording changes in family status or other information relative to eligibility or coverage status. All records relevant to eligibility or coverage status under this Policy shall be made available by you.

Errors or Delays

Clerical errors or delays by us in keeping or reporting enrollment records will not make any coverage invalid if it would otherwise be validly in force, or continue coverage which would otherwise be validly terminated. If you intentionally omit information that you should have provided, or provided incorrect information, it may be corrected, if it is determined that any such correction will not be prejudicial to us. You agree that you will be liable to us for any claims payments we make on behalf of any individual who was not eligible for coverage at the time the Service or Supply was rendered.

Entire Agreement

This Policy, including the application for coverage and any Application Forms, sets forth the exclusive and entire understanding and agreement between you and WellAway and shall be binding upon all Covered Persons, WellAway and any of our subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of this Policy, which includes the terms of coverage and/or benefits set forth herein, your Summary of Benefits and/or any Endorsements.

Evidence of Coverage

You have been provided with this Policy and an Identification Card as evidence of coverage.

Governing Law

The terms of coverage and benefits to be provided hereunder and the rights of the parties hereunder shall be construed in accordance with the laws of Bermuda.

Identification Cards

The Identification Cards issued to you in no way create, or serve to verify eligibility to receive coverage and benefits under this Policy. ID cards are our property and must be destroyed or returned to us immediately following termination of your coverage.

Indemnification

You shall indemnify and hold WellAway harmless against all claims, demands, liabilities, or expenses (including reasonable attorney's fees and court costs), which are related to, arise out of, or are in connection with any acts or omissions by you or any of your agents, in the performance of your obligations under this Policy.

Misstatement of Age, Residence, or Tobacco User

If any written information relevant to determining your Premium has been misstated by you, the Premium amount you owe under this Policy will be changed based on the corrected information provided to us. If we accepted Premiums based on such

misstatement that we would not have accepted Premium for if the correct information had been stated, our only liability will be the return of any unearned Premium or an adjustment to your Premium accordingly. We will not provide any coverage for that time period. This right is in addition to any other rights we may have under this Policy and applicable laws and regulations.

Modification of Network

Our Networks are subject to change at any time without prior notice to you, or your approval. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to you, or your approval. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time Services are rendered. Under this Policy, your financial responsibility will vary depending on a Provider's participation status.

Non-Waiver of Defaults

Any failure by us at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions set forth herein, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect our right at any time to enforce or avail ourselves of any such remedies as we will be entitled to under applicable laws or regulations, or this Policy.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed, postage prepaid (unless otherwise required to be sent via certified or registered mail as set forth in this Policy), and addressed as set forth below. Such notice shall be deemed effective as of the date delivered or so deposited in the mail.

If to us:
WellAway Limited
Victoria Place
31 Victoria Street
5th Floor
PO Box HM 1624
Hamilton HM GX
Bermuda

If to you:
To the latest address provided by you according to our records. You must immediately notify us of any address change.

Our Obligations Upon Termination

Upon termination of your coverage for any reason, we shall have no further liability or responsibility under this Policy with respect to you or any Covered Dependents, except as specifically set forth herein.

Promissory Estoppel

You hereby expressly acknowledge that this Policy constitutes a Policy solely between you and us. No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Policy. You further acknowledge and agree that you have not entered into this Policy based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations created under this Policy. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Policy.

Relationship Between the Parties

WellAway and Providers
Neither WellAway nor any of its officers, directors or employees provides Health Care Services to you. By accepting this coverage and benefits, you agree that health care Providers rendering Health Care Services are not our employees or agents. In this regard, we hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider. We do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care Provider. Any decisions made by us concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for the purpose of determining whether such Services are

covered, and not for the purpose of recommending any treatment or non-treatment. We assume no liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

WellAway and Policyholder
You are not our agent or our ConciergeCare Counselor and shall not be liable for any acts or omissions of WellAway, its agents, servants, or employees. Additionally, neither you nor WellAway shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which WellAway has made or hereafter makes arrangements for the provision of Covered Services. WellAway is not your agent, servant, or ConciergeCare Counselor and shall not be liable for any acts or omissions of yours or any person or organization with which you have entered into any agreement or arrangement. By acceptance of Covered Services hereunder, you agree to the foregoing.

WellAway and the CFE
Your WellAway coverage as outlined herein is secondary to all benefits and coverage provided by the CFE. Any decisions made by the CFE are separate and independent of the decisions made by WellAway.

Medical Treatment Decisions
Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical Services or Supplies, must be made solely by you, your family and your treating Physician in accordance with the physician/patient relationship. It is possible that you or your treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Reservation of Right to Policy
We reserve the right to contract with any individuals, corporations, associations, partnerships, or other entities for assistance with the servicing of coverage and benefits to be provided by us or obligations due under this Policy.

Right of Recovery
Whenever we have made payments in excess of the maximum provided for under this Policy, we will have the right to recover any such payments, to the extent of such excess, from you or any other person, plan, or organization that received such payments.

Right of Reimbursement
If any payment under this Policy is made to you or on your behalf with respect to any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, we will have a right to be reimbursed by you (out of any settlement or judgment proceeds you recover) one dollar ($1.00) for each dollar paid under the terms of this Policy minus a pro rata share for any costs and attorney's fees incurred in pursuing and recovering such proceeds.

Our right of reimbursement will be in addition to any subrogation right or claim available to us, and you must execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by us to exercise our right of reimbursement hereunder. You or your attorney must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. You must not do anything to prejudice our right of reimbursement hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Right to Receive and Release Necessary Information
In order to administer coverage and benefits, we may, without the consent of or notice to any person, plan, or organization, release to or obtain from any person, plan, or organization any information with respect to any person covered under this Policy or an applicant for enrollment which we deem to be necessary.

Third Party Beneficiary
This Policy was issued by WellAway to the Policyholder, and was entered into solely and specifically for the benefit of WellAway and the Policyholder. The terms and provisions of this Policy shall be binding solely upon, and inure solely to the benefit of WellAway and the Policyholder, and no other person shall have any rights, interests or claims hereunder, or be entitled to sue for a breach hereof as a third party beneficiary or otherwise. WellAway and the Policyholder hereby specifically express their intent that health care Providers that have not entered into contracts with us to participate in our Network shall not be third party beneficiaries under this Policy.

Other Important Information

Your Rights & Responsibilities

We are committed to providing quality health care coverage at a reasonable cost while maintaining your dignity and integrity. Consistent with our commitment and recognizing that In-Network Providers are independent contractors and not our agents, the following statement of your Rights and Responsibilities has been adopted.

Rights

1. To be provided with information about our services, coverage and benefits, the In-Network Providers delivering care and your rights and responsibilities.

2. To receive medical care and treatment from In-Network Providers who have met our credentialing standards.

3. To expect In-Network Providers to:

   a. discuss appropriate or Medically Necessary treatment options for your Condition, regardless of cost or benefit coverage;

   b. permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant physician/patient relationship requirements;

   c. advise whether your medical care or treatment is part of a research experiment, and to give you the opportunity to refuse any experimental treatments; and

   d. inform you about any medications you are told to take, how to take them, and their possible side effects.

4. To expect courteous service from us and considerate care from our In-Network Providers with respect and concern for your dignity and privacy.

5. To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal procedures set forth in this Policy.

6. To inform In-Network Providers that you refuse treatment, and to expect them to honor your decision, if you choose to accept the responsibility and the consequences of your decision. In such event, you are encouraged (but not required) to:

   a. complete an advance directive, such as a living will and provide it to Providers; and

   b. have someone help make decisions, or to give another person the legal responsibility to make decisions about medical care on your behalf.

7. To have access to your medical records and to be assured that the confidentiality of your medical records is maintained in accordance with applicable laws and regulations.

8. To call or write to us at any time with helpful comments, questions and observations whether concerning something you like about our plans or something you feel is a problem. You may also make recommendations regarding our rights and responsibilities guidelines. Please call the telephone number on your ID Card.

Responsibilities

1. To cooperate with anyone providing your care and treatment.

2. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.

3. To take responsibility for understanding your health issues and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions about your care and to ask questions if you do not understand or need an explanation.

4. To provide accurate and complete information concerning your health issues and medical history and to answer all questions truthfully and completely.

5. To pay your Cost Share amounts and be financially responsible for non-covered Services and to provide current information concerning your coverage status to any In-Network Provider.

6. To follow the process for filing an appeal about medical or administrative decisions that you feel were made in error.

7. To request your medical records in accordance with our rules and procedures and in accordance with applicable laws and regulations.

8. To review information regarding Covered Services, policies and procedures as stated in this Policy.

Statement on Advance Directives

Because this Policy is for coverage in the United States, Hospitals and Physicians in the United States must adhere to the Patient Self Determination Act if you are hospitalized, receiving care or critically ill and want certain decisions about your care, treatment and/or death treated or handled in certain ways.

The following information is provided in accordance with certain laws that exist in the Patient Self-Determination Act to advise you of your rights in the state where you reside, or similar applicable laws and regulations of another state or federal law to make decisions concerning your medical care, including your right to accept or refuse medical or surgical treatment, the right to prepare an advance directive, and explain our policy on advance directives. The information is general and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

In the United States, the state law where you reside, or a similar applicable law of another state or federal law, recognizes your right as a competent adult to make an advance directive instructing your Physician to provide, withhold, or withdraw life-prolonging procedures, or to name someone to make treatment decisions for you in the event that you are found to be incompetent and suffering from a terminal Condition. Advance directives provide patients with a way to direct the course of their medical treatment even after they are no longer able to consciously participate in making their own health care decisions.

An “advance directive” is a witnessed oral or written statement which indicates your choices and preferences with respect to medical care made by you while you are still competent. An advance directive can address such issues as whether to provide any and all health care, including extraordinary life-prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care Provider should consult in making treatment decisions.

There are three types of documents in the United States that are commonly used to express an individual’s advance directives: a living will, a health care surrogate designation and a durable power of attorney for health care.

A living will is a declaration of a person’s desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal Condition and is not able to express his or her wishes. It does not become effective until the patient’s Physician and one other Physician determine that the patient suffers from a terminal Condition and is incapable of making decisions.

Another common form of advance directive is the health care surrogate designation. When properly executed, a health care surrogate designation grants authority for the surrogate to make health care decisions on behalf of the patient in accordance with the patient’s wishes. The surrogate’s authority to make decisions is limited to the time when the patient is incapacitated and must be in accordance with what the patient would want if the patient was able to communicate his or her wishes. While there are some decisions the surrogate cannot make, by law, such as consent to abortion or electroshock therapy, any specific limits on the surrogate’s power to make decisions should be clearly expressed in the health care surrogate designation document.

Finally, there is the durable power of attorney for health care. This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical Condition.

A suggested form of living will and designation of health care surrogate is available from many states depending on your state of residence. There is no requirement that you have an advance directive and your health care Provider cannot condition treatment on whether or not you have one. The state law where you reside, or a similar applicable law of another state or federal law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

1. A judicially appointed guardian;
2. A spouse;
3. An adult child or a majority of the adult children who are reasonably available for consultation;
4. A parent;
5. Siblings who are reasonably available for consultation;
6. An adult relative who has exhibited special care or concern, maintained regular contact, and is familiar with the person's activities, health and religious or moral beliefs; or
7. A close friend who is an adult, has exhibited special care and concern for the person, and who gives the health care facility or the person's attending Physician an affidavit stating that he or she is a friend of the person, is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, religious and moral beliefs.

Deciding whether to have an advance medical directive, and if so, the type and scope of the directive, can be complex. It may be helpful for you to discuss advance directives with your spouse, family, friends, religious or spiritual advisor or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, Physician and whomever else will be faced with the task of carrying out those wishes knows what you would want.

It is our policy to recognize your right to make health care treatment decisions in accordance with your own personal beliefs. You have a right to decide whether or not to execute an advance directive to guide treatment decisions in the event you become unable to do so. We will not interfere with your decision. It is your responsibility to provide notification to your Providers that an advance directive exists. If you have a written advance directive, we recommend that you furnish your Providers with a copy so that it can be made a part of your medical record.

The state law where you reside or a similar applicable law of another state or federal law does not require a healthcare Provider or facility to commit any act which is contrary to the Provider's or facility's moral or ethical beliefs concerning life-prolonging procedures. If a Provider or facility in our network, due to an objection on the basis of conscience, would not implement your advance directive, you may request treatment from another Provider or facility.

Definitions

The following definitions will help you understand the terms that are used in this Policy, including the Summary of Benefits and any Endorsements that are part of this Policy. As you read through this Policy you can refer to this section. We have identified defined terms in the Policy, the Summary of Benefits and any Endorsements by capitalizing the first letter(s) of the term.

Accident or Accidental means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness. Accidents are not the result of either services received, physical training, an Activity of Daily Living not resulting from a blow or fall, or an intentionally self-inflicted injury (unless the injury is the result of a medical Condition, physical or mental, and domestic violence).

Accidental Dental Injury means an injury to Sound Natural Teeth caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Activities of Daily Living means basic tasks of everyday life such as bathing, dressing, eating, toileting, transferring and walking.

Adoption or Adopt(ed) means the act of creating a legal parent/child relationship where it did not exist, declaring that the child is legally the child of the adoptive parents and their heir-at-law and is entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as defined by applicable state or federal laws or regulations.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Policy in connection with:

1. A Pre-Service Claim or a Post-Service Claim;

2. A Concurrent Care Decision, as described in the CLAIMS PROCESSING section; or

3. Rescission of coverage, as described in the TERMINATION OF COVERAGE section.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount may be changed at any time without notice to you or your consent. In no event will the Allowed Amount be greater than the amount the Provider actually charges.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to applicable state or federal laws or regulations. Ambulatory Care Center means a properly licensed ambulatory center that: 1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Physician is not possible; 2) shares clinical information about the treatment with the patient's primary Physician; 3) is usually housed in a retail business; and 4) is staffed by at least one (1) master's level advanced registered nurse practitioner (ARNP) who operates under a set of clinical protocols that strictly limit the Conditions the ARNP can treat. Although no Physician is present at the Ambulatory Care Center, medical oversight is based on a written collaborative agreement between a supervising Physician and the ARNP.

Ambulatory Surgical Center means a facility properly licensed pursuant to applicable state or federal laws or regulations, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Application Forms means those forms, electronic or paper, used to maintain accurate enrollment files under the Policy and which are approved for use by us.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and meets one of the following criteria:

1. The study or investigation is approved or funded by one or more of the following:

a. The National Institutes of Health.

b. The Centers for Disease Control and Prevention.

c. The Agency for Health Care Research and Quality.

d. The Centers for Medicare and Medicaid Services.

e. cooperative group or center of any of the entities described in clauses g(i) through (iv) below.

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. Any of the following entities below if the conditions described in paragraph (2) are met:

i. The Department of Veterans Affairs.

ii. The Department of Defense.

iii. The Department of Energy.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For a study or investigation conducted by a Department (listed above), the study or investigation must be reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines: (1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For purposes of this definition, the term “Life-Threatening Disease or Condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Artificial Insemination (AI) means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care Provider for the purpose of producing a pregnancy.

Benefit Period means the period of coverage lasting twelve (12) months from the beginning of your Policy’s Effective Date and each twelve (12) month period thereafter.

Birth Center means any facility, institution, or place, licensed pursuant to applicable state or federal laws or regulations, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy. A Birth Center is not an Ambulatory Surgical Center or a Hospital.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term “Bone Marrow Transplant” includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term “Bone Marrow Transplant” also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care

Provider Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells, such as Hospital room and board and ancillary Services.

Breast Reconstructive Surgery means surgery to reestablish symmetry between the two breasts.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for cardiac therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Certified Nurse Midwife means a person who is licensed pursuant to applicable state or federal laws or regulations, as an advanced Registered Nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a properly licensed nurse who is a certified Registered Nurse anesthetist pursuant to applicable state or federal laws or regulations.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to you with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize your life or health or your ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed without the proposed Services being rendered.

Coinsurance means the sharing of health care expenses for Covered Services between you and us. After your Deductible is met, we will pay a percentage of the Allowed Amount for Covered Services, as listed in the Summary of Benefits. The percentage you are responsible for is your Coinsurance.

Company means under this Policy, the insurance company insuring the risk, by the name of Davies Insurance Limited on behalf of the WellAway Segregated Account.

ConciergeCare Counselor means is a generic job title in the insurance service industry. ConciergeCare Counselor interacts with Covered Persons to provide answers to inquiries involving Insurer’s products, plans and services.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized coverage, benefits, or payment for that course of treatment or number of treatments in writing.

Condition means a disease, illness, ailment, injury, or pregnancy.

Copayment or Copay means the dollar amount established solely by us which must be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost Share may include, but is not limited to, Coinsurance, Copayment and Deductible amounts. Applicable Cost Share amounts are identified in your Summary of Benefits.

Country of Origin means the country in which a person or thing is deemed to have originated for the purposes of laws and regulations.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility requirements, described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under the Policy other than as a Policyholder.

Covered Person means a Policyholder or Covered Dependent.

Covered Services/Services means those Health Care Services which meet the criteria listed in the WHAT IS COVERED? section.

Creditable Coverage means health care coverage which is continuous to a date within 63 days of your Enrollment Date. Such health care coverage may include any of the following:

1. A group health plan;

2. Individual health insurance;

3. Medicare Part A and Part B;

4. Medicaid;

5. Benefits to members and certain former members of the uniformed services and their dependents;

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

7. A state health benefits risk pool;

8. A health plan offered under chapter 89 of Title 5, United States Code;

9. A public health plan;

10. A health benefit plan of the Peace Corps;

11. Children's Health Insurance Program (CHIP);

12. Public health plans established by the federal government; or

13. Public health plans established by foreign governments.

Custodial or Custodial Care means care that serves to assist a person in the Activities of Daily Living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider who is recognized for payment under this Policy, before our payment for Covered Services begins. Not all plans include a Deductible.

Dentist means a person who is properly licensed by applicable state or federal laws or regulations, as a doctor of dental surgery (D.D.S.), or doctor of dental medicine (D.M.D.), doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is legally qualified to practice medicine or dentistry and perform surgery at the time and place the Service is rendered, and acting within the scope of his or her license.

Diabetes Educator means a person who is properly certified pursuant to applicable state or federal laws or regulations, to supervise diabetes Outpatient self-management training and educational Services.

Dialysis Center means an Outpatient facility certified by the Centers for Medicare and Medicaid Services (or a similar regulatory agency of the applicable state) to provide hemodialysis and peritoneal dialysis Services and support.

Dietitian means a person who is properly licensed pursuant to applicable state or federal laws or regulations to provide nutrition counseling for diabetes Outpatient self-management Services.

Domestic Partner means a person of the same or opposite gender with whom the Policyholder has established a Domestic Partnership.

Domestic Partnership means a relationship between the Policyholder and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;

2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;

3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;

4. the Policyholder has submitted to us acceptable proof of evidence of common residence and joint financial responsibility; and

5. the Policyholder has completed and submitted any required forms to us and we have determined the Domestic Partnership eligibility requirements have been met.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is not for comfort or convenience; (d) generally is not useful to an individual in the absence of a Condition; and (e) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under applicable state or federal laws or regulations to provide Durable Medical Equipment in the patient's home under a Physician's prescription.

Effective Date means, with respect to eligible individuals properly enrolled, when coverage first becomes effective, 12:01 a.m. on the date printed on the first page of this Policy; and with respect to eligible individuals who are subsequently enrolled, means 12:01 a.m. on the date coverage will begin as specified in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute Symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may reasonably be expected to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

Emergency Services means, with respect to an Emergency Medical Condition:

1. a medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under Section 1867 of such Act to Stabilize the patient.

Endorsement means a document issued by us that changes or modifies language in this Policy. Endorsements may also be referred to as amendments.

Enrollment Date means the date of enrollment of the individual under this Policy.

Essential Health Benefits (EHB) means Health Care Services included in the Affordable Act's definition and includes Services in the following ten categories:

1. Ambulatory Patient services

2. Emergency services

3. Hospitalization

4. Maternity and Newborn Care

5. Mental Health and Substance Use Disorder services, including Behavioral Health treatment

6. Prescription drugs

7. Rehabilitative and Habilitative services and devices

8. Laboratory services

9. Preventive and Wellness services and Chronic Disease Management

10. Pediatric Services including Oral and Vision care

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by us:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the appropriate state health authority and approval for marketing has not, in fact, been given at the time such is furnished to you;

2. Such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;

3. Such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;

4. Reliable Evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

5. Reliable Evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

6. Reliable Evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature using generally accepted scientific, medical, or public health methodologies or statistical practices;

7. There is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or

8. Such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

“Reliable Evidence” shall mean (as determined by us):

1. Records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;

2. Reports, articles, or written assessments in authoritative Medical Literature and scientific literature;

3. Published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;

4. The written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;

5. The written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

6. The records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Services or supplies which are determined by us to be Experimental or Investigational are excluded as described in the WHAT IS NOT COVERED? section. In making benefit determinations, we may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

FDA means the United States Food and Drug Administration.

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care Provider in which fertilization takes place inside the tube.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Gestational Surrogacy Contract or Arrangement means an oral or written agreement, regardless of the state or jurisdiction where executed, between the Gestational Surrogate and the intended parent or parents.

Gestational Surrogate means a woman, regardless of age, who contracts, orally or in writing, to become pregnant by means of assisted reproductive technology without the use of an egg from her body.

Grace Period means the period immediately following the Premium due date as indicated on the Policyholder's billing statement.

Grievance means a written expression of dissatisfaction that is not an Adverse Benefit Determination.

Habilitative Services means Health Care Services that are short-term and help a person to acquire or attain an age appropriate bodily function necessary to participate in Activities of Daily Living.

Health Care Services or Services means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds and other Services rendered or supplied, by or at the direction of, a licensed Provider.

Home Health Agency means a properly licensed agency or organization which provides health Services in the home pursuant to applicable state or federal laws or regulations.

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in

your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization duly licensed pursuant to applicable state or federal laws or regulations to provide Hospice Services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive Services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to applicable state or federal laws or regulations that offers Services which are more intensive than those required for room, board, personal Services and general nursing care; offers facilities and beds for use beyond twenty-four (24) hours; and regularly makes available at least clinical laboratory Services, diagnostic x-ray Services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent. The term Hospital does not include: an Ambulatory Surgical Center, a Skilled Nursing Facility, a stand-alone Birth Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or rehabilitative care.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by The Joint Commission, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services; it only expands the setting where Covered Services can be performed for coverage purposes.

Identification (ID) Card means the cards we issue to Policyholders. The cards are our property, and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Policy.

Independent Clinical Laboratory means a laboratory, independent of a Hospital or Physician's office, which is a fixed location, properly licensed pursuant to State Statutes, or a similar applicable law of another state or Federal law, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Center means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An independent diagnostic testing center must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable laws or laws of the state in which it operates. Further, such an entity must meet our criteria for eligibility as an independent diagnostic testing center.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated in your Summary of Benefits under the heading "In-Network". Otherwise, In-Network means, when used in reference to a Provider, any health care Provider who, at the time Covered Services are rendered to you, is an In-Network Provider under the terms of this Policy.

In-Network Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to participate In-Network or is a Premium Care/Select Provider included in the panel of Providers designated by us as Premium Care/Select Providers for your specific plan. For payment purposes under this Policy only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of domicile or residence who or which, at the time Health Care Services are rendered to you, participates as an In-Network Provider on behalf of WellAway or its third-party administrator.

In-Network Provider Provision means any provision that conditions payment of benefits for select Health Care Services, in whole or in part, on the use of In-Network Providers, facilities or exclusive Pharmacies. Health Care Services that are subject to the In-Network Provider Provision are identified in your Summary of Benefits and the WHAT IS COVERED? section of your Policy.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to a woman's uterus.

Inpatient means a Covered Person who is treated as a registered bed patient in a Hospital or facility for whom a room and board charge is made. A stay is up to and including midnight of the date of admission and shall be considered one (1) day, and an additional day will be counted at each midnight census after the first day that the Covered Person is still a patient.

Intensive Outpatient Treatment means treatment in which an individual receives at least three (3) clinical hours of institutional care per day twenty-four (24-hour period) for at least three (3) days a week and returns home or is not treated as an Inpatient during the remainder of that twenty-four (24) hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to applicable state or federal laws or regulations.

Massage or Massage Therapy means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Policy, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Material Misrepresentation means the omission, concealment of facts or incorrect statements made on any application or Application Forms by an applicant, Covered Person or Policyholder which would have affected your eligibility under this Policy, issuance of different benefits, or issuance of this Policy at a different premium rate had they been known.

Medical Literature means peer reviewed literature included in the PubMed/Medline database of the National Library of Medicine.

Medically Necessary or Medical Necessity means that, with respect to a Health Care Service, a Provider, exercising prudent clinical judgment, provided, or is proposing or recommending to provide, the Health Care **Service** to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its Symptoms, and that the Health Care Service was/is:

1. In accordance with Generally Accepted Standards of Medical Practice;

2. Clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury, disease or Symptoms;

3. Not primarily for your convenience, your family's convenience, your caregiver's convenience or that of your Physician or other health care Provider; and

4. Not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. Inpatient), and/or an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or Symptoms.

The Insurer retains the right to determine the Medical Necessity of a planned Treatment. Individuals with intellectual disabilities and vulnerable healthcare environments may require a special consideration of their health care needs. The appropriateness of care and the Treatment plan will be reviewed in consultation with the attending Physician and alternative care options may be recommended.

Medical Policy Guidelines means the guidelines when certain medical Services are considered Medically Necessary by medical industry standards. The medical guidelines are written to cover a given Condition for the majority of people. Medical guidelines are based on constantly changing medical science, so they are reviewed and updated periodically.

Medicare means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.

Medication Guide means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require Prior Coverage Authorization and Self-Administered Prescription Drugs that may be covered under this Policy, which is subject to change at any time. To view the Medication Guide, you may access the Medication Guide on your member portal at www.wellaway.com/account/login or call your ConciergeCare Counselor using the telephone number on your ID Card.

Mental Health Professional means a person properly licensed to provide mental health Services pursuant to applicable state or federal laws or regulations. This professional may be a clinical social worker, mental health counselor, mental health nurse practitioner, psychiatric pharmacist or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination who provide counseling Services.

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD10-CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to applicable state or federal laws or regulations.

Network means an "A" rated national PPO Network comprised of both Premium Care/Select Providers and In-Network Providers, who have agreed to provide Health Care Services at reduced rates to Covered Persons under this Policy.

Non-Network Provider means a Provider who does not take any insurance plans and has chosen to "opt-out" of billing an insurance company.

Occupational Therapist means a person properly licensed to practice Occupational Therapy pursuant to applicable state or federal laws or regulations.

Occupational Therapy means Habilitative Services or a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on your Summary of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered to you, is not an In-Network Provider under the terms of this Policy.

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to participate In-Network.

Out-of-Pocket Costs means your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include Deductibles, Coinsurance and Copayments for Covered Services plus all costs for services that aren't covered.

Outpatient means a Covered Person who receives Services or Supplies while not an Inpatient.

Outpatient Rehabilitation Facility means an entity which renders, through Providers properly licensed pursuant to State Law or a similar applicable law of another state or Federal law, or a similar applicable law of another state or Federal law: Outpatient Physical Therapy, Speech Therapy, and Occupational Therapy for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet our criteria for eligibility as an outpatient rehabilitation facility. The term Outpatient rehabilitation facility, as used herein, shall not include any Hospital including a general

acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation Inpatient Services, or rehabilitation Outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described, of the State or Federal Administrative Code or a similar applicable law of another state or Federal law.

Pain Management includes, but is not limited to, Services for pain assessment, medication, biofeedback, and/or counseling. Pain management programs feature multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least 6 clinical hours of institutional care per day twenty-four (24) hour period) for at least 5 days per week and returns home or is not treated as an Inpatient during the remainder of that twenty-four (24) hour period. A Hospital shall not be considered a "home" for purposes of this definition.

Pharmacy Benefit Manager (PBM) In the United States, a **Pharmacy Benefit Manager (PBM)** is most often a third party administrator (TPA) of prescription drug programs. They are primarily responsible for processing and paying prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to applicable state or federal laws or regulations.

Physical Therapy means the use of physical agents for the treatment of a disability resulting from a Condition. Physical Therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries.

Physician means any individual who is properly licensed by applicable state or federal laws or regulations, as a doctor of medicine (M.D.), doctor of osteopathy (D.O.), doctor of podiatry (D.P.M.), doctor of chiropractic (D.C), doctor of dental surgery or dental medicine (D.D.S. or D.M.D), or doctor of optometry (O.D.).

Physician Assistant means a person properly licensed to perform surgical first assisting Services pursuant to applicable state or federal laws or regulations.

Physician Specialty Society means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

Policy includes this document, your application for this Policy, any Application Forms signed by the Policyholder and any amendments and/or Endorsements.

Policyholder means an individual who meets and continues to meet all applicable eligibility requirements described in the ELIGIBILITY AND ENROLLMENT FOR COVERAGE section and who is enrolled and actually covered under Policy other than as a Covered Dependent.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) that is received by us on a properly completed claim form or electronic format acceptable to us in accordance with the provisions of the CLAIMS PROCESSING section.

Premium Care/Select Provider means a Physician, or a group of Physicians that have been established and so designated as a Premium Care/Select Provider under this Policy.

Premium means the total amount required to be paid by the Policyholder to us in order to be covered under this Policy. The Premium is determined on the basis of the applicable Rates, Risk Class and certain demographics of individuals covered under this Policy.

Prescription means an order for Drugs, Services or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs, Services or Supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed with a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: “Caution: Federal law prohibits dispensing without a Prescription”.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of this Policy condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Policy do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Primary Care Physician (PCP) means a Physician who specializes in internal medicine, family practice, general practice, or pediatrics.

Prosthetic Device means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or nonfunctional body part or organ.

Prosthetist/Orthotist means a person or entity that is properly licensed or registered, if applicable, under applicable state or federal laws or regulations to provide Services consisting of the design and fabrication of medical devices such as braces, splints and artificial limbs prescribed by a Physician.

Provider means any facility, person or entity recognized for payment by us under this Policy.

Psychiatric Facility means a facility properly licensed under applicable state or federal laws or regulations to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Policy, a Psychiatric Facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to applicable state or federal laws or regulations.

Rate means the amount we charge for coverage. The rate will vary depending on the Risk Class of each covered individual.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to applicable state or federal laws or regulations.

Registered Nurse First Assistant means a person properly licensed to perform surgical first assisting Services pursuant to applicable state or federal laws or regulations.

Rehabilitation Services means Services rendered for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to Occupational Therapy, Speech Therapy, and Physical Therapy.

Rehabilitative Therapies means therapies with the primary purpose of restoring or improving a bodily or mental function impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, or Occupational Therapy.

Rescission or Rescind refers to WellAway’s action to retroactively cancel or discontinue coverage under this Policy. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premium.

Restricted Area means countries, providers and/or facilities where medical Services cannot be covered under this Policy. Please consult with PayerFusion for a complete list of Restricted Areas.

Risk Class is a grouping of Covered Persons who have similar characteristics. For example, Covered Persons who: are the same age; live in the same geographical area; and who have elected the same benefit plan may be grouped into a Risk Class. The Risk Class of each Covered Person is determined by WellAway.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Site of Service Differential means when Services are provided in hospital-based facility, the costs of the clinical personnel, equipment, and supplies are higher, and could result in multiple bills, than if such Services were provided in an independent free-standing facility. For this reason, reimbursement for the Services provided in a hospital-based facility may be lower than if the Services were performed in an independent free-standing facility. This difference in reimbursement (based on where the Service is performed), is referred to as a "Site of Service Differential." This financial differential will be applicable to all bills generated as a result of the encounter at the hospital-based facility and will be the Covered Person's responsibility.

Skilled Nursing Facility means an institution or part thereof which meets our criteria for eligibility as a skilled nursing facility and which: 1) is licensed as a skilled nursing facility according to applicable state or federal laws or regulations; 2) is accredited as a skilled nursing facility by The Joint Commission or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by us.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

Specialty Drug means an FDA-approved Prescription Drug that has been designated solely by us, as a specialty drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to provide specific Prescription Drug products, as determined by us. In-Network Specialty Pharmacies are listed in the Medication Guide. The fact that a pharmacy is a participating pharmacy does not mean that it is a Specialty Pharmacy.

Speech Therapist means a person properly licensed to practice Speech Therapy pursuant to applicable state or federal laws or regulations.

Speech Therapy means Health Care Services provided for the treatment of speech and language disorders by a Physician, Speech Therapist or licensed audiologist, including language assessment and language restorative therapy Services.

Stabilize shall have the same meaning with regard to Emergency Services as the term is defined in Section 1867 of the Social Security Act which imposes specific obligations on Medicare-participating hospitals that offer Emergency Services to provide a medical screening examination, when a request is made for examination or treatment for an Emergency Medical Condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with Emergency Medical Conditions. If a hospital is unable to Stabilize a patient within its capability, or if the patient requests, or we request it, an appropriate transfer should be implemented.

Standard Reference Compendium means (a) the United States Pharmacopoeia Drug Information; (b) the American Medical Association Drug Evaluation; and/or (c) the American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under applicable state or federal laws or regulations, to provide necessary care and treatment for Substance Dependency. For purposes of this Policy a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

Substance Dependency means a Condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Supply(ies) means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, cotton swabs, and similar items and any birth control device.

Symptoms means a sensation or feeling that the Covered Person may experience and consider not to be normal. Such feeling or sensation may be in the form of pain or change of bodily fluids.

Tobacco User means an individual's use of any tobacco product, including, but not limited to, cigarettes, cigars, chewing tobacco, snuff and pipe tobacco four (4) or more times a week in any six (6) month period.

Urgent Care Center means a properly licensed facility that:
1) is available to provide Services to patients at least sixty (60) hours per week with at least 25 of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the urgent care center is closed; 3) employs or Contracts with at least one or more board certified or board eligible Physician and Registered Nurse (RN) who are physically present during all hours of operation. (Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children); and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations. An Urgent Care Center also means a licensed facility that provides a lower level of care such as an Ambulatory Care Center. For purposes of this Policy, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

Usual, Customary and Reasonable Charge means reasonable medical expenses commonly charged in the applicable country for the specific treatment received, in accordance with standard medical and generally accepted procedures in such country. The Usual, Customary and Reasonable Charge for a Service or Supply that is unusual, or not often provided in the area, or that is provided by only a small number of Providers in the area, will be determined by WellAway. WellAway will consider such factors as: (1) complexity; (2) degree of skill needed; (3) type of specialist required; and (4) range of Services or Supplies provided by a Provider.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the result zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.