Filing at a Glance

Company:	MDwise Marketplace, Inc.
Product Name:	MDwise Marketplace
State:	Indiana
TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02I.005D Individual - HMO
Filing Type:	Form/Rate
Date Submitted:	05/11/2014
SERFF Tr Num:	MDWI-129534072
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Implementation Date Requested:	01/01/2015
Author(s):	zSERFFStaff zIndustrySupportBW, Charlotte Macbeth, Elizabeth Eichhorn, Tammy Chadd, Amber Kerstiens, Eric Essley, Terry Cole, Jason Fricke
Reviewer(s):	Paul Hyslop (primary), Karl Knable
Disposition Date:	08/08/2014
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State Filing Description:

State: *Indiana* **Filing Company:** *MDwise Marketplace, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *MDwise Marketplace*
Project Name/Number: *MDwise Marketplace/62033IN001*

General Information

Project Name: MDwise Marketplace
Project Number: 62033IN001
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

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Submitted By: Amber Kerstiens

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Created By: Elizabeth Eichhorn
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: MDwise intends to file 20 QHPs, covering Bronze, Silver and Gold across the State of Indiana.

Filing Description:
MDwise Marketplace

Company and Contact

Filing Contact Information

Elizabeth Eichhorn, Compliance Officer
1200 Madison Avenue
Suite 400
Indianapolis, IN 46225

eeichhorn@mdwise.org
317-822-7232 [Phone]

Filing Company Information

MDwise Marketplace, Inc.
1200 Madison Avenue
Suite 400
Indianapolis, IN 46225
(317) 822-7300 ext. [Phone]

CoCode:
Group Code: 4637
Group Name: IU Health
FEIN Number: 46-5270582

State of Domicile: Indiana
Company Type: HMO
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: Yes

Company	Amount	Date Processed	Transaction #
MDwise Marketplace, Inc.	$70.00	06/10/2014	82994372

State: *Indiana* **Filing Company:** *MDwise Marketplace, Inc.*
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Product Name: *MDwise Marketplace*
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Form Schedule

Lead Form Number: 62033-2015-1

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		MDwise Marketplace	62033-2015-1	POL	Initial		33.800	Final MDwise Marketplace, Inc 62033-2015-1 Policy Adult Child On Off Exchange 6.5.2014 redline.pdf, Final MDwise Marketplace, Inc 62033-2015-1 Policy Adult Child On Off Exchange 6.5.2014 clean .pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[Individual/Child-Only/On/Off Exchange] Contract

(Herein called this Contract)

issued by

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

An Indiana Not-for-Profit Health Maintenance Organization

AGREEMENT AND CONSIDERATION

[MDwise Marketplace Plan]

MDwise Marketplace, Inc. (herein referred to as MDwise, We, Us, and Our) has issued a Contract to You [to provide coverage for a Dependent]. Persons Covered under this Contract are considered to be Enrollees of MDwise. [This Contract provides Coverage only for Enrolled Dependents. The Subscriber is never Covered under this Contract.]

This Contract sets forth in detail [Your][the] rights and obligations [of the Subscriber and Dependent] as [an][the] Enrollee. It is important that You **READ THIS CONTRACT CAREFULLY.** You should familiarize Yourself with its terms and conditions before receiving Health Services.

This Contract is made in consideration of the [Subscriber's][Enrollee's] Application [submitted through the Exchange] and payment of the required Premium. The [Subscriber's][Enrollee's] Application is made a part of this Contract by this reference.

This Contract shall take effect on the date specified below. This Contract will be continued in force by the payment of the required Premium when due, subject to the termination provisions of this Contract. We shall fund all benefits payable under this Contract.

This Contract is delivered in and governed by the laws of the State of Indiana. All Coverage under this Contract shall begin at 12:00 midnight and end at 11:59:59 p.m. Eastern Standard Time.

Information regarding this Contract may be obtained by contacting Us at: [1-855-417-5615 or www.MDwisemarketplace.org]. If the Enrollee has material modifications or questions related to their health insurance coverage, contact the [Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596].

Authorized Representative

TEN-DAY FREE LOOK

The Subscriber has the right to examine this Contract for 10 days from the date You received the Contract. If, for any reason, the Subscriber does not want this Contract, he or she may return it to Us within 10 days from the date You received the Contract. The Contract will be deemed delivered when deposited in the United States mail with first class postage prepaid, or when it is personally delivered, to the address shown above. Upon return, this Contract will be deemed void and any Premium will be refunded. Any Health Services received during this 10-day period are solely the responsibility of the Subscriber if the Contract is deemed void. In making this decision, You should review the enrollment date restrictions of the Open Enrollment to identify any conditions for enrolling in a different Qualified Health Plan.

[DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for

individuals with low to modest incomes through Advance Payment Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for health insurance coverage issued through the Indiana Marketplace. Please be advised that this Contract does not qualify for these affordability programs because it is not issued through the Indiana Marketplace.]

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FOREWORD

Introduction

The [Subscriber and] Enrolled Dependents, [if any], are Enrollees of MDwise. [You][Enrollees] will be Covered as provided by this [Individual][Child-Only] Contract. (Referred to herein as this Contract.)

This Contract replaces and supersedes any Contract that We may have previously issued to the Subscriber [or Enrollee]. This Contract is an individual product and is not subject to the Employee Retirement Income Security Act of 1974, as amended.

How To Use This Contract

This Contract must be read in its entirety for a clear meaning. Many of its provisions are interrelated. You may get a false impression if You read just one or two provisions.

Certain terms used in this Contract are defined. Defined terms will be capitalized in this Contract. The meaning of defined terms should be taken into account in interpreting this Contract.

This Contract may be amended from time to time. When that happens, We will send You a new Contract or Amendment pages for this Contract. Keep this Contract in a safe place for Your future reference.

Obtaining Health Services

As an Enrollee You must obtain Health Services directly from Participating Providers. The only exceptions are those listed below.

(A) Emergency Health Services, and
(B) Health Services that meet all 3 requirements below:
  ~~a.~~(1) are not available through Participating Providers~~,~~
  ~~b.~~(2) have been recommended by a Participating Provider, and
  ~~c.~~(3) We have approved in advance ~~in writing~~ through written ~~p~~Prior ~~a~~Authorization.

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You are responsible for verifying the participation status of a Provider before receiving Health Services.

If You fail to check a Provider's participation status as required and as a result use a Non-Participating Provider (1) the Health Services, other than Emergency Services, will not be Covered, and (2) You will be responsible for paying for such services.

The participation status of a Provider may change from time to time. So it is important that You check the status each time before receiving Health Services.

We can give You the information You need in order to locate a Participating Provider. You can verify a Provider's participation status by contacting Us or by referencing Our provider directory at www.mdwisemarketplace.org.

~~In the event We require You to receive Health Services through a single Participating Provider, We will notify You in writing of the termination of that single Participating Provider, any other Participating Provider seen by You in the previous year, and any hospital.~~

Except for Emergency Health Services, Your ~~p~~Provider is ~~are~~ responsible for obtaining a ~~written Referral~~ ~~p~~Prior ~~a~~Authorization before receiving any Health Services from a Non-Participating Provider. A ~~Referral~~ ~~p~~Prior ~~a~~Authorization to a Non-Participating Provider must be initiated in writing by ~~a Participating~~that Provider and approved in writing by Us prior to the time of the service. ***Your providers failure to obtain the required ~~Referral~~ ~~p~~Prior ~~a~~Authorization will result in the Health Services not being Covered. You will be responsible for paying for such services. It is your responsibility to confirm that the appropriate authorization was obtained prior to services.***

Coverage for some Health Services is subject to Our prior written approval. Non participating and Participating Providers are responsible for obtaining Our Prior Authorization for such services on Your behalf.

Contact Us

Your satisfaction as an Enrollee is very important to Us. Please contact Us if You have a question or concern about Your Coverage or procedures You must follow. You can reach Our Customer Service Department during normal business hours at [1-855-417-5615, or www.MDwisemarketplace.org.]

Article 1

DEFINITIONS

This Article defines the terms used throughout this Contract. It is not intended to set forth Covered or Non-Covered Health Services.

"Adverse Benefit Determination" – a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Enrollee's eligibility to participate in the Contract, as well as any rescission of Coverage under this Contract or any decision to deny Coverage in an initial eligibility determination.

"Allowed Amount" – Reasonable and Customary Charges for Health Services incurred while Coverage is in effect.

"Affordable Care Act" or "ACA" - the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.

"Alternate Facility" - a Non-Hospital health care facility that, pursuant to the law of the jurisdiction in which treatment is received provides one of the following.

A. One (1) or more of the following on an outpatient basis surgical services, Emergency Health Services, rehab services, lab services, diagnostic services, or
B. Provides on an inpatient or outpatient basis Behavioral Health and Mental Health Services or Chemical Dependency Services, if Covered under the Contract.

An Alternate Facility may include an attachment to a Hospital but does not include a Provider's office.

"Appeal"- an oral or written request for Us to change Our decision regarding a Grievance or a claims dispute.

"Autism Spectrum Disorder" - a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Health and Mental Health" - a physical or behavioral condition having an emotional or psychological origin or effect. Behavioral Health and Mental Health includes behavioral or emotional disorders as well as chemical dependency.

"Brand Name Drug" - a prescription drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

"CMS" - the Centers for Medicare and Medicaid Services.

"Calendar Year" - January 1 through December 31 of any given year.

"Chemical Dependency" - alcoholism and chemical or drug dependency.

"Child" – child of the Subscriber or Subscriber's spouse, including the following listed below.

1) Natural child,
2) Stepchild,
3) Legally adopted child,
4) Child placed for the purpose of adoption, or
5) Child placed under legal guardianship or legal custody.

"CHIP" – the Children's Health Insurance Program, as implemented by the Federal Balanced Budget Act of 1997.

"Claim Documentation" – information required by Us to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, Explanation Of Benefit (EOB)/Explanation Of Payment (EOP) medical bills or records, other Contract information, and network repricing information.

"Coinsurance" - a percentage of the Allowed Amount that You must pay for certain covered Health Services. (See also Copay.)

"Confinement" and **"Confined"** - an uninterrupted stay following formal admission to a Hospital, Inpatient Transitional Care Unit, or Alternate Facility. Confinement and Confined refer to inpatient care.

"Contract" – this Contract that includes the Application [of the Subscriber][for Coverage] and any ~~A~~amendments to this Contract signed by Our executive officer. Such items constitute the entire agreement regarding the benefits, exclusions and other conditions between MDwise and the Subscriber.

"Contract Month" - calendar month.

"Copays" or **"Copay"** - a dollar amount that You must pay directly to a Provider for certain Covered Health Services. Such dollar amount is in addition to the Premium. (See also Coinsurance.)

"Cosmetic Procedures" - procedures that improve physical appearance but do not correct or materially improve a physical function. Cosmetic Procedures include, but are not limited to, drug treatment, plastic surgery, and nutritional procedures and treatments.

"Cover" - pay for Health Services to the extent they are Covered under this Contract.

"Coverage" or **"Covered"** - Your right to payment for Health Services, subject to the terms, conditions, limitations and exclusions of this Contract.

"Covered Person" or **"Enrollee"** - the Subscriber or an Enrolled Dependent, but only while the person is Covered under this Contract. References to You and Your throughout this Contract are references to a Covered Person or Enrollee.

"Custodial Care"- Non-health-related services such as assistance in activities of daily living or health-related services that do not seek to cure, are provided when the medical condition of the Enrollee is not changing, and do not require administration by skilled, licensed medical personnel.

"Deductible" - the amount an Enrollee must pay in a Calendar Year for Covered Health Services before We will pay. Copays do not apply toward the Deductible. Coinsurance does apply toward the Deductible.

"Delivery System" - a defined group of Participating Providers, linked through a contract to each Delivery System, which supply a full range of Health Services. The Delivery System contracts with Us to provide Health Services to Enrollees who have selected the Delivery System for providing and coordinating all Covered Health Services.

Your PMP's Delivery System will be Your Delivery System. Your Delivery System may be referred to throughout this Contract as "Tier 1" and the Delivery System that is not Your Delivery System, may be referred to as "Tier 2."

"Dental Care" - all services provided by or under the direction of a Dentist. Such services include preventive care and all other care of the teeth and the surrounding tissues, correction of a faulty meeting of the teeth, and surgical procedures that involve the hard or soft tissues of the mouth.

"Dentist" - any Provider, D.D.S., or medical dentistry, D.M.D., who is duly licensed and qualified to provide Dental Care under the laws of the jurisdiction in which treatment is received.

"Dependent" - a person who is [either the Subscriber's legal spouse or] a Child until he or she attains age [26][21].

"Designated Representative"- an individual You have appointed to assist or represent You with a Grievance, Appeal or External Appeal. This person may include, but not be limited to Providers, attorneys, friends or family members. You must identify Your Designated Representative to Us in writing in order to prevent the disclosure of Your medical information to unauthorized persons.

"Designated Transplant Facility" - a Hospital or Alternate Facility that has entered into an agreement with or on Our behalf to render Health Services for Covered transplants. The facility may or may not be located within Our Service Area.

"Durable Medical Equipment" or "DME" - medical equipment that meets the following requirements.

(A) Can withstand repeated use and is not disposable,
(B) Is used to serve a medical purpose,
(C) Is generally not useful to a person in the absence of a Sickness or Injury,
(D) Is appropriate for use in the home, and
(E) Is the most cost-effective type of medical apparatus appropriate for the condition.

"Effective Date"- the date when Your Coverage begins under this Contract.

"Effective Date of Termination" - the date when Your Coverage ends under this Contract.

"Eligible [Subscriber][Dependent]" – an individual who satisfies the eligibility requirements to enroll as a [Subscriber][Dependent], as set forth in Article 2 of this Contract.

"Emergency" - a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to do any of the following.

(A) Place an Enrollee's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(B) Result in serious impairment to the Enrollee's bodily functions, or
(C) Result in serious dysfunction of a bodily organ or part of the Enrollee.

"Enrolled Dependent"[or "Enrollee"] – a Dependent who is enrolled for Coverage under this Contract.

"Enrollee" – a person who is enrolled for coverage under this Contract.

"Essential Health Benefits" – those benefits identified by CMS as Essential Health Benefits and included in the benchmark plan identified by the state of Indiana.

"Experimental, Investigational or Unproven" - services, treatments, supplies, drugs, devices or procedures We have determined to be any one or more of the following at the time a Coverage determination for any particular case is made.

(A) Considered by any government agency or subdivision or the CMS Medicare Coverage Issues Manual to be experimental, investigational, not reasonable and necessary, or any similar finding. Government agencies and subdivisions include, but are not limited to the U.S. Food and Drug Administration and the Agency for Healthcare Research and Quality.
(B) Not covered under Medicare reimbursement laws, regulations, or interpretations, on the basis that such are experimental, investigational, unproven, not reasonable and necessary, or any similar finding.
(C) Not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use.
(D) Not identified as appropriate for the proposed use in the American Hospital Formulary Service, the U.S. Pharmacopoeia Dispensing Information, or the American Medical Drug Evaluations.
(E) Subject to review and approval by any institutional review board for the proposed use.
(F) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the U.S. Food and Drug Administration regulations (regardless of whether the trial is actually subject to U.S. Food and Drug Administration oversight).

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(G) Not demonstrated through prevailing peer reviewed medical literature to be safe and effective for treating or diagnosing the condition for which it is proposed.

Determinations regarding whether a particular service, treatment, supply, drug, device or procedure is considered to be Experimental, Investigational or Unproven are made by Our Medical Director under Our procedural guidelines.

"External Appeal" - a voluntary Appeal process in which an Internal Review Organization reviews certain Appeal decisions We made and determines whether to uphold or reverse them.

"FDA" - the United States Food and Drug Administration.

[**"Federally Facilitated Exchange" or "Exchange" -** the health benefit exchange established by the Affordable Care Act for the state of Indiana. You can reach the Exchange at the following toll free number, email, website or mailing address.

Health Insurance Marketplace
200 Independence Ave. SW
Washington, DC 20201
www.healthcare.gov
1-800-318-2596]

"Formulary" - a list of Prescription Drugs that We prefer for dispensing to Enrollees. We will review and change the list from time to time.

"Genetic Screening or Testing" - a laboratory test that is a direct test of a person's genes or chromosomes to detect abnormalities or defects.

"Grace Period" - applicable period of time identified in Sections 5.~~3~~4 and 5.~~4~~5

"Grievance" - an oral or written complaint submitted in accordance with Our formal Grievance procedure by the Enrollee or on behalf of the Enrollee regarding any aspect of Our organization relating to the Enrollee.

"Health Services" - medical or health care services, whether or not Covered under this Contract, which include but are not limited to medical evaluation, diagnosis, treatments, procedures, drugs, therapies, devices, and supplies.

"Home Health Care Services" - Health Services provided by a Home Health Agency authorized to provide such services under the law of the jurisdiction in which treatment is received.

"Hospice Care Agency" - an agency or organization that meets all of the requirements listed below.

(A) Is certified to render Hospice Care,
(B) provides twenty-four hour care, seven days a week,
(C) is under the direct supervision of a Participating Provider, and
(D) maintains written records of the services provided.

"Hospice Care or Services" - a program of care that meets all of the requirements listed below.

(A) Is provided by a licensed Hospice Care Agency,
(B) focuses on palliative rather than curative treatment, and
(C) provides supportive measures to an Enrollee with a prognosis of less than six months to live.

"Hospice Facility"– a facility that is licensed and operated in accordance with the law of jurisdiction in which treatment is received, and provides twenty-four (24) hour nursing services.

"Hospital" - an institution that meets all of the requirements listed below.

(A) Is operated under the law,
(B) is primarily engaged in providing Health Services on an inpatient basis,
(C) provides for the care and treatment of injured or sick people,
(D) has medical, diagnostic and surgical facilities,

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(E) is operated by or under the supervision of a staff of Providers,
(F) has 24-hour nursing services, and
(G) is licensed as a Hospital in the jurisdiction in which it operates.

A Hospital is not primarily a place for rest, Custodial Care, or care of the aged. A Hospital is not an Inpatient Transitional Care Unit, nursing home, convalescent home or similar institution.

"Independent Review Organization or IRO" - an organization certified by the Indiana Department of Insurance to conduct External Appeals.

"Maternity Services" – all Health Services related to Pregnancy including all of the following listed below.
(A) Prenatal and postnatal care, including newborn hearing test,
(B) childbirth, and
(C) early termination of Pregnancy.

"MDwise" – MDwise Marketplace, Inc. references to We, Us, and Our throughout this Contract are references to MDwise.

"Medicaid" - Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs, as amended from time to time.

"Medical Director" - a licensed Provider of medicine or osteopathy appointed by Us to provide medical review of Health Services proposed or rendered for Enrollees.

"Medically Necessary" - Health Services that We have determined to be ***all*** of the following listed below.
(1)(A) Medically appropriate and necessary to meet the Enrollee's basic health needs,
(2)(B) the most cost-effective method of treatment and rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Health Service,
(3)(C) consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and healthcare coverage organizations and governmental agencies,
(4)(D) accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered at a frequency and duration considered by the medical community as medically appropriate,
(5)(E) required for reasons other than the comfort or convenience of the Enrollee or his or her Provider,
(6)(F) of a demonstrated medical value in treating the condition of the Enrollee, and
(7)(G) consistent with patterns of care found in established managed care environments for treatment of the particular health condition.

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The definition of Medically Necessary used in this Contract relates only to Coverage, and may differ from the way in which a Provider engaged in the practice of medicine may define Medically Necessary.

The fact that a Provider has performed or prescribed a Health Service does not mean that it is Medically Necessary. Nor does the fact that a particular Health Service may be the only option available for a particular condition mean that it is Medically Necessary. We retain the right to make all final decisions as to which Health Services are or were Medically Necessary, subject to the procedures specified in this Contract.

"Medicare" – the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended from time to time.

"Non-Covered" – those Health Services not Covered under the terms of this Contract.

"Non-Restorative Condition" - a condition where You will not (1) return to the state You were in prior to an Injury or an illness, or (2) achieve a state or perform a function(s) that never existed.

"Non-Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has not entered into an agreement with Your Delivery System or one of Our Delivery Systems.

"Open Enrollment" - an annual period [set by the Exchange] during which individuals eligible to enroll [in Qualified Health Plans] may enroll [in a Qualified Health Plan or may change Qualified Health Plans][in this Contract].

"Orthotic" - an appliance or apparatus used to support, align, or correct deformities or to improve the function of movable parts of the body, such as but not limited to braces or splints.

"Out-of-Pocket Limit" - the maximum amounts of Coinsurance and Copays an Enrollee must pay each Calendar Year for Covered Health Services. Once this limit is met, Coinsurance or Copays for such Services are not required for the rest of that Calendar Year. Amounts paid for Coinsurance, Copays and the Deductibles apply toward the Out-of Pocket Limit.

"Participating Pharmacy" - a pharmacy that has entered into an agreement with Us, or our Pharmacy Benefits Manager, to provide Prescription Drug services to Enrollees, and includes any subcontractors of such Participating Pharmacy

"Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has entered into an agreement with Your Delivery System or one of Our Delivery Systems, and includes any subcontractors of such Participating Providers.

Participating Providers within Your Delivery System are considered Tier 1 Participating Providers. Participating Providers that are not in Your Delivery System, but that are in one of Our Delivery Systems are considered Tier 2 Participating Providers.

"Physician" - a license medical provider, holding an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) degree.

"Post-service Grievance~~Claim~~" - any Grievance that involves Health Services that have already been provided.

"Premium" - the fee ~~w~~We charge for each [Subscriber and] Enrolled Dependent Covered under this Contract. The Premium is paid in consideration for the benefits and services provided by Us under this Contract.

"Prescription Drug" - a drug that has been approved by the FDA, and under federal or state law can only be dispensed with a prescription. These are known as legend drugs. Prescription Drugs also include insulin, diabetic supplies, and inhaler aid devices.

"Pre-service Grievance~~Claim~~" - a Grievance that must be decided before an Enrollee can obtain Health Services Covered under the Contract.

"Primary Medical Provider" or **"PMP"** – a Participating Provider in Your Delivery System practicing and duly licensed as a Physician in family practice, internal medicine, gynecology, obstetrics, or pediatrics, and who has agreed to assume primary responsibility for Your medical care under this Contract.

"Preauthorization" - the process of obtaining approval from Us that a Health Service, treatment plan, Prescription Drug, or DME is medically necessary prior to those services being rendered. "Preauthorization" may also be referred to as "Prior Authorization."

"Provider" - a Doctor, Hospital, Inpatient Transitional Care Unit, Home Health Care Agency, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

[**"Qualified Health Plan" -** a health plan offered on the Exchange that satisfies the requirements set forth under the

ACA (42 U.S.C. 18021(a)(1)).]

"Reasonable and Customary Charge" - the amount paid for a Health Service in a geographic area based on what Providers in the area usually charge for the same or similar Health Service.

"Reconstructive Surgery" - any surgery incidental to any of the following listed below.

(A) An injury,
(B) A Sickness, or
(C) Congenital defects and birth abnormalities.

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Reconstructive Surgery for congenital defects and birth abnormalities includes but is not limited to orthodontic and oral surgery involved in the management of cleft lip and cleft palate for an Enrollee.

Reconstructive Surgery includes the following reconstruction for a Covered mastectomy (1) all stages of reconstruction of the breast on which the mastectomy has been performed, and (2) surgery and reconstruction of the other breast to produce symmetry, in the manner determined by the attending Provider and the Enrollee to be appropriate, subject to the provisions of this Contract.

"Routine Care Costs" - the cost of Medically Necessary services related to the care method that is under evaluation in a clinical trial. The term does not include any of the following listed below.

(A) The health care service, item, or investigational drug that is the subject of the clinical trial.
(B) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
(C) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
(D) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
(E) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where a clinical trial is conducted.
(F) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
(G) A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.

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"Routine Immunization" - an immunization administered to the age-appropriate general population and recommended by the (A) Centers for Disease Control and Prevention (CDC), (B) American Academy of Pediatrics, and (C) American Academy of Family Physicians.

"Semi-private Room" - a room with two or more beds in a Hospital, an Approved Inpatient Transitional Care Unit, or an Alternate Facility.

"Service Area" - the geographic area We serve, as defined in the Schedule of Benefits. For this product the "Service Area" may not include Our licensed Service Area in its entirety, as approved by the Indiana Department of Insurance.

"Skilled Nursing Care" - services from licensed nurses in Your own home or in a nursing home.

"Special Enrollment" - periods during which individuals eligible to enroll [under this Contract][in Qualified Health Plans] may enroll in [a Qualified Health Plan, or may change Qualified Health Plans][in this Contract], as a result of triggering events provided in Section 2.5 [and as determined by the Exchange].

~~**"Specialty Pharmacy"** - a Participating Pharmacy that has entered into an agreement with Us to provide Specialty Drug services to Enrollees.~~

"Stabilize" - to provide Health Services to an Enrollee in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the Enrollee's condition is not likely to occur.

This includes Emergency Health Services provided to an Enrollee in a Hospital's care setting throughout or during

the following discharge, transfer to another health care facility, or transfer to the Hospital's inpatient setting.

"Subscriber" - an individual whose name is on the Contract and [is][has] enrolled [an Eligible Dependent] for Coverage under this Contract. [The term Subscriber does not include Enrolled Dependents][A Subscriber is the legal parent or legal guardian of the Enrolled Dependent. A Subscriber does not have Coverage under this Contract].

"Urgent Care" - the treatment of an unexpected Sickness or Injury that is not life or limb threatening but requires prompt medical attention.

"Urgent Care Center" - a licensed medical service center that provides Urgent Care.

"Urgent ~~Care~~ Grievance~~Claim~~" - a request for a Health Service that, if subject to the time limits applicable to Post-service ~~Claims~~ Grievances or Pre-Service ~~Claims~~ Grievances would do either of the following.

(A) Would seriously jeopardize Your life, health or ability to reach and maintain maximum function, or

(B) In the opinion of physicians familiar with Your condition, would subject You to severe pain that cannot be adequately managed unless We approve the Claim.

Once identified as such, an Urgent ~~Care Claim~~ Grievance will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

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Article 2

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Section 2.1 Eligibility of [the Subscriber] and Dependents. To be eligible to enroll as a [Subscriber\[Dependent], You must be all of the following listed below.

(A) Under age [65][21].
(B) Residing in Our Service Area.
(C) A legal resident of Indiana.
(D) Not eligible for or enrolled in Medicare, Medicaid or CHIP.
(E) Not covered by any other group or individual health benefit plan.
(F) [Eligible for Coverage on the Exchange]
~~(D)~~(G) [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective].
~~(E)~~(H) ~~Not eligible for or enrolled in Medicare, Medicaid or CHIP.~~

[To be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the Exchange application completed by the Subscriber, and meet the definition of Dependent as well as all Dependent eligibility criteria established under this Contract and by the Exchange.]

We shall not require any person to submit to Genetic Screening or Testing, or use the results of such in determining eligibility for enrollment, inquire as to the results of Genetic Screening or Testing, or make an adverse decision against any person based on such results.

Section 2.2 Pre-Existing Conditions and Nondiscrimination. No Eligible Subscriber or Dependent will be refused enrollment based on health~~,~~ status, health care needs, expected length of life, quality of life, genetic information, previous medical information, disability or age.

Section 2.3 Enrollment and Effective Date for Coverage. Sections 2.4 through 2.5~~6~~ provide information on how [an Eligible] Subscriber may enroll [an Eligible Dependent] in this Contract during the applicable enrollment periods [set by the Exchange] and the Effective Dates for Coverage for such enrollments. Regardless of how [an Eligible] Subscriber enrolls [an Eligible Dependent] in this Contract, enrollment is subject to Our receiving initial

payment of Premium. No Coverage shall be Effective before this Contract takes effect. No Dependent shall be Covered until [You are Covered][enrolled for Coverage].

The Effective Date of this Contract is stated on Page 1.

~~**Section 2.4 Initial Open Enrollment and Effective Date for Coverage.** This Section 2.4 explains how an Eligible Subscriber enrolls for Coverage during the initial Open Enrollment period set by the Exchange and sets forth the Effective Date for Coverage for such enrollment.~~

~~**(A) Enrollment during Initial Open Enrollment.** The initial Open Enrollment period begins October 1, 2013 and extends through March 31, 2014. An Eligible Subscriber can enroll for Coverage by submitting a completed application to the Exchange during the initial Open Enrollment period. The Exchange will notify Us of Your selection and transmit to Us all of the information necessary to enroll You for Coverage. If We do not receive the initial selection during initial Open Enrollment, the person can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.~~

~~If a person qualifies as a Dependent but does not enroll when the Eligible Subscriber first applies for enrollment, the Dependents can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.~~

~~As stated in Section 2.1, to be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the application completed by the Subscriber and submitted to the Exchange, and meet all Dependent eligibility criteria established by Us.~~

~~(B) **Effective Date for Coverage for Initial Open Enrollment.** The Effective Date for Coverage for You and Your Enrolled Dependents, if any, is determined by the date the Exchange receives Your selection according to the applicable timeframes listed below.~~

~~(A) If the selection is received by the Exchange before December 15, 2013, the Effective Date for Coverage will be January 1, 2014.~~

~~(B) If the selection is received by the Exchange between the first and the fifteenth day of January, February, or March during the initial Open Enrollment period, the Effective Date for Coverage will be of the first day of the following month.~~

~~(C) If the selection is received by the Exchange between the sixteenth and the last day of December, January, February or March during the initial Open Enrollment period, the Effective Date for Coverage will be the first day of the second following month.~~

Section 2.4~~5~~ Annual Open Enrollment and Effective Date for Coverage. This Section 2.~~5~~4 explains how an Eligible Subscriber enrolls[an Eligible Dependent] for Coverage during the Open Enrollment periods [set by the Exchange] ~~after the initial Open Enrollment period~~ and sets forth the Effective Date for Coverage for such enrollment.

(A) Enrollment during Open Enrollment. During an Open Enrollment period, an Eligible Subscriber can enroll for Coverage by submitting a completed application to [Us}[the Exchange] during Open Enrollment. [The Exchange will notify Us of Your selection and transmit to Us all of the information necessary to enroll You for Coverage.] If We do not receive the selection during Open Enrollment, the eligible person can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.

[If a person qualifies as a Dependent but does not enroll when the Eligible Subscriber first applies for enrollment, the Dependents can only enroll for Coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.]

[As stated in Section 2.1, to be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the application completed by the Subscriber and submitted to [Us][the Exchange], and meet all Dependent eligibility criteria established by Us.]

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(B) Effective Dates for Coverage during Annual Open Enrollment. For applications received during any annual Open Enrollment period, Coverage will be effective [according to the dates listed below][on the date identified by the Exchange].

(1) If the selection is received by [Us][the Exchange] between the first and the fifteenth day of the ~~January, February, or March during the initial~~ Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or ~~of~~ the first day of the following month.

~~(1)~~(2) If the selection is received by [Us][the Exchange] between the sixteenth and the last day of ~~December, January, February or March during~~ the ~~initial~~ Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or the first day of the second following month.

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Section 2.5~~6~~ Special Enrollment and Effective Date for Coverage. This Section 2.5~~6~~ explains how an Eligible Subscriber may enroll for Coverage during a Special Enrollment period [set by the Exchange] and sets forth the Effective Date for Coverage for such enrollment.

Special Enrollment period Effective Dates for Coverage depend on the type of event, the date of request for a special enrollment period, and the date of plan selection. [CMS][We] will determine enrollee eligibility for all special enrollment periods.

[For additional information on Special Enrollment period set by the Exchange and how to enroll in or change Qualified Health Plans during a Special Enrollment period, You may contact the Exchange at [1-800-318-2596] or visit the Exchange website at [www.healthcare.gov.]

(A) [Special Enrollment Triggering Events.

(1) Loss of Minimum Essential Coverage.

(2) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.

(3) Obtaining status as a United States citizen, national, or lawfully present individual.

(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.

(5) Violation of a Qualified Health Plan of a material provision of its contract.

(6) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(7) Relocation to a new service area of the Exchange.

(8) An Indian, as defined in Section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(9) Demonstration to the Exchange, in accordance with the guidelines established by the United States Department of Health and Human Services, that You or Your Dependent satisfy other exceptional circumstances provided by the Exchange.

(10) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

(A) [Special Enrollment Triggering Events.

(1) Involuntary loss of Minimum Essential Coverage for any reason other than fraud, failure to pay Premium, or misrepresentation of material fact.

(2) Loss of Minimum Essential Coverage due to dissolution of marriage.
(3) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.
(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.
(5) Violation of a Qualified Health Plan of a material provision of its contract.
(6) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.
(7) Relocation to a new service area of the Exchange.
(8) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

~~(A)~~(B) **New Dependents as a Result of Marriage or Loss of Essential Minimum Coverage.** If [You have][the Subscriber has] a new Dependent as a result of marriage, or due to [Your][the] Dependent's loss of essential minimum coverage, [You][the Subscriber] may elect to enroll [Your][the new] Dependent in this Contract, provided [You request][the Subscriber requests] enrollment within 60 days of the date of marriage or loss of essential minimum coverage. The Effective Date for Coverage will be on the first day of the month following the date of marriage or loss of essential minimum coverage. If We receive [an application form][notification from the Exchange] to add [Your][the new] Dependent more than 60 days after this qualifying event, We will not be able to enroll that person until the next Open Enrollment period.

(C) **New Dependents as a Result of Birth, Adoption, or Placement for Adoption.** If You have a new Dependent as a result of birth, adoption, or placement for adoption, Your new Dependent will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption or placement for adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for Your Dependent beyond 31 days, provided You submit [an application form to Us][a form through the Exchange] to add Your Dependent to the Contract and pay the required premium. The form must be submitted to [Us][the Exchange] within 60 days after the date of birth or adoption. If the form is not submitted to [us][the Exchange] within 60 days after the date of birth or adoption, Coverage will cease on the expiration of the 31 day period provided above.

[If an Enrolled Dependent has a child as a result of birth, adoption, or placement for adoption, the Enrolled Dependent's child will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption, or placement for adoption or date of entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for the Enrolled Dependent's child beyond 31 days, provided: (1) the child is placed under legal guardianship or legal custody of the Subscriber or the Subscriber's spouse and the child otherwise satisfies the eligibility requirements to enroll as a Dependent as set forth in this Article 2; (2) the Subscriber submits a form [to Us][through the Exchange] to add the child to the Contract within 60 days after the date of birth or adoptions; and (3) the Subscriber pays the required premium.]

~~(B)~~(D) [**CHIP.** Eligible Dependents may also enroll under either of the two additional circumstances identified in (1) and (2).

(1) The Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility.

(2) The Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

You must request Special Enrollment for Your Dependent within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive notification to add Your Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, We will not be able to enroll that person until the next Open Enrollment period.]

~~(C)~~(E) **Other Qualifying Events.** For all other Special Enrollment qualifying events[identified by the Exchange], the Effective Date for Coverage for [You and Your] Enrolled Dependents, [if any], is determined based on the date [We receive][the Exchange] receives Your selection according to the applicable timeframes listed below.

(1) If the selection is received [by Us] [by the Exchange] between the first and the fifteenth day of the month, the Effective Date for Coverage will be of the first day of the following month.

(2) If the selection is received by [Us}][the Exchange] between the sixteenth and the last day of the month, the Effective Date for Coverage will be of the first day of the second following month.

Section 2.6~~7~~ Notify Us [or the Exchange] of Eligibility Changes. The Subscriber is responsible for notifying Us [or the Exchange] in writing of any change in eligibility that affects [the Subscriber or the][any] Enrolled Dependents. We [or the Exchange] must be notified no later than 30 days from the date of the event. We have the right to bill the Subscriber for the cost of any Health Services We have paid during the period of time the person was not enrolled under the Contract.

A change in the eligibility [of the Enrolled Dependent] may be any of the following listed below.

~~(D)~~(A) [A determination of ineligibility made by the Exchange.]

~~(E)~~(B) [Any change with respect to the eligibility standards specified by the Exchange for which You are required to notify the Exchange.]

~~(F)~~(C) Address change.

~~(G)~~(D) [Marriage.

~~(H)~~(E) Divorce.]

~~(I)~~(F) Death.

~~(J)~~(G) [Birth of a Dependent].

~~(K)~~(H) [Change in disability status of a Dependent.]

~~(L)~~(I) Dependent Child] is no longer eligible because they have reached the limiting age.

Section 2.~~8~~7 Service Area Requirements. [Subscribers][Dependents] must live in Our Service Area. ~~Covered Health Services must be received from a Participating Provider, except for (A) Emergency Health Services, or (B) Referral Prior Authorized Health Services.~~

Article 3

BENEFITS AND COVERED HEALTH SERVICES

Subject to the Exclusions sets forth in this Contract and the terms and conditions of this Contract, We will Cover the following Medically Necessary Health Services [for an Enrolled Dependent].

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copay, and Benefit Limitation information.

You are responsible for any fees incurred for Non-Covered Health Services.

Section 3. 1 Ambulance Services. Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and

staffed by Emergency Medical Technicians, paramedics, or other certified medical professionals from or between any of the following listed below.

- From Your home, scene of accident or medical Emergency to a Hospital,
- Between Hospitals,
- Between a Hospital and Skilled Nursing Facility, or
- From a Hospital or Skilled Nursing Facility to Your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when You are not transported will be Covered if Medically Necessary.

Ambulance services are a Covered Health Service only when Medically Necessary, except when ordered by an employer, school, fire or public safety official and the Enrollee is not in a position to refuse, or when an Enrollee is required by Us to move from a Non-Participating Provider to a Participating Provider.

Ambulance trips must be made to the closest local facility that can give Covered Health Services appropriate for Your condition. If none of these facilities are in Your local area, You are Covered for trips to the closest facility outside Your local area.

Non-Covered Services for Ambulance include any of the following.

- Trips to a Physician's office or clinic, or a morgue or funeral home.
- Ambulance usage when another type of transportation can be used without endangering the Enrollee's health.
- Ambulance usage for the convenience of the Enrollee, family or Provider.

Section 3.2 Behavioral Health and Mental Health Services.

- Inpatient services. Medical management, individual or group psychotherapy, psychological testing, family counseling with family members to assist in Your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
- Observation stays. Overnight stays in behavioral health hospital facilities that do not meet inpatient levels of Medical Necessity, but do meet observation level based on nationally accepted criteria.
- Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
- Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
- Outpatient Treatment or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

~~Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.~~

To assist You in obtaining appropriate and quality care, We will ask Your Provider to submit a treatment plan to Us within 48 hours of an inpatient or observation level of care, or after You have had an initial outpatient evaluation and nine (9) subsequent visits in an outpatient setting. We may discuss the goals of treatment and changes in the treatment plan, including alternative courses of treatment, with Your Provider in order to manage Your benefits effectively and efficiently.

Non-Covered Behavioral Health Services include all of the following.

- Supervised living or halfway houses.

- Health Services or care provided by a residential treatment center, school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, outward bound programs, even if psychotherapy is included.
- Health Services related to non-compliance of care if the Enrollee ends treatment for Substance Abuse against the medical advice of a Provider.

Section 3.3 Dental Health Services Related to Accidental Injury. Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are Covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Treatment for pain is only Covered if it is the result of an accidental injury. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Health Services for Accidental Dental include, but are not limited to all of the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia.

Section 3.4 Other Dental Health Services. Anesthesia and Hospital charges for dental care, for an Enrollee less than 19 years of age or an Enrollee who is physically or mentally disabled, are Covered if the Enrollee requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Enrollee's condition under general anesthesia. This Coverage does not apply to treatment for temporal mandibular joint disorders (TMJ). Extraction of teeth to prepare the jaw for radiation treatment or neoplastic disease is Covered.

Routine dental care is not a Covered Health Service under this Contract.

Section 3.5 Diabetic Equipment, Education and Supplies. Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when all of the following requirements listed below are met.

- Ordered in writing by a Physician or a podiatrist.
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Health Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes pursuant to Sections 3.13, 3.16, and 3.17.

Section 3.6 Diagnostic Health Services. Diagnostic Health Services are tests or procedures performed when You have specific symptoms, to detect or monitor Your condition. Coverage for Diagnostic Health Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to those listed below.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- Computer Tomography and Computer Axial Tomography Scans (CAT).

- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Health Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy necessary (e.g. intravenous dye) to perform tests are Covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Diagnostic Breast Cancer Screening Mammography. The following breast cancer screening mammography Health Services are Covered Diagnostic Health Services.

- If the female Enrollee is at least 35 years of age, she may have one (1) Covered baseline breast cancer screening mammography performed before she becomes 40 years of age.
- If the Enrollee is less than 40 years of age and is high risk, she may have one (1) breast cancer screening mammography performed every year.
- Any additional mammography views that are required for proper evaluation..
- Ultrasound services, if determined Medically Necessary by the physician treating the Enrollee.

A woman is considered "high risk" if she meets at least one (1) of the following.

(1) Has a personal history of breast cancer.
(2) Has a personal history of breast disease proven benign by biopsy.
(3) Has a mother, sister, or daughter who has had breast cancer.
(4) Is at least 30 years of age and has not given birth.

Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Diagnostic Health Service for an Enrollee under the age of fifty (50) if the Enrollee is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsympomatic Enrollee, in accordance with the current American Cancer Society guidelines.

Diagnostic Prostate Cancer Screening. If an Enrollee is at least 50 years of age, one (1) prostate specific antigen test is Covered annually. If an Enrollee is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test is Covered annually.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Section 3.7 Emergency Health Care Services. Benefits for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever You are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copay/Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, Your Physician or the Inpatient facility -must seek authorization for your admission ~~notify Us or verify that Your Physician has notified Us of Your admission~~ within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, Your ~~p~~Provider will be notified whether the Inpatient setting is appropriate and considered ~~m~~Medically ~~n~~Necessary.~~, and if appropriate, the number of days considered Medically Necessary. By calling Us,~~If ~~p~~Prior ~~a~~Authorization is not obtained within 48 hours of your admission You may be ~~You may avoid~~ financially responsible~~ility~~ for Your~~any~~ Inpatient care. ~~that is determined to be not Medically Necessary under Your Contract. If Your Provider is a Non-Participating Provider, You will be financially responsible for any care We determine is not Medically Necessary.~~

Care and treatment provided once You are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or Stabilize Your condition in an Emergency may be Covered if We authorize the continuation of care and it is Medically Necessary. Transfer to a Participating Provider will be made available to persons receiving post-stabilization care in a Non-Participating Provider facility.

Section 3.8 Urgent Care Center Services. An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. ~~If You call Your Physician prior to receiving care for an Urgent Care medical problem and Your Physician provides written authorization that You to go to an emergency room, Your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.~~

Section 3.9 Home Care Services. Health Services performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Enrollee must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Health Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Services.
- Nutritional Guidance.
- Home Health Aide Services. The Enrollee must be receiving skilled nursing or therapy. Health Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Massage, Music, and Manipulation Therapy which will not be Covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

Non-Covered Home Health Care Services include the following.

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services as such services are Covered under Therapy Services.
- Helpful environmental materials such as hand rails, bath stools ramps, telephones, air conditioners, and similar services, appliances and devices.
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.

- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if Your ~~p~~Provider obtains prior approval from Our Home Infusion Therapy Administrator. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Section 3.10 Hospice Services. Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician and hospice medical director. Covered Health Services will continue if the Enrollee lives longer than six months, provided the hospice medical director or other hospice doctor recertifies that You are terminally ill.

Covered Hospice Services include the following list.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

Non-Covered Hospice Services include services provided by volunteers and housekeeping services.

Section 3.11 Inpatient Services. Inpatient Services include all of the following.

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for Room, Board and General Nursing Services,
- Ancillary (related) services, and
- Professional Health Services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room if it is Medically Necessary that You use a private room. You will be required to supplement the difference in cost if a private room is desired, but not Medically Necessary.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive Health Services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and Health Services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Health Services.
- Therapy Services.

Professional Health Services

Medical care visits limited to one visit per day by any one Physician.

- Intensive medical care for constant attendance and treatment when Your condition requires it for a prolonged time.

- Concurrent care for a medical condition by a Physician who is not Your surgeon while You are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of Your condition requires the skills of separate Physicians.
- Consultation which is a personal bedside examination by another Physician when ordered by Your Physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

When an Enrollee is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copay per admission in the Schedule of Benefits is waived for the second admission.

Section 3.12 Maternity Services. Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. Maternity Services are used for normal or complicated pregnancy and ordinary routine nursery care for a healthy newborn. In order to aid in facilitating a pregnant Enrollee's prenatal care, she is required to notify Us of her pregnancy within 7 days of the date that she becomes aware that she is pregnant.

If the Enrollee is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider to have Covered Maternity Services paid at the Delivery System level. If the Enrollee is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Delivery System level if the Enrollee is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date.

Covered Maternity Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period.

If a newborn child is required to stay as an Inpatient past the mother's discharge date, the Health Services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copay.

Coverage for the Inpatient postpartum stay for You and Your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care and Postnatal Care.

Covered Maternity Services include post-delivery care visits at Your residence by a Physician or Nurse performed no later than 48 hours following You and Your newborn child's discharge from the Hospital. Coverage for this visit includes all of the following listed below.

1. Parent education,
2. Assistance and training in breast or bottle feeding, and
3. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

We will Cover an examination given at the earliest feasible time to Your newborn child for the detection of the following disorders.

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia.
- Galactosemia.
- Maple Syrup urine disease.
- Homocystinuria.
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
- Physiologic hearing screening examination for the detection of hearing impairments.

- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.
- HIV testing in infants exposed to HIV/AIDS.
- Pulse oximetry screening examination for the detection of low oxygen levels.

Section 3.13 Medical Supplies, Durable Medical Equipment and Appliances.

- Medical and surgical supplies –Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera and Remicade. Covered Health Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.
  - Covered Health Services include the following.
    1. Allergy serum extracts
    2. Chem strips, Glucometer, Lancets
    3. Clinitest
    4. Needles/syringes
    5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Health Services
    6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.
  - Non-Covered Health Services include the following.
    1. Adhesive tape, band aids, cotton tipped applicators
    2. Arch supports
    3. Doughnut cushions
    4. Hot packs, ice bags
    5. vitamins
    6. medijectors

- Durable Medical Equipment - The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Contract will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Health Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Enrollee, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is Covered.

  - Covered Health Services include the following.
    1. Hemodialysis equipment
    2. Crutches and replacement of pads and tips
    3. Pressure machines
    4. Infusion pump for IV fluids and medicine
    5. Glucometer
    6. Tracheotomy tube
    7. Cardiac, neonatal and sleep apnea monitors
    8. Augmentive communication devices are Covered when We approve based on the Enrollee's condition.
    9. CPAP machines when indicated for sleep apnea.
  - Non-Covered items include the following.
    1. Air conditioners

2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Enrollee is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

- Prosthetics – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Health Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are Covered.

  - Covered Health Services include, the following.
    1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
    2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
    3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
    4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
    5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Enrollee selects eyeglasses and frames, then reimbursement for both lenses and frames will be Covered.
    6. Cochlear implant.
    7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
    8. Restoration prosthesis (composite facial prosthesis).
    9. Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Benefit Period).

  - Non-Covered Prosthetic appliances include the following.
    1. Dentures, replacing teeth or structures directly supporting teeth.
    2. Dental appliances.
    3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
    4. Artificial heart implants.
    5. Wigs (except as described above following cancer treatment).
    6. Penile prosthesis in men suffering impotency resulting from disease or injury.

- Orthotic Devices – The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered. The casting is Covered when an orthotic appliance is billed with it, but not if billed separately.

    - Covered Health Services for Orthotic Devices include the following.
        1. Cervical collars.
        2. Ankle foot orthosis.
        3. Corsets (back and special surgical).
        4. Splints (extremity).
        5. Trusses and supports.
        6. Slings.
        7. Wristlets.
        8. Built-up shoe.
        9. Custom made shoe inserts.
    - Orthotic appliances may be replaced once per year per Enrollee when Medically Necessary in the Enrollee's situation. However, additional replacements will be allowed for Enrollees under age 18 due to rapid growth, or for any Enrollee when an appliance is damaged and cannot be repaired.
    - Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.
    - Non-Covered Health Services for Orthotic Devices include the following.
        1. Orthopedic shoes (except therapeutic shoes for diabetics).
        2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
        3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
        4. Garter belts or similar devices.

- Prosthetic limbs & Orthotic custom fabricated brace or support –
    - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be Covered if they satisfy both requirements listed below.
        1. Determined by Your Physician to be Medically Necessary to restore or maintain Your ability to perform activities of daily living or essential job related activities, and
        2. Not solely for comfort or convenience.
    - Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the Coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.
    - Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are Covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract.

Replacements and Repairs. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be Covered, as approved by Us.

The repair, adjustment or replacement of the purchased equipment, supply or appliance is Covered if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be Covered if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

Section 3.14 Outpatient Services. Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Contract. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us.

When Diagnostic Health Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copay is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these Health Services.

Section 3.15 Autism Spectrum Disorder Services.
Coverage is provided for the treatment of Autism Spectrum Disorders. Treatment is limited to Health Services prescribed by Your Physician in accordance with a treatment plan.

- Autism Spectrum Disorder, as defined in the definition section of the Policy, means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Coverage for Health Services will be provided as prescribed by Your treating Physician in accordance with the treatment plan.
- Any exclusion or limitation in this Contract in conflict with the Coverage described in this provision will not apply.
- Coverage for Autism Spectrum Disorders will not be subject to dollar limits, Deductibles, Copay or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copays or Coinsurance provisions that apply to physical illness under this Contract.

Section 3.16 Physician Home Visits and Office Services. Covered Health Services include care provided by a Physician in their office or Your home. Refer to the Sections 3.2, 3.9, 3.12, and 3.17 for Health Services Covered by the Contract. For Emergency Care refer to Sections 3.7 and 3.8.

- Office Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copay is required.

- Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in Your home.

- Diagnostic Health Services when required to diagnose or monitor a symptom, disease or condition.

- Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

- Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Section 3.17 Preventive Care Services. Preventive Care Services include, Outpatient services and Office Services. Screenings and other Health Services are Covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

- Enrollees who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Health Services benefit.
- Preventive Care Services in this section shall meet requirements as determined by federal and state law.
- Health Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF.

Section 3.18 Routine Care Costs as Part of a Cancer or Other Life-Threatening Disease or Condition Clinical Trial. Routine Care Costs as part of an ~~approved~~ Approved ~~clinical~~ Clinical ~~trial~~ Trial ~~for the prevention, detection, or treatment of cancer or other life-threatening disease or condition~~ if the Health Services are otherwise Covered Health Services under this Contract ~~and the clinical trial is performed according to all of the following standards~~.

An Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

~~Using a particular care method to prevent, diagnose, or treat a cancer or other life-threatening disease or condition for which:~~

- ~~there is no clearly superior, non-investigational alternative care method, and~~
- ~~available clinical or preclinical data provides reasonable basis from which to believe that the care method used in the research study is at least as effective as any non-investigational alternative care method.~~

~~2. In a facility where personnel providing the care method to be followed in the research study have:~~

- ~~received training in providing the care method,~~
- ~~expertise in providing the type of care required for the research study, and~~
- ~~experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise, and~~

~~3.~~1. ~~To scientifically determine the best care method to prevent, diagnose, or treat the cancer or other life-threatening disease or condition, and~~The trial is approved or funded by one, or a combination, of the following:

- A National Institutes Health institute,~~;~~
- A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center,~~;~~
- The ~~federal~~ United States Food and Drug Administration,~~;~~
- The United States Department of Veterans Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
- The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
- The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).
- The Centers of Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare and Medicaid Services.
- The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 C.F.R. 146.103~~, or~~.
- A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.
- A qualified non-governmental research entity in guidelines issued by the National Institutes of health for center support grants.

2. A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.
~~4.~~3. A study or investigation done for drug trials which are exempt from the investigational new drug application.

Your PMP must provide Us with written authorization for Your participation in a Cancer Clinical Trial.

Routine Costs as part of an Approved ~~cancer~~ Cclinical T~~t~~rial does not include any of the following.

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial,
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.
- Transportation, lodging, food, or other expense for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the cancer clinical trial.
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient.
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

The term "life threatening condition" means any disease or condition from which death is likely unless the disease or condition is treated.

Section 3.19 Surgical Services. Coverage for Surgical Services when provided as part of Physician Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to the list below.

- Performance of accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary.
- Usual and related pre-operative and post-operative care.
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

- Covered Surgical Services include the following.
  - Operative and cutting procedures.
  - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
  - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services. Certain Reconstructive Services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are Covered. Reconstructive Services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract. Covered Reconstructive Services are limited to the following list.

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further Coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or Younger.
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia.
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect.

- Tongue release for diagnosis of tongue-tied.
- Congenital disorders that cause skull deformity such as Crouzon's disease.
- Cleft lip.
- Cleft palate.

Mastectomy Notice. An Enrollee who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive Coverage for all of the following listed below.

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Section 3.20 Sterilization. Sterilization is a Covered Service.

Section 3.21 Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder. Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders if provided within Our guidelines.

Section 3.22 Therapy Services. When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, Coverage for these Therapy Services is limited to the following list.

- Physical Medicine Therapy Services. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.
    - Physical Therapy Services including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Physical Therapy Services include but are not limited to maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness, repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients), range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities, general exercise programs, diathermy, ultrasound and heat treatments for pulmonary conditions, diapulse, work hardening.
    - Speech Therapy Services for the correction of a speech impairment.
    - Occupational Therapy Services for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Occupational Therapy Services include but are not limited to supplies (looms, ceramic tiles, leather, utensils), therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again, general exercises to promote overall fitness and flexibility, therapy to improve motivation, suction therapy for newborns (feeding machines), soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial, adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
    - Manipulation Therapy Services includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy Services as specified in the Schedule of Benefits. Manipulation Therapy Services rendered in the home as part of Home Care Services are not Covered.
- Other Therapy Services

- Cardiac Rehabilitation Services to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not Covered.
- Pulmonary Rehabilitation Services to restore an individual's functional status after a pulmonary or cardiac event, or to improve respiratory capacity in persons with chronic lung conditions.
- Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- Dialysis Treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of Coverage the Contract will not require You to receive dialysis treatment at a Participating Provider dialysis facility if that facility is further than 30 miles from Your home. If You require dialysis treatment and the nearest Participating Provider dialysis facility is more than 30 miles from Your home, the Contract will allow You to receive treatment at a Participating Provider dialysis facility nearest to Your home as Covered Health Service.
- Radiation Therapy Services for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, treatment planning.
- Inhalation Therapy Services for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Inhalation Therapy Services include but are not limited to, introduction of dry or moist gases into the lungs, nonpressurized inhalation treatment, intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive airway pressure ventilation (CPAP), continuous negative pressure ventilation (CNP), chest percussion, therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers, broncho-pulmonary drainage and breathing exercises.
- Pulmonary Rehabilitation Services to restore an individual's functional status after an illness or injury. Covered Pulmonary Rehabilitation Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also Covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary Rehabilitation Services in the acute Inpatient rehabilitation setting is not a Covered Health Service.
- Nutritional Counseling Services that are Medically Necessary or that are ordered by a Participating Provider. Limit of twelve (12) sessions annually.

Section 3.23 Physical Medicine and Rehabilitation Services. A structured therapeutic program under the supervision of a physical medicine and rehabilitation specialist and developed treatment plan of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical Medicine and Rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

~~Non-Covered Physical Medicine and Rehabilitation Services include the following.~~

- ~~Admission to a Hospital mainly for physical and/or occupational therapy.~~
- ~~Long term rehabilitation in an Inpatient setting.~~

Long term rehabilitation for longer than 60 days in an inpatient setting is not a Covered Service.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Health Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing

services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Health Service.

Section 3.24 Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services. The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Enrollee cost shares.

Covered Transplant Procedure. Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period**.** Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Transplant Provider agreement. Contact the Case Manager for specific Participating Transplant Provider information for Health Services received at or coordinated by a Participating Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Transplant Provider Facility.

Prior Approval and Precertification. In order to maximize Your benefits, We strongly encourage You to call Our transplant department to discuss benefit Coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We may require additional work-ups and/or treatments before determining eligibility for the transplant benefit (e.g. psychotherapy). We will assist You in maximizing Your benefits by providing Coverage information, including details regarding what is Covered and whether any clinical Coverage guidelines, medical policies, Participating Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of Your I.D. Card. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are Covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging. The Contract will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Enrollee receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Enrollee must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed.

Non-Covered Services for transportations and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by Us.
- Frequent Flyer miles.

- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Section 3.25 Prescription Drug Benefits.

Pharmacy Benefits Manager**.** The pharmacy benefits available to You under this Contract are managed by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which We contract to manage Your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, ~~a Specialty pharmacy,~~ and provides clinical management services. The management and other services the PBM provides include, among others, making recommendations to, and updating, the Covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and, operating a Mail Service pharmacy~~, and a Participating Specialty Drug Pharmacy~~. The PBM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, Drug interactions or Drug/pregnancy concerns.

You may request a copy of the Covered Prescription Drug list by calling the Customer Service telephone number on the back of Your I.D. Card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage. You may request a list of Pharmacies in the PBM network by calling the customer service number listed on the back of Your I.D. Card.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Health Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Contract can determine Medical Necessity. The Contract may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Health Services will be limited based on Medical Necessity, quantity and/or age limits established by the Contract, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit Coverage. At the time You fill a prescription, the Participating Pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee which is reviewed and adopted by Us. We, or the PBM may contact Your Provider if additional information is required to determine whether Prior Authorization should be granted. We communicate the results of the decision to both You and Your Provider.

If Prior Authorization is denied, You have the right to appeal through the appeals process outlined in Article 8.

For a list of the current Drugs requiring Prior Authorization, please contact the Pharmacy Customer Service telephone number on the back of Your I.D. card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage under Your Contract. Refer to the Prescription Drug benefit sections in this Contract for information on Coverage, limitations and exclusions. Your Participating Provider or Participating Pharmacist may check with Us to verify Covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Contract.

- Therapeutic Substitution of Drugs is a program approved by Us and managed by the PBM. This is a voluntary program designed to inform Enrollees and Physicians about possible alternatives to certain prescribed Drugs. We, or the PBM, may contact You and Your prescribing Physician to make You aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only You and Your Physician can determine whether the therapeutic substitute is appropriate for You. For questions or issues involving therapeutic Drug substitutes, call the Customer Service telephone number on the back of Your I.D. card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

- Step Therapy. Step therapy protocol means that an Enrollee may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Enrollees access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Participating ~~Specialty~~ Pharmacies**.** The PBM's Participating ~~Specialty~~ Pharmacies are available to Enrollees who use medically necessary drugs~~Specialty Drugs. "Specialty Drugs" are Prescription Legend Drugs which are any of the following listed below.~~
~~Are only approved to treat limited patient populations, indications or conditions, or~~
~~Are normally injected, infused or require close monitoring by a physician or clinically trained individual, or~~
~~Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.~~

~~Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug Prescription Orders, subject to a day supply limit for Retail and Mail Service, and subject to the applicable Coinsurance or Copay shown in the Schedule of Benefits.~~

Participating mail service pharmacies have toll free access to registered pharmacists to answer your questions. Participating ~~S~~specialty p~~P~~harmacies have dedicated patient care coordinators to help You manage Your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists. ~~to answer questions regarding Your medications.~~

You may obtain a list of the Participating ~~Specialty~~ Pharmacies, and Covered ~~Specialty~~ Drugs, by calling the Customer Service telephone number on the back of Your ID card, or review the lists on Our website at *www.mdwisemarketplace.org*.

Covered Prescription Drug Benefits include the following.

- Prescription Legend Drugs.
- ~~Specialty Drugs.~~
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are Covered when obtained through an eligible Pharmacy.
- If certain supplies, equipment or appliances are not obtained by Mail Service or from a Participating Pharmacy then they are Covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits and may be subject to applicable DME Copays or Coinsurance.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Non-Covered Prescription Drug Benefits

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.

- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by Us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for Coverage under the Medical Supplies benefit, they are Covered Health Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Health Services.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Refills of lost or stolen medications.
- Refills earlier than 72 hours before Your next refill is due.
- Refills on expired Prescription Drugs.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, are not Covered, unless otherwise required by law or approved by Us. "Clinically equivalent" means Drugs that, for the majority of Enrollees, can be expected to produce similar therapeutic outcomes for a disease or condition.

Deductible/Coinsurance/Copay. Each Prescription Order may be subject to a Deductible and Coinsurance/Copay. If the Prescription Order includes more than one Covered Drug, a separate Coinsurance/Copay will apply to each Covered Drug.

Days Supply. The number of days supply of a Drug which You may receive is limited. The days supply limit applicable to Prescription Drug Coverage is shown in the Schedule of Benefits. If You are going on vacation and You need more than the days supply allowed for under this Contract, You should ask Your Pharmacist to call the PBM and request an override for one additional refill. This will allow You to fill Your next prescription early. If You require more than one extra refill, please call the Pharmacy Customer Service telephone number on the back of Your I.D. Card.

Prescription Drug Classifications. Your Copay/Coinsurance amount may vary based on whether the Prescription Drug~~, including Covered Specialty Drugs,~~ has been classified by Us as a ~~Generic~~Tier 1, ~~Preferred Brand~~Tier 2, ~~Non-Preferred Brand~~Tier 3, ~~and Specialty~~ or Tier 4 Prescription Drug. The determination of Prescription Drug class is made by Us based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, and where appropriate certain clinical economic factors.

- ~~Generic Prescription~~ Tier 1Drugs have the lowest ~~Coinsurance or~~ Copay. This class will contain low cost and preferred medications that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- ~~Preferred Brand Prescription~~ Tier 2 Drugs will have a higher ~~Coinsurance or~~ Copay than Tier 1 ~~Generic~~ Prescription Drugs. This class will contain preferred medications that may be Generic, single source, or multi-source Brand Drugs.
- ~~Non-Preferred Brand~~ Tier 3Prescription Drugs will have a ~~higher~~ required Coinsurance ~~or Copay than Preferred Brand Prescription Drugs~~payment after You have hit your Deductible. This class will contain non-preferred and high cost medications. This will include medications considered Generic, single source brands, and multi-source brands.
- ~~Specialty~~ Tier 4 Prescriptions are subject to a day supply limit for Retail and Mail Service, and are subject to the applicable Coinsurance shown in the Schedule of Benefits. Coinsurance payment will occur after You have hit your Deductible. Tier 4 Drugs are Prescription Legend Drugs which are any of the following listed below.
    - Are only approved to treat limited patient populations, indications or conditions, or
    - Are normally injected, infused or require close monitoring by a physician or clinically trained individual, or
    - Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

~~Prescription Drugs will have a higher Coinsurance or Copay than Non-Preferred Brand Prescription Drugs.~~

Class and Formulary Assignment Process. We have established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of Prescription Drug class assignments and formulary inclusion are made by Us based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, generic availability, the degree of utilization of one Drug over another in Our patient population, and where appropriate, certain clinical economic factors.

We retain the right at Our discretion to determine Coverage for dosage formulations in terms of Covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may Cover one form of administration and exclusion or place other forms of administration in another tier.

Special Programs. From time to time We may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, ~~Generic~~ Tier 1 Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copays or Coinsurance for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program. The Half-Tablet Program will allow Enrollees to pay a reduced Copay on selected "once daily dosage" medications. The Half-Tablet Program allows an Enrollee to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Enrollee's decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of Your I.D. Card.

Section 3.26 Payment of Prescription Drug Benefits. The amount of benefits paid is based upon whether You receive the Covered Health Services from a Participating Pharmacy~~, including a Participating Specialty Pharmacy~~, a Non-Participating Pharmacy, or the PBM's Mail Service Program. It is also based upon how We have classified the Prescription Drug ~~or Specialty Drug~~. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The amounts for which You are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copay/Coinsurance for which You are responsible.

Your Copay(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Contract from Drug manufacturers or similar vendors. For Covered Health Services provided by a Participating ~~or Specialty Drug Participating~~ Pharmacy or through the PBM's Mail Service, You are responsible for all Deductibles and/or Copay/Coinsurance amounts.

For Covered Health Services provided by a Non-Participating Pharmacy, You will be responsible for the amount(s) shown in the Schedule of Benefits.

How to Obtain Prescription Drug Benefits. How You obtain Your benefits depends upon whether You go to a Participating or a Non-Participating Pharmacy.

- Participating Pharmacy – Present Your written Prescription Order from Your Physician, and Your I.D. Card to the pharmacist at a Participating Pharmacy. The Pharmacy will file Your claim for You. You will be charged at the point of purchase for applicable Deductible and/or Copay/Coinsurance amounts. If You do not present Your I.D. Card, You will have to pay the full retail price of the prescription. If You do pay the full charge, ask Your pharmacist for an itemized receipt and submit it to Us with a written request for refund.
- ~~Specialty~~Tier 4 Drugs - You or Your Physician can order Your ~~Specialty~~Tier 4 Drugs directly from a ~~Specialty~~ Participating Pharmacy, simply call the Pharmacy Customer Service telephone number on the back of Your ID card.
- Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy~~, including a Non-Participating Specialty Pharmacy~~. You must submit a Prescription Drug claim form for reimbursement consideration. These forms are available from Us, the PBM, or from the Group. You must complete the top section of the form and ask the Non-Participating Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, You must attach an itemized receipt to the claim form and submit to Us or the PBM. The itemized receipt must show all of those items listed below.
    - Name and address of the Non-Participating Pharmacy.
    - Patient's name.
    - Prescription number.
    - Date the prescription was filled.
    - Name of the Drug.
    - Cost of the prescription.
    - Quantity of each Covered Drug or refill dispensed.
- You are responsible for the amount shown in the Schedule of Benefits.
- The Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from Your Physician, or have Your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copay amounts to the Mail Service when You request a prescription or refill.

Drug Exception Program. This is a program designed to allow Enrollees to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. The Drug Exception Program is separate from and in addition to the Grievance Procedures set forth in Article 8. Please call the Customer Service number on the back of your I.D. Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary.

Section 3.27 Pediatric ~~Eyewear~~ Vision Benefits. Pediatric ~~eyewear~~ vision services are~~is~~ Covered under this Contract for Enrollees under the age of 19. Adult eyewear is not Covered under this Contract.

- A complete pediatric eye exam, including dilation if professional indicated

- One pair of eyeglass lenses. Lenses include single vision, bifocal, trifocal or lenticular. You may choose plastic or polycarbonate lenses and scratch resistant coating.
- One pair of eyeglass frames.
- Contact lenses in lieu of eyeglasses.
- Low vision services including a comprehensive low vision exam, optical/non-optical aids, and supplemental testing.

Please refer to the Schedule of Benefits for detailed information. ~~Adult eyewear is not Covered under this Contract.~~

Article 4

EXCLUSIONS

Section 4.1 We do not provide Coverage for any of the following.

1. Health Services that are not Medically Necessary.
2. Health Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available for a condition will not make it eligible for Coverage if We deem it to be Experimental/Investigative.
3. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
4. Health Services that are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
5. Any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
6. A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
7. Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
8. Court ordered testing or care unless Medically Necessary.
9. Health Services for which You have no legal obligation to pay in the absence of this or like Coverage.
10. Physician or Other Practitioners' charges for consulting with Enrollees by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Enrollee except as otherwise described in this Contract.
11. Surcharges for furnishing and/or receiving medical records and reports.
12. Charges for doing research with Providers not directly responsible for Your care.
13. Charges that are not documented in Provider records.
14. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
15. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
16. Health Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
17. Health Services prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
18. Completion of claim forms or charges for medical records or reports unless otherwise required by law.

19. Mileage, lodging and meals costs, and other Enrollee travel related expenses, except as authorized by Us or specifically stated as a Covered Health Service.
20. Health Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Enrollee had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.
21. Charges in excess of Our Allowed Amounts.
22. Health Services incurred prior to Your Effective Date.
23. Health Services incurred after the termination date of this Coverage except as specified elsewhere in this Contract.
24. Any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts) or for the removal of tattoos. Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not Covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Enrollee was Covered by another carrier/self funded plan prior to Coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.
25. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
26. Custodial Care, convalescent care or rest cures.
27. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Enrollee's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
28. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
29. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a
30. Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
31. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
32. Wilderness camps.
33. Routine foot care (including the cutting and removal of corns and calluses), Nail trimming, cutting and debriding, Hygienic and preventive maintenance foot care, including, but not limited to the following list.
    1. Cleaning and soaking the feet.
    2. Applying skin creams in order to maintain skin tone.
    3. Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
34. Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses.
35. Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including, but not limited to the list below.
    1. Extraction, restoration and replacement of teeth.
    2. Medical or surgical treatments of dental conditions.
    3. Services to improve dental clinical outcomes.
36. Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Health Service.

37. Dental implants.
38. Dental braces.
39. Dental x-rays, supplies and appliances and all associated expense, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following listed below.
    1. Transplant preparation.
    2. Initiation of immunosuppresives.
    3. Direct treatment of acute traumatic injury, cancer or cleft palate.
40. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
41. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as Covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
42. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not Covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Contract or any previous [MDwise Contract], and it applies if the surgery was performed while the Enrollee was Covered by a previous carrier/self funded plan prior to Coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to myocardial infarction, excessive nausea/vomiting, pneumonia, and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.
43. Marital counseling.
44. Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
45. Vision orthoptic training.
46. Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.
47. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
48. Services to reverse voluntarily induced sterility.
49. Diagnostic testing or treatment related to infertility.
50. Personal hygiene, environmental control, or convenience items including but not limited to the following list.
    1. Air conditioners, humidifiers, air purifiers,
    2. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals,
    3. Charges for non-medical self-care except as otherwise stated,
    4. Purchase or rental of supplies for common household use, such as water purifiers,
    5. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds,
    6. Infant helmets to treat positional plagiocephaly,
    7. Safety helmets for Enrollees with neuromuscular diseases, or
    8. Sports helmets.
51. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
52. Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Contract.
53. Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.
54. Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

55. Self-help training and other forms of non-medical self care, except as otherwise provided in this Contract.
56. Examinations relating to research screenings.
57. Stand-by charges of a Physician.
58. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
59. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
60. Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility, Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
61. Manipulation Therapy services rendered in the home as part of Home Care Services.
62. For any new FDA Approved Drug Product or Technology **(including but not limited to medications, medical supplies, or devices)** available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
63. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
64. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
65. Abortion, except in the following cases.
    1. The pregnant woman became pregnant through an act of rape or incest.
    2. An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.
66. Any services or supplies provided to a person not Covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
67. Surgical treatment of gynecomastia.
68. Treatment of hyperhidrosis (excessive sweating).
69. Any service for which You are responsible under the terms of this Contract to pay a Copay, Coinsurance or Deductible, and the Copay, Coinsurance or Deductible is waived by any Participating Provider.
70. Human Growth Hormone for children born small for gestational age. It is only a Covered Health Service in other situations when allowed by Us through Prior Authorization.
71. Complications directly related to a service or treatment that is a Non-Covered Health Service under this Contract because it was determined by Us to be Experimental/Investigational or non Medically Necessary. Directly related means that the Health Service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
72. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
73. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
74. Treatment of telangiectatic dermal veins (spider veins) by any method.
75. Reconstructive Health Services except as specifically stated in Section 3.19 of this Contract, or as required by law.

76. Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
77. Non-preventive medical nutritional therapy from a Non-Participating Provider.
78. Health Services from a Non-Participating Provider, except as specified elsewhere in this Contract.

Section 4.2 Experimental/Investigative Health Services Exclusion. We do not provide Coverage for any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the Health Service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply satisfies any or all of the following listed below.

- Cannot be legally marketed in the United States without the final approval of the FDA, or other licensing or regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any Health Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Health Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

- The scientific evidence is conclusory concerning the effect of the Health Service on health outcomes,
- The evidence demonstrates the Health Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects,
- The evidence demonstrates the Health Service has been shown to be as beneficial for the total population for whom the Health Service might be proposed as any established alternatives, and
- The evidence demonstrates the Health Service has been shown to improve the net health outcomes of the total population for whom the Health Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

Off-Label Drug Treatment. Coverage for a Drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

~~(8)~~(1) The Drug is recognized for treatment of the indication in at least one standard reference compendium.

~~(9)~~(2) The Drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the Drugs' use to be contraindicated or the Drug has not been approved by the FDA for any indication.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof, or

- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Documents of an IRB or other similar body performing substantially the same function, or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Medical records, or
- The opinions of consulting Providers and other experts in the field.

Article 5

PREMIUM PAYMENT

Section 5.1 Premium Rate. Your Premium rate is determined using the following acceptable rating factors: age, tobacco use, family size, and geography.

[Your][An Enrollee's] tobacco use impacts the determination of [Your][the] Premium rate. Upon enrollment, You will attest to [Your][an Enrollee's] tobacco use. If You report false or incorrect information to Us [or the Exchange] about [Your][an Enrollee's] tobacco use upon enrollment, We may retroactively apply the appropriate tobacco rating factor to [Your][the] Premium as if the correct information had been accurately reported from the Effective Date for Coverage.

Section 5.2 Payment of Premium. The Subscriber is responsible for paying the Premium to Us on a monthly basis. The first Premium is due and payable on the Effective Date of this Contract. Subsequent Premium payments are due and payable on or before the first day of each month thereafter that this Contract is in effect. Payment must be made on or before each due date. Even if You have not received a bill from Us, You are still obligated to pay, at a minimum, the amount of the prior bill. A service charge in the maximum allowable amount under law will be charged for any non-sufficient check used to pay the Premium.

Section 5.3 Adjustments to Premium. We reserve the right to change the Premium annually. You will receive 30 days notice of any change in Premiums.

Section 5.4 General Grace Period. Following payment of the initial Premium, a Grace Period of one (1) month shall be granted for the payment of any Premium. This Grace Period shall not extend beyond the date this Contract terminates. During the one (1) month Grace Period this Contract shall continue in force.

Any claims incurred and submitted during the grace period will not be considered for payment until Premium is received. If Premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of Coverage.

[Section 5.5 Three-Month Grace Period for Subscribers Receiving Advance Payments of the Premium Tax Credit.
For [a Subscriber][or Enrollee] receiving advance payments of the premium tax credit who has previously paid at least one full month's premium during the benefit year, a Grace Period of three (3) consecutive months shall be granted for the payment of any Premium.

During this 3-month Grace Period, We shall do all of the following listed below.

(1) Pay all claims for Covered Emergency and Health Services rendered to [the Subscriber][an Enrolled Dependent] during the first month of the Grace Period and may pend claims for Covered Emergency and Health Services rendered to the Subscriber in the second and third months of the Grace Period.

(2) Notify the Department of Health and Human Services of such non-payment.
(3) Notify Participating Providers of the possibility for denied claims when a Subscriber is in the second and third months of the Grace Period.

During this 3-month Grace Period, We shall do all of the following listed below.
(1) Continue to collect advance payments of the premium tax credit on behalf of the Subscriber from the Department of Treasury.
(2) Return advance payments of the premium tax credit on the behalf of the Subscriber for the second and third months of the Grace Period if the Subscriber exhausts the grace period.]

Section 5.6 Payment upon Termination. If Premium has been paid for any period of time after the termination date, We will refund that Premium to You. The refund will be for the period of time after Your Coverage ends. Also, if an [Enrollee][Enrolled Dependent] dies while this Contract is in force, We will refund the Premium paid for any period after the month~~date~~ of the [Enrollee's][Enrolled Dependent's] death to You or Your estate for that [Enrollee][Enrolled Dependent].

Article 6

PROCEDURES FOR OBTAINING HEALTH SERVICES

Our authorization does not guarantee Coverage for the Health Service or procedure reviewed. Benefits of this Contract are determined in accordance with all of the terms, conditions, limitations, and exclusions.

Section 6.1 Selection of a Primary Medical Provider. We require the designation of a Primary Medical Provider (PMP). You have the right to designate any PMP who is a Participating Provider in Your Service Area and who is available to accept [You and Your Enrolled Dependents][an Enrollee]. Until You make this designation, We will designate a PMP for You. For information on how to select a PMP, and for a list of PMPs in Your Delivery System, contact the customer service telephone number on the back of your I. D. Card or refer to the provider directory on Our website, www.mdwisemarketplace.org. [For Children, you][You] may designate a pediatrician as the PMP.

[You do][An Enrollee does] not need Preauthorization or a referral from Us or from any other person (including a PMP) in order to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetrics or gynecology. The Participating Provider, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services or following a pre-approved treatment plan. For a list of Participating Providers who specialize in obstetrics or gynecology, contact the customer service telephone number on the back of your I.D. Card or refer to Our website, www.mdwisemarketplace.org.

Section 6.2 Preauthorization. The Health Services listed below do not require Preauthorization.
(A) Emergency Services.
(B) Preventive Services provided by a Participating Provider.

A Provider that provides [You][an Enrollee] with Emergency Services may not charge You except for an applicable Copay or Deductible.

All other Health Services must be made through Your PMP. [Your][An Enrollee's] PMP will determine whether Preauthorization is required. The following is a list of Health Services that require Preauthorization. This list is not exhaustive.
(A) Elective/Urgent Inpatient Admissions.
  (1) Medical.
  (2) Surgery.
  (3) Sub-acute rehabilitation and skilled nursing facility.
  (4) Inpatient behavioral health and substance abuse.
(B) Observation stay.

(C) Skilled nursing facility services.
(D) Hospice Care – Inpatient and Outpatient.
(E) Hysterectomy.
(F) Transplantation evaluations and procedures/surgery.
(G) Reduction mammoplasty surgery
(H) Reconstructive services/plastic surgery/potentially Cosmetic Procedures.
(I) Home Health Care Services.
(J) MRI, MRA, CT scans and PET scans.
(K) All Non-Participating Provider services.
(L) Durable Medical Equipment and supplies greater than $500 (total per ~~item~~claim) per rental or purchase.
(M) Prosthetics greater than $500/per prosthetic.
(N) Pharmacy Services, including,
    (1) Biotech Injectables
    (2) Enteral Products
    (3) As otherwise specified on the MDwise preferred drug list.
(O) Occupational Therapy (authorization required after the initial evaluation).
(P) Physical Therapy (authorization required after the initial evaluation).
(Q) Speech Therapy (authorization required after the initial evaluation).
(R) Transportation – non-emergent.
(S) Certain ~~M~~mental disorders/substance abuse.
(T) Outpatient services, including outpatient surgical procedures and certain other procedures.
(U) Pain management programs.

Section 6.3 Health Services by Participating Providers. Health Services rendered by Participating Providers are Covered if the Health Services meet all of the following conditions.

~~(C)~~(A) Are ordered by a Participating Provider (including Health Services performed at Participating facilities),
~~(D)~~(B) Provided by or under the direction of a Participating Provider,
~~(E)~~(C) Medically Necessary, and
~~(F)~~(D) Specified as Covered by this Contract.

Section 6.4 Verification of Participation Status. You must confirm that the Provider is a Participating Provider and whether the Participating Provider is a Provider in Tier 1 or Tier 2 before receiving Health Services. This is important since this Contract is aimed at providing Coverage for Health Services rendered by Participating Providers.

You must show the Participating Provider Your I.D. card before receiving Health Services.

If You do not identify [Yourself][an Enrolled Dependent] to the Participating Provider as an Enrollee within 90 days from the date Health Services are incurred a Participating Provider may bill You for Your Health Services, and You shall be responsible for 100% of the cost of Your Health Services.

The Provider needs to know that [You are][an Enrolled Dependent] an Enrollee in order to follow Our procedures, such as Prior Authorization. If failure to show Your I.D. card results in non-compliance with Our required procedures and Coverage is denied, You shall be responsible for 100% of the cost of Your Health Services.

Section 6.5 Health Services by a Non-Participating Provider. Non-Emergency Health Services rendered by a Non-Participating Provider will be Covered in the following circumstances only.

(A) Referral to Non-Participating Providers. The Allowed Amounts of non-Emergency Health Services provided by a Non-Participating Provider shall be Covered if all of the following conditions listed below are satisfied.
    (1) The specific Health Services cannot be provided by or through Participating Providers,
    (2) The services are Medically Necessary, and
    (3) Your PMP referred You to the Non-Participating Provider.

~~You t~~The ~~n~~Non-~~p~~Participating ~~p~~Provider must obtain written approval from US, in the form of a ~~p~~Prior ~~a~~Authorization,~~referral from Us and Your PMP~~ before You receive~~receiving~~ non-Emergency Health Services ~~ordered or provided~~ by a Non-Participating Provider. If Your N~~n~~on-~~p~~Participating ~~p~~Provider does not receive ~~p~~Prior ~~a~~Authorization, You will be responsible for all costs associated with those Health Services. Additional Health Services not authorized in the original request~~referral~~ require a new authorization~~referral~~.

(B) National Committee for Quality Assurance (NCQA). Continuity of care with the Non-Participating Provider is required under current NCQA standards.

Section 6.6 Emergency Health Services. We will Cover Allowed Amounts for Emergency Health Services rendered by Participating or Non-Participating Providers. Such services must meet the requirements listed below.

(A) Provided during the course of the Emergency,
(B) Medically Necessary for evaluating and treating an Emergency condition, up to the point of Stabilization, and
(C) Provided by or under the direction of a Provider.

Health Services are not Covered if We determine that the situation was not an Emergency, as defined by this Contract.

Subsequent follow-up care by Non-Participating Providers after the condition is no longer an Emergency is not Covered without Our prior written approval.

Section 6.7 Inpatient Emergency Health Services by Non-Participating Providers. If [You are][an Enrollee is] hospitalized in a Non-Participating facility due to an Emergency, You must notify Us within 48 hours after Emergency Health Services are initially provided or as soon thereafter as is reasonably possible. You must make available full details of the Emergency Health Services received, at Our request.

Any continued stay in a Non-Participating facility after the condition is Stabilized and is no longer an Emergency (1) requires coordination by a Participating Provider, and (2) requires Our prior written authorization. We may elect to transfer You to a Participating Hospital once it is medically appropriate to do so.

Health Services rendered by Non-Participating Providers are not Covered if You (1) fail to notify Us within 48 hours of the initiation of Emergency Health Services or as soon as reasonably possible thereafter, or (2) choose to remain in a Non-Participating facility after We have notified You of the intent to transfer You to a Participating facility.

Section 6.8 Access to Health Services. Additional information on access to Health Services can be obtained through any means listed below.

(A) Our Participating Provider Directory.
(B) Our Enrollee newsletter.
(C) Our Customer Service Department at the number or website below.
1-855-417-5615~~1-800-XXX-XXXX~~
www.mdwisemarketplace.org

Article 7

PROCEDURES FOR REIMBURSEMENT OF ALLOWED AMOUNTS

Section 7.1 Identification Card ("I.D. Card").

The Subscriber[, and spouse, if applicable,] will receive an I.D. Card. The I.D. Card will identify [any Dependents

that are][each Dependent] Covered under the Contract. You may be charged a fee for additional or replacement cards.

Information on Your I.D. Card is needed for the Participating Provider to bill Us. *You must show Your I.D. Card every time You request Health Services[for an Enrolled Dependent]*. If You do not show the I.D. Card, Participating Providers have no way of knowing that [You are][the Dependent is] an Enrollee.

When failure to show an I.D. Card results in non-compliance with required procedures, Coverage may be denied.

Section 7.2 Participating Provider Services. We pay [Your] Participating Providers for [Your][an Enrollee's] Covered Health Services. You may be responsible for paying the Participating Provider for any applicable Copays, Coinsurance, or Deductibles included under this Contract. Please refer to the Schedule of Benefits for any applicable Deductible, Coinsurance or Copay information.

Section 7.3 Procedures for Health Services Received from Non-Participating Providers. If [You receive][an Enrollee receives] Health Services from a Non-Participating Provider, the rules below apply for claims submitted by You or by a Non-Participating Provider on Your behalf.

Claim Forms. You can locate Our claim forms on Our website, www.mdwisemarketplace.org, or You can notify us of a claim and ~~w~~We will mail You Our claim forms. If ~~y~~You do not receive Our usual claim forms within fifteen (15) days of this request, You may file a claim without them. The claims must contain written Claim Documentation.

Notice of Claim**.** You must inform Us of the claim within thirty (30) days of the date the Covered Health Service began or as soon as reasonably possible.

Claim Documentation. You must send ~~u~~Us written Claim Documentation within one hundred and eighty (180) days of the date the Covered Health Service began or as soon as reasonably possible. Claim Documentation furnished more than one (1) year late will not be accepted, unless You had no legal capacity in that year.

Cooperation By You. You or Your representative must fully cooperate with Us in determining Our rights and obligations under this Contract. You must cooperate as often as may be reasonably necessary. This means You or Your representative must do all of the following items, as requested.

(1) Sign, date and deliver to Us authorization to obtain any medical or other information, records, or documents We deem relevant from any person or entity.
(2) Give Us, or Our representatives, any medical or other information, records or documents ~~w~~We deem relevant.
(3) Answer, under oath or otherwise, any questions We deem relevant, which We or Our representative may ask.
(4) Furnish any other information, aid or assistance that We may require, including without limit, assistance in communicating with any person or entity (including requesting any person or entity to promptly give Us, or Our representative, any information, records or documents requested by Us).

If You or Your representative fails to give any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by Us unless and until We receive the item or information or You do the action ~~w~~We have requested, subject to the terms and conditions of this Contract.

In addition, failure on Your part or on the part of Your representative, to give ~~u~~Us any of the items or information requested or to take any action requested may result in the denial of Your claims.

Payment of Claims. Any payment made by Us in good faith under this Section shall fully discharge Our obligation to the extent of the payment. We reserve the right to deduct any overpayment made under this Contract from any future benefits payable under this Contract.

Foreign Claims Incurred for Emergency Care. Claims incurred outside the United States for Emergency Care and treatment must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper Claim Documentation.

Assignment. We will reimburse a Hospital or Provider if You assign in writing [Your][an Enrollee's] health insurance benefits, and We approve the assignment. Any assignment to a Hospital or Provider providing treatment, whether with or without Our approval, shall not confer upon such Hospital or Provider any right or privilege granted to You under this Contract except for the right to get benefits, if any, that We have determined are due and payable.

Physical Examination and Autopsy. We shall have the right and opportunity to examine [You][an Enrollee} while a claim is pending or while a dispute over a claim is pending. These examinations are made at Our expense and as often as We may reasonably require. We also have the right to have an autopsy made where the law does not prohibit it.

Legal Action. You may not bring any suit on a claim until at least sixty (60) days after the required Claim Documentation is given. You may not bring any suit more than three (3) years after the date Claim Documentation is required.

Section 7.4 Filing a Claim for Non-Participating Provider Services. If You need to file a claim under the procedures identified in Section 7.3, submit Your claim to the address below. The claim forms are ~~also~~ available on our website, www.mdwisemarketplace.org.

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

Be sure Your claim includes all of the information listed below.

~~(B)~~(A) Your name and address.
~~(C)~~(B) Patient's name, date of birth, and Enrollee I.D. number (shown on Your I.D. card).
~~(D)~~(C) Name and address of the Non-Participating Provider of services.
~~(E)~~(D) Diagnosis from the Provider.
~~(F)~~(E) Bill which gives a CPT code, or description of each charge.
~~(G)~~(F) Date the Injury or Sickness began.

Some claims may require more information before being processed. Benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

Section 7.5 Coverage through Non-custodial Parent. Whenever a Child under the age of 18 is an Enrolled Dependent under this Contract through a [Subscriber that is a] non-custodial parent, We shall, upon the custodial parent's written request do all of the following.

(A) Provide any information to the custodial parent that is necessary for the child to obtain benefits through this Contract.
(B) Permit the custodial parent, or the Provider with the custodial parent's approval, to submit claims for Covered Health Services without the non-custodial parent's approval.
(C) Pay claims submitted by the custodial parent or the Provider in accordance with (B) above, directly to the custodial parent or Provider.

Section 7.6 Payment of Claims. We shall pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for Your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. Claims submitted by Providers are also governed by Indiana Code § 27-13-36.2.

Article 8

GRIEVANCE PROCEDURES

Section 8.1 Who May File. You or Your Designated Representative may file any of the following.

(A) A Grievance.
(B) An Appeal.
(C) A request for an External Appeal.

In each of these review processes, Your notice to Us is considered to be filed on the date We first receive it orally or in writing.

Detailed information on how to submit all of the above may be found in this Contract, on Our website, in newsletters, and in medical management determination letters sent to Enrollees when a Health Service is denied. At least annually in a newsletter, We notify Enrollees about the Grievance and Appeal process and the availability of External Appeals.

Neither You nor Your Designated Representative will be subject to retaliation from Us for exercising Your rights to any of the review processes described in this Article. Also, We may not take any action against a Provider solely on the basis that the Provider represents You in any of the review processes described in this Article.

Section 8.2 Internal Grievance ~~Claim~~ Procedure. The MDwise Customer Service Department is responsible for the processing of Grievances. All Grievances are thoroughly researched and documented, and as necessary, are referred for resolution beyond the Customer Services Department. You may file a Grievance in writing or by calling MDwise Customer Service directly and a Customer Service representative will assist You in filing the Grievance.

We must receive Your request to initiate the Grievance process within 180 days from the date We provide You an initial notice of denial. We will acknowledge Your Grievance, orally or in writing, within three business days of Our receipt of it.

In Your Grievance, You should express Your concerns in detail and provide copies of any supporting documents. You should provide us with the following information:

(A) Your Name [and the patient's name]
(B) [The patient's] Date of Birth
(C) Date of Grievance
(D) Type of Grievance
(E) Summary of the substance of the Grievance
(F) Summary of the actions taken.

We will document the substance of the Grievance and any actions taken.

You are permitted to review the Grievance claim file and to present evidence and testimony as part of the internal claims and appeals process.

The MDwise Customer Service Representative appointed to Your Grievance will conduct a thorough investigation of the facts of Your Grievance, including any aspects involving critical care, and make a decision regarding it. Other Providers or individuals We employ may be consulted before the decision is made.

Our decision regarding Your Grievance must be made as soon as possible. We will notify you in writing no later than

(A) 15 days after the date Your Grievance was filed, for a Pre-service ~~Claim~~Grievance, and

(B) 20 business days after Your Grievance is filed, for a Post-service ~~Claim~~Grievance, when the issue is resolved and inform You of Your right to Appeal Our decision. If Your Grievance is considered an Urgent Grievance~~Care Claim~~ or Concurrent Care Claim, We will follow the timing requirements outlined in Sections 8.3 and 8.4 respectively.

If We are not able to make a decision by the applicable deadline due to reasons beyond Our control We will notify You in writing of the reason for the delay not more than 14 days after the date Your Grievance was filed, for a Pre-service ~~Claim~~Grievance, and not more than 19 business days after Your Grievance is filed, for a Post-service ~~Claim~~Grievance. We shall also issue You a written notification of the resolution of Your Grievance not more than 10 business days after notifying You of the reason for delay.

If We do not receive from You all of the information necessary to complete the review of Your Grievance, You will be afforded an extension of at least 45 days within which to provide ~~the~~ Us with the specified information. We will resolve Your Grievance not more than ~~2~~10 business days after We receive such necessary information.

We will provide You with any new or additional evidence considered, relied upon, or generated by Us in connection with the claim, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date. Before We issue a final decision based on a new or additional rationale, We will provide You with the rationale, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date.

We will notify You in writing of the resolution of the grievance within 5 business days after the resolution.

If You are not satisfied with Our decision regarding Your Grievance, You have the right to file an Appeal with Us as set forth in Section 8.5 of this Contract.

Section 8.3 Urgent Grievance~~Care Claim~~ Procedure. If You are not satisfied with a decision We made either before or after You have filed a Grievance and Your situation meets the requirements of an Urgent Grievance~~Care Claim~~, You have the right to use this Urgent Care procedure. Once identified as such, an Urgent Grievance~~Care Claim~~ will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

Your Urgent Grievance~~Care Claim~~ may be expressed to Us orally or in writing and should set forth all issues, comments, or other documented evidence that support it. We will treat Your Urgent Grievance~~Care Claim~~ pursuant to the procedure described in Section 8.2 and Section 8.4, except that We will shorten the time limits as follows.

We will acknowledge Your Urgent ~~Care Claim~~Grievance within 24 hours (and include any request for additional information, if appropriate).

We will decide Your Urgent ~~Care Claim~~Grievance as soon as possible, but no later than 72 hours after the receipt of the initial request for the Urgent Grievance~~Care Claim~~. You will receive written or electronic notification of Our decision. We may notify You of Our decision orally, provided that a written or electronic notification is furnished to You no later than 3 days after the oral notification.

If You do not provide sufficient information for Us to determine whether or to what extent the benefits You seek are Covered or payable under the Contract, We will notify You within 24 hours of the specific information that You must submit for Us to answer Your Claim.

If You are notified that You need to provide additional information, You will have at least 48 hours in which to provide the additional information. We shall notify You of Our decision no later than 48 hours after We receive the requested information. If You do not provide the requested information, We shall notify You of Our decision no later than 48 hours after the end of the time that You were given to provide the information.

Section 8.4 Concurrent Care ~~Claim~~ Procedure. If We reduce or terminate a Concurrent Care plan or course of treatment (other than by amending the Contract) before the end of the originally approved period of time or number

of treatments, You will be notified sufficiently in advance of the reduction or termination to allow You to file a Grievance and Appeal of the decision before the benefit is reduced or terminated.

If Your request to extend a particular course of treatment beyond the period of time or number of treatments involves an Urgent Grievance~~Care Claim~~,

(A) We will notify You of Our decision as soon as possible, taking into account the medical exigencies, and
(B) We will notify You of Our determination, whether adverse or not, within 24 hours of Our receipt of Your request, provided that Your request was made to Us at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Section 8.5 Internal Appeal Procedure. If You are not satisfied with Our decision regarding Your Grievance, You have the right to submit an Appeal to Us within 180 days of Our decision regarding Your Grievance. You may file an appeal in writing or You may call MDwise Customer Service directly and a Customer Service Representative will assist You in filing the Appeal. We will acknowledge Your Appeal, orally or in writing, within three business days of Our receipt of it.

We will continue to provide You with Coverage under this Contract pending the outcome of the Appeal.

You may request continuation of Health Services during the Appeal process if an authorized Health Service is being terminate, reduced or suspended before the expiration of the original authorization date. Pre-service authorization requests and re-authorization request after a number of approved number of days, services, or visits expired do not apply. In the event of request for Concurrent Care Claim reviews beyond original authorization, You and Your provider will be notified of the Appeals process, as indicated in Section 8.4.

We will document the substance of the Appeal and the actions taken.

Your representative may act on Your behalf with respect to requesting an Appeal and the procedures involved. We allow You the opportunity for representation by anyone You choose, including a provider or attorney. For Urgent ~~Care Claim~~Grievance Appeals, a health care practitioner with knowledge of Your condition may act as Your representative.

We will investigate the substance of the Appeal, including any aspects of clinical care involved.

Our Appeal Committee (the Committee) will resolve the Appeal. The Committee shall be comprised of qualified individuals who were not involved in the investigation or resolution of the Grievance or involved in the matters giving rise to it. If the Appeal concerns health care procedures, treatments, or services that have been proposed, refused, or delivered, the Committee shall include one or more individuals who meet all of the following requirements

(A) Have knowledge of the Health Services at issue.
(B) Are in the same licensed profession as the Provider who proposed, refused or delivered the Health Service at issue.
(C) Are not involved in the matter giving rise to the appeal or the previous Grievance process.
(D) Do not have a direct business relationship with You or with the Provider who recommended the Health Service at issue.

You or Your Designated Representative may (A) appear in person before the Committee, or (B) communicate with the Committee through appropriate other means, if unable to attend in person.

You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

To support Your Appeal, You should submit to the Committee any written issues, arguments, comments, or other documented evidence. The Committee shall review all findings and pertinent documents, including any aspects of clinical care, whether or not We have considered them previously. The Committee will not afford any special deference to the original denial of Your Grievance. In no event shall Your claim that was previously denied under the terms of the Contract and upheld by an Appeals ruling be reconsidered by the Committee for review.

The Committee's decision regarding Your Appeal will be made as soon as possible and with regard to the clinical urgency of the Appeal, but not later than

(A) 30 days after the Appeal was filed, for Pre-Service ~~Claims~~Grievances.
(B) 45 days after the Appeal was filed, for Post-Service ~~Claims~~Grievances.

The Committee's decision regarding Your Appeal of an adverse benefit determination for an Urgent Grievance~~Care Claim~~ will be made not later than 72 hours after the receipt of Your request for review.

~~We will notify You in writing of the Committee's decision within 5 business days after it is decided.~~

Section 8.6 External Review of Grievances. You may pursue an External Appeal if You are not satisfied with Our Appeal decision. An Independent Review Organization ("IRO") is available for Appeals that involve an Adverse Determination of the following:

(A) a Medically Necessary Service,
(B) a Utilization Review Determination, or
(C) the experimental or investigational nature of a proposed Health Service, or
(D) a decision to rescind Your Contract

If Your Appeal did not involve one of the above three areas, You are not entitled to an External Appeal. Requests for excluded benefits or exceeded benefits are not eligible for External Appeal. [Also, if You are a Medicare recipient and have a right to an external review under Medicare (42 U.S.C. 1395 *et seq.*, as amended from time to time), there is no right to request an External Appeal.]

If Your situation qualifies, You or Your representative must file a written request for an External Appeal with Us no later than 120 days after You receive notice of the Appeal decision.

You may not file more than one External Review appeal grievance.

You shall not be subject to retaliation for exercising Your right to an External Review.

You are permitted to utilize the assistance of other individuals, including providers, attorneys, friends, and family members throughout the External Review process.

You are permitted to submit additional information relating to the proposed Health Service as issue throughout the External Review process.

You are required to cooperate with the IRO by providing or authorizing the release of any necessary medical information that We have not already provided.

We shall cooperate with the selected IRO by promptly providing any information requested by the IRO.

You may request an Expedited Appeal if Your External Review is of a Grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize Your life or health, or Your ability to reach and maintain maximum function. If You request an Expedited Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 72 hours after Your Expedited Appeal is filed, and
(B) notify You within 24 hours of after making the determination.

If Your External Review is a Standard Grievance Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 15 business days after the Standard Grievance Appeal, and
(B) notify You within 72 hours of making the determination.

An Expedited External Review can occur concurrently with the Appeals process for Urgent Care and Concurrent Care Claims.

When making its determination, the IRO shall apply,
(A) standards of decision making that are based on objective clinical evidence, and
(B) the terms of Your Contract.

You shall not pay any of the costs associated with the services of an IRO. All of the costs must be paid by Us.

We shall notify You of the IRO's decision within 2 business days of receiving it, including the basis/rationale for the decision.

The IRO's decision in an External Appeal is binding on Us, but You may have other legal remedies.

After You have received notification of the IRO's determination regarding Your External Review, You may request the IRO provide You with all information reasonably necessary to enable You to understand the,
(A) effect of the determination on You, and
(B) manner in which We may be expected to response to the IRO's determination.

We will authorize or provide disputed services promptly, and as expeditiously as Your health condition requires if the services were not furnished while the Appeal was pending and at any level reverses a decision to deny, limit or delay services.

Section 8.7. Suspension of the External Review Process. The External Appeal process will be suspended if the information You submit during the External Appeal is relevant to Our decision, and was not previously reviewed by Us during the Grievance or Appeal stages.

During the suspended External Review process, We will reconsider the new information You presented to Us and notify You of Our decision within the relevant timeframe listed below.
(A) 15 business days after the new information is provided to Us for a Standard Grievance Appeal, or
(B) 72 hours after the new information is provided to Us for an Expedited Appeal Grievance.

If We uphold the Grievance Appeal decision, You may request that the External Appeal resume.

Section 8.8 Contact Us. Questions regarding Your policy or Coverage should be directed to Our address, telephone number or website listed in this Section.

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423
www.mdwisemarketplace.org
1-855-417-5615

Section 8.9 Indiana Department of Insurance. If You need the assistance of the governmental agency that regulates insurance, or have a complaint You have been unable to resolve with Your insurer, You may contact the Department of Insurance by mail, telephone or email the Indiana Department of Insurance at the contact information provided for in this Section.

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

Consumer Hotline – (800) 622-4461, (317) 232-2395

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

Section 8.10 Indiana Medical Malpractice Act. The review procedures described in this Article do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

Article 9

RENEWABILITY AND TERMINATION

Section 9.1 Renewability and Termination of Contract. We must renew or continue in force this Contract at Your option. We may terminate or refuse to renew this Contract only for the following reasons.

(A) Non-payment of premium, subject to the notice and Grace Periods defined in this Contract.
(B) We rescind coverage based upon fraud or an intentional misrepresentation of material fact made by You under the terms of the Contract.
(C) We receive a written request from You to terminate this Contract as provided in Section 9.6.
(D) [We receive notice from the Exchange that] [You][all Enrolled Dependents] are no longer eligible for coverage [under this Contract][through the Exchange].
(E) You obtain coverage from another [~~c~~Qualified ~~h~~Health ~~p~~Plan through the Exchange][health plan] during an Open Enrollment period or a Special Enrollment period.
(F) [Our status as a Qualified Health Plan for the Exchange is terminated by the Exchange.]
(G) You no longer reside or live in Our Service Area.
(H) Death [of the Subscriber].

Section 9.2 Discontinuance of a Particular Type of Contract. We may discontinue a particular contract if We do all of the following.

(A) We provide You with written notice at least 90 days before the date the contract form will be discontinued.
(B) We offer You the option to purchase any other individual contract We currently offer.
(C) We act uniformly without regard to any health status-related factor of Enrollees or [Dependents of Enrollees] that may become eligible for Coverage.

Section 9.3 Discontinuance of All Coverage. We may discontinue all contracts in the individual market in Indiana if We do all of the following.

(A) We provide You and the Indiana Department of Insurance with written notice at least 180 days before the date Your Coverage will expire.
(B) We discontinue and do not renew all Contracts We issue or deliver for issuance in the State of Indiana in the individual market.
(C) We act uniformly without regard to any health status-related factor of Enrollees or Dependents of Enrollees that may become eligible for Coverage.

Section 9.4 Exception for Uniform Modification of Coverage. We may, at the time of renewal, modify this Contract if the modification is consistent with the laws of the state of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

Section 9.5. Notice and Effective Date of Termination. We shall provide You with written notice of our intent to terminate or not renew this Contract. This notice will identify the date upon which Your Coverage will cease. This date will be referred to as the "Effective Date of Termination".

Our notice to the Subscriber shall be deemed as notice to [the Subscriber's Enrolled Dependents][each Enrolled Dependent] and is sufficient if mailed to the Subscriber's address as it appears in Our records. Notice is effective when deposited in the United States mail with first class postage prepaid.

Termination of this Contract shall not prejudice any claim for Health Services rendered before the Effective Date of Termination. All requests for reimbursement, however, must be furnished as provided in Article 7.

Section 9.6 Process for Termination of Coverage By Written Request of Subscriber. You may terminate this Contract or Coverage for an Enrollee under this Contract with reasonable notice to [the Exchange or] Us. Reasonable notice is defined as fourteen (14) days prior to the requested Effective Date of Termination.

If You provide reasonable notice, the Effective Date of Termination is the date specified in Your notice. If You do not provide reasonable notice, the Effective Date of Termination is fourteen (14) days after We receive Your termination request, or an earlier date specified by Us if we are able to effectuate termination in fewer than fourteen (14) days.

If an Enrollee is newly eligible for Medicaid, the Children's Health Insurance Program for the state of Indiana, or the Basic Health Plan for state of Indiana (if such a plan is implemented), the Effective Date of Termination is the day before such coverage begins.

Section 9.7 Process for Termination of Coverage [Due to Loss of Eligibility].

~~(D)~~(A) **[Process for Termination of Coverage] When the [Enrolled Dependent] [Subscriber] is No Longer Eligible for Coverage [Under this Contract][Through the Exchange].** In the case of termination due to a [Subscriber][an Enrolled Dependent] no longer being eligible for Coverage [under this Contract][through the Exchange], the Effective Termination Date is the last day of the month following the month in which [the Subscriber loses eligibility][notice is sent to Us by the Exchange], unless the [Subscriber][Enrolled Dependent] requests an earlier Effective Termination Date.

~~(E)~~(B) **[Process for Termination of Coverage When a Dependent is No Longer Eligible Under the Contract**. In the case of termination due to a Dependent no longer being eligible for Coverage under this Contract, the Effective Termination Date is the last day of the month following the day in which the Dependent loses eligibility.]

Section 9.8 Process for Termination of Coverage Due to Non-Payment of Premiums. In the case of termination due to non-payment of premiums by a Subscriber subject to the general Grace Period identified in Section 5.3 of this Contract, the Effective Date of Termination will be the earliest date of the last paid date of Coverage if (1) the Grace Period expires and any Premiums remain unpaid, or (2) We receive written notice of termination from the Subscriber during the Grace period

[In the case of termination due to non-payment of premiums by a Subscriber subject to the 3-month Grace Period identified in Section 5.4 of this Contract, the Effective Date of Termination will be on the last day of the first month of the three-month Grace Period. The [Subscriber][Enrolled Dependent] will receive notice of termination of Coverage no later than thirty (30) days prior to this Effective Date of Termination.]

Section 9.9 Process for Termination of Coverage When the [Subscriber][Enrolled Dependent] Changes to Another [Qualified Health Plan][Health Plan] During an Open Enrollment Period or Special Enrollment Period. In the case of termination due to a [Subscriber][Enrolled Dependent] changing to another [Qualified Health Plan][health plan] during an Open Enrollment period or Special Enrollment period, the Effective Date of Termination under the Contract shall be the day before the Effective Date of coverage in the [Subscriber's][Dependent's] new [Qualified Health Plan][health plan].

Section 9.10 Continued Inpatient Hospital Benefits. We will continue inpatient Hospital benefits for [a Covered Person][an Enrollee] if (1) We terminate this Contract, and (2) [the Covered Person][an Enrollee is hospitalized for a medical or surgical condition on the Effective Date of Termination. Such continued benefits shall end on the earliest of the dates specified in (A) through (E) below.

(A) The date [the Covered Person][an Enrollee] is discharged from the Hospital.
(B) The date [the Covered Person][an Enrollee] is covered under other health coverage if that coverage covers the inpatient hospital benefits.
(C) Sixty (60) days after the date this Contract ends.
(D) The last day the required Premium has been paid, if the grace period expires and the Subscriber has not made the required payment.
(E) The date the Subscriber terminates Coverage for the Subscriber and any Enrolled Dependents.

This section does not apply if this Contract ends due to Our receivership.

[**Section 9.11. Extended Coverage for Disabled Children.** Coverage for a Child may continue beyond age 26 if all of the following factors exist.

(A) The Child is incapable of self-sustaining employment due to a mental or physical disability.
(B) The Child is primarily dependent upon the Subscriber for support and maintenance.
(C) We receive written proof of such incapacity and dependency from a Participating Provider, that is acceptable to Us, within 120 days of the Child reaching the age of 26.

This extended Coverage will continue so long as the Child remains so incapacitated and dependent, unless Coverage is otherwise ended by the terms of this Contract.

We may require proof from a Participating Provider that is satisfactory to Us of the Child's continued incapacity and dependency.]

Section 9.12 Reinstatement. If [Your][this] Contract was terminated for non-payment of Premium, You may request reinstatement of the Contract from [Us][the Exchange] within 30 days of the Effective Date of Termination. You must remit all premium that was due for the Coverage upon reinstatement. Upon receipt of the outstanding Premium [and notice from the Exchange][-or Us,] We will reinstate Coverage as of the Effective Date of Termination.

Article 10

RECOVERY SOURCE/SUBROGATION

Section 10.1 Recovery Source. The following persons or entities are collectively referred to as a Recovery Source or Recovery Sources.

(A) Any person alleged to have caused the Enrollee to suffer Sickness, Injuries or damages,
(B) The employer of the Enrollee, or
(C) Any person or entity obligated to provide benefits or payments to the Enrollee. This includes, but is not limited to, underinsured or uninsured motorist protection and liability insurance.

Section 10.2 Recovery. An amount owed by a Recovery Source pursuant to a settlement, judgment, or otherwise.

Section 10.3 Our Rights to Reimbursement, Recovery, and Subrogation. If You obtain a Recovery from a Recovery Source for a Sickness or Injury or other condition for which You have received Health Services, then We will not Cover such Health Services to the extent of such recovery. However, if We Covered such Health Services the conditions listed below apply.

(A) You shall reimburse Us immediately from a collected Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) Other costs incurred in obtaining or collecting the Recovery,
  regardless of whether or not that collected amount fully compensates You.
(B) For a Recovery not yet collected, You grant to Us a first priority lien against such Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) other costs incurred in obtaining and eventually collecting the Recovery,
  regardless of whether or not the Recovery fully compensates You. We may give notice of such lien to the Recovery Source. You also assign to Us any benefits that You may have under any car insurance policy or other sources in order to enforce Our rights under this Article.
(C) We are subrogated to Your rights to seek a Recovery from a Recovery Source under any legal or equitable theory that You could assert against that Recovery Source. At Our option, We may bring a lawsuit against

the Recovery Source in Your name or take, in Our sole discretion, such other necessary and appropriate action to preserve or enforce Our rights under this Article.

(D) You grant to Us a first priority lien against any Recovery We obtain under this subsection, whether or not You are fully compensated by the Recovery, to the extent of 100% of the Covered Health Services and Our reasonable costs, including attorneys fees, of pursuing and collecting the Recovery.

All Recoveries will be deemed as compensation for Covered Health Services regardless of how the Enrollee or the Enrollee's legal representative defines it.

We shall be responsible only for those legal fees and expenses relative to Your Recovery to which We agree in writing.

If the Sick or Injured Enrollee is a minor, any Recovery shall be subject to this Article to the extent permitted by applicable law, regardless of whether such Enrollee's parent, trustee, guardian, or other representative has access to or control of the Recovery.

The Enrollee agrees that acceptance of Covered Health Services is constructive notice of this Article in its entirety and constitutes full consent to it.

Section 10.4 Your Full Cooperation Required. In order to protect Our rights under this Article, You shall cooperate by doing all of the actions listed below.

~~(C)~~(A) Hold any collected Recovery in trust for Our benefit under this Article.

~~(D)~~(B) Notify Us of a claim or suit against a Recovery Source within 60 days of the action and of a proposed settlement at least 30 days before it is entered. You shall not, without Our written approval, accept any settlement that does not fully compensate or reimburse Us. If You fail to notify Us in accordance with this section, We shall not be obligated to cover the Health Services that provide a basis for the claim, suit or settlement.

~~(E)~~(C) Execute and deliver such documents as We may reasonably request including, but not limited to, documents to protect and perfect Our liens, to affect an assignment of benefits, and to release records.

~~(F)~~(D) Provide Us, or any party acting on Our behalf, any facts We need to subrogate the claim in a timely manner, but not more than one year after Our initial request for information or You will be responsible for any incurred claims.

~~(G)~~(E) Provide such other cooperation and information as We may reasonably request including, but not limited to, responding to requests for information about an accident, Sickness or Injuries and making court appearances.

~~(H)~~(F) Not prejudice Our rights.

Article 11

Coordination of Benefits

Section 11.1 Applicability. This Coordination of Benefit ("COB") section applies when an Enrollee has Coverage for Health Services under more than one "Plan," as defined below. The Order of Benefit Rules in Section 11.3 determines whether the benefits of this Contract are determined before or after those of another Plan. If the Order of Benefit Rules determines that this Contract is the "Primary Plan," as defined below, then the benefits of this Contract will not be reduced. If the Order of Benefit Rules determines that this Contract is the "Secondary Plan," as defined below, then the benefits of this Contract may be reduced.

Section 11.2 Definitions. The following definitions apply throughout this Article 11, but do not apply to the rest of the Contract:

(A) "**Allowable Expense**" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the

claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(B) "**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this COB provision or a similar provision takes effect.

(C) "**Plan**" means this Contract and any of the following arrangements that provide benefits or services for, or because of, medical or dental care or treatment:

(1) Employer insurance or Employer-type coverage, whether insured or uninsured. This includes prepayment, Employer practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
(3) Each arrangement described in (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(D) "**Plan Year**" means, for the initial Plan Year, the twelve-month period commencing with the date that Employer's coverage under this Contract becomes effective. Thereafter, it means the twelve-month period commencing on the anniversary of Employer's Coverage under this Contract.

(E) "**Primary**" or "**Primary Plan**" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If this Contract is Primary to another Plan, this Contract's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(F) "**Secondary**" or "**Secondary Plan**" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If this Contract is Secondary to another Plan, this Contract's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

Section 11.3 Order of Benefit Rules.

General. If there is a basis for benefits under this Contract and another Plan, this Contract is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those of this Contract, and (2) the rules of this Contract and the other Plan require this Contract to be the Primary Plan.

Specific Rules. The following rules will be applied in the order they appear to determine whether this Contract is Primary or Secondary to another Plan:

(1) Non-Dependent or Dependent. The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) Dependent Child or Parents not Separated or Divorced. If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(3) Dependent Child or Separated or Divorced. If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:

a. the Plan of the parent with custody of the Child is Primary;
b. the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and
c. the Plan of the parent without custody of the child is the last Plan to be Primary.

If a QMCSO states that a parent is responsible for the health care expense of a child, that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(4) Joint Custody. If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph (2), Dependent Child or Parents not Separated or Divorced will apply.

(5) Active or Inactive Employee. A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(6) Dependent of Active or Inactive Employee. A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) Continuation Coverage. If an individual has Continuation Coverage under this Contract and also has coverage under another Plan as an employee or dependent, the other Plan is Primary to this Contract. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) Longer or Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

Section 11.4 Effect on the Benefits of this Contract. Section 11.4 applies when the Order of Benefit Rules in Section 11.3 determine that this Contract is Secondary to one or more other Plans.

This Contract's benefits will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under this Contract in the absence of this COB provision; and
(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of COB provisions like this Contract's COB provisions, whether or not a claim is made.

The benefits of this Contract will be reduced so that they and the benefits payable under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this Contract.

Section 11.5 Facility of Payment. If another Plan provides a benefit that should have been paid or provided under this Contract, We may reimburse the Plan for the benefit. We may then treat the amount as if it were a benefit provided under this Contract and will not be responsible for providing that benefit again. This provision applies to the payment of benefits as well as to providing services. If services are provided, then We will reimburse the other Plan for the reasonable cash value of those services.

Section 11.6 Right of Recovery. If this Contract provides a benefit that exceeds the amount of benefit it should have provided under the terms of these COB provisions, We may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following.

(1) The individuals We have paid or for whom We have provided the benefit;
(2) Insurance Companies; or
(3) Other Organizations.

Article 12

GENERAL PROVISIONS

Section 12.1 Entire Contract. The Contract, the Appendix, and any Amendments make up the entire Contract of Coverage between You and Us.

All statements made by the Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce Coverage under this Contract or be used in defense of a legal action unless it is contained in the Application.

Section 12.2 Limitation of Action. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought unless brought within 3 years from the date the cause of action first arose.

[The Enrollee's][Your] damages shall be limited to recovery of actual benefits due under the terms of this Contract. [The Enrollee waives][You waive] any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

Section 12.3 Amendments and Alterations. No agent has authority to change this Contract or to waive any of its provisions. No person has authority to make oral changes to this Contract.

We will give You 60 days advance notice before any material modifications to this policy, including changes in preventive benefits.

Section 12.4 Relationship Between Parties. The relationships between MDwise and Participating Providers are ***solely*** contractual relationships between a payor (MDwise) and independent contractors (Participating Providers). Non-Participating Providers have no contractual relationship with Us, nor are they Our independent contractors.

Providers are not Our agents or employees. We and Our employees are not employees or agents of Providers.

The relationship between a Provider and any Enrollee is that of Provider and patient. The Provider is ***solely*** responsible for the services provided to any Enrollee. The Participating Pharmacy is ***solely*** responsible for the pharmacy services provided to any Enrollee.

Section 12.5 Second Opinion Policy. A second opinion may be required at Our discretion prior to the scheduling of certain Health Services. We will advise You if a proposed Health Service is subject to the second opinion policy. If so, You must consult with a second Participating Provider prior to the scheduling of the service.

You must (1) contact Us to obtain a list of Participating Providers who are authorized to render a second opinion, and (2) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first

Provider.

You must obtain the second opinion within 31 days of the first opinion or as soon thereafter as is reasonably possible. Second opinions We have arranged as described above are provided at no cost to You.

A second opinion may also be obtained at the request of an Enrollee, subject to separate benefit restrictions and/or Copays/Coinsurance described elsewhere in this Contract.

Section 12.6 Wellness and Cost Containment Programs. We may implement wellness or cost containment programs for Enrollees. Such programs may Cover services and supplies that would not otherwise be Covered. Such programs are in Our sole discretion. They may be discontinued at any time without prior approval from other parties.

Section 12.7 Confidentiality of Non-Public Personal Information. As required by the Gramm-Leach-Bliley Financial Services Modernization Act of 1999, We provide You with notice that We protect the nonpublic personal information that We receive about You and Your Dependents. We obtain certain nonpublic information about You through this Contract. This includes information from You on Applications or other forms, and information about Your transactions with Us, Our affiliates, or others. We have always been committed to maintaining the confidentiality of Your information and we take the following steps to protect our nonpublic personal information

(A) We restrict access to information to authorize individuals who need to know this information in order to provide services and products to You or relating to Your Contract.
(B) We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard Your information.
(C) We do not disclose this information about You or any former customers, except as permitted by law.
(D) We make disclosures to affiliates, as applicable, as permitted by law.

Section 12.8 Confidentiality of Medical Information
By accepting Coverage, You authorize and direct any person or institution that has attended, examined, or treated You to furnish Us any and all related information and records. Such must be provided to Us at any reasonable time, upon Our request.

We and Our designees have the right to any and all records concerning Health Services as necessary to accomplish any of action listed below.

(A) To implement and administer the terms of this Contract,
(B) For appropriate medical review or other quality assessment, or
(C) For purposes of health care research.

Any information We obtain that pertains to Your diagnosis, treatment or health is confidential. We shall not disclose such information to any person except to fulfill Our obligations as described above, or as required by state or federal law.

Examples of when We may release such information as required by law are listed below.

(A) Upon Your express written consent.
(B) When a Child under the age of 18 is an Enrolled Dependent through a custodial parent, non-custodial parent, step-parent or legal guardian, except when the minor child has lawfully obtained Covered Health Services without the consent or notification of a parent or legal guardian.
(C) Under a statute or court order for the protection of evidence or the discovery of evidence, in the event of litigation between You and MDwise in which the information is pertinent.

We may claim any legal right against disclosure of the information that the Provider who supplied it may claim.

Section 12.9 Records. The Subscriber shall furnish Us with all information and proof that We may reasonably require with regard to any matters pertaining to this Contract.

The following items shall be open for Our inspection at any reasonable time (1) all documents furnished by an Enrollee in connection with the Coverage, and (2) any other records pertinent to Coverage under this Contract.

Both MDwise and Participating Providers may charge You reasonable fees to cover costs for completing medical abstracts or for other forms which You request.

Section 12.10 Examination of Enrollees. We may reasonably require that You be examined if a question or dispute about the provision of or payment for Health Services arises. The exam will be performed by a Participating Provider acceptable to Us. We will pay for the exam.

Section 12.11 Typographical or Administrative Error. Typographical or administrative errors shall not deprive an Enrollee of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

Section 12.12 Right of Recovery. If We pay for Health Services or benefits that, according to the terms of the Contract, should not have been paid, We reserve the right to recover such amounts from [You}[~~the~~ an Enrollee], the Provider to whom they have been paid, or any other appropriate party.

Section 12.13 Notice. Our notice to the Subscriber is deemed notice to all Enrolled Dependents. Such notice includes notice of termination of this Contract.

Our notice is sufficient if mailed to the Subscriber's address shown in Our records at the time of the mailing. Notice is deemed delivered when deposited in the United States mail with first class postage prepaid, unless otherwise stated in this Contract.

Any notice from You concerning this Contract must be sent to Our address listed in this Section.

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

Section 12.14 Contract is Not Worker's Comp Insurance. The Coverage provided under the Contract does not replace, supplement or provide a substitute for benefits to which an Enrollee is entitled under worker's comp, occupational disease, and similar laws.

The Contract does not Cover Health Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's comp, occupational disease and similar laws, even when the circumstances below are present.

~~(E)~~(A) If the Enrollee's employer is not properly insured or self-insured under such laws.
~~(F)~~(B) When an Enrollee refuses to use his or her employer's designated Provider.
~~(G)~~(C) When an Enrollee has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

An Enrollee must contact his employer or its worker's comp or occupational disease insurer for the provision or payment of such Health Services and expenses.

Section 12.15 Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on its Effective Date shall apply.

Any Contract provision which, on this Contract's Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

Section 12.16 Non-Discrimination. In compliance with state and federal law, We shall not discriminate on the basis of age, gender, color, race, disability, marital status, sexual preference, religious affiliation, or public assistance status.

We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are

written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care.

We shall not, with respect to any person and based upon any health factor or the results of Genetic Screening or Testing (1) refuse to issue or renew Coverage, (2) cancel Coverage, (3) limit benefits, or (4) charge a different Premium.

Section 12.17 General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within Our control (1) We will Cover Health Services as provided in this Contract to the extent that facilities and personnel are then available, and (2) We shall have no liability or obligation for delay or failure to provide Health Services due to lack of available facilities or personnel.

[**Section 12.18 Medicare.** Any Health Services Covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare, We will calculate benefits as if they had enrolled.

The benefits under this Contract for Enrollees age 65 and older or Enrollees otherwise eligible for Medicare do not duplicate any benefit for which Enrollees are entitled under Medicare, except when federal law requires Us to be the primary payor.

Where Medicare is the primary payor, all sums payable by Medicare for Health Services provided to Enrollees shall be reimbursed by or on behalf of the Enrollees to Us to the extent We have made payment for such Health Services.]

MDwise ~~Silver 87%~~[BENEFIT PLAN] Schedule of Benefits

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copays, maximums and other limits that apply when You receive Covered Health Services from a Provider. Please refer to the "Benefits and Covered Health Services" article of this Contract for a more complete explanation of the specific Health Services Covered by the Contract. All Covered Health Services are subject to the conditions, exclusions, limitations, terms and provisions of this Contract including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Enrollee's responsibility for Covered Health Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Health Services must be provided by a Participating Provider. Services provided by Non-Participating providers are Not Covered and the cost of services will be Your responsibility unless otherwise specified in this Contract.

Coinsurance and Deductibles, as well as any maximums, are calculated based upon the Allowed Amount, not the Provider's charge.

Under certain circumstances, if We pay the Provider amounts that are Your responsibility, such as Deductibles, Copays or Coinsurance, We ~~may~~ will collect such amounts directly from ~~You~~ the ~~p~~Provider who will in turn collect them from you. You agree that ~~We~~ the ~~p~~Provider has~~ve~~ the right to collect such amounts from You.

Essential Health Benefits provided within this Contract are not subject to lifetime or annual dollar limitations. Certain non-Essential Health Benefits, however, may be subject to either lifetime and/or annual dollar limitations.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories.

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services and chronic disease management, and
- Pediatric vision services.

Such benefits shall be consistent with those set forth under the ACA and any regulations issued pursuant thereto.

BENEFIT PERIOD – Calendar Year
DEPENDENT AGE LIMIT – Until the Child attains age 26
CONTRACT SERVICE AREA: _____

MDWISE MARKETPLACE ~~"SILVER 87%"~~[BENEFIT PLAN]

DEDUCTIBLE		
	Tier 1	**Tier 2**
Per Enrollee	~~$250~~[$0-$5,500]	~~$1,500~~[$0-$6,600]
Per Family	[$0-$11,000]~~$750~~	~~$4,500~~[$0-$13,200]

The amounts paid toward the Tier 1 Deductible are concurrent with and apply toward the Tier 2 Deductible. The Deductible applies to all Covered Health Services except for office visits for primary care physicians and ~~all specialist visits~~, Generic drugs, and preventive care. Copays do not apply toward the Deductible. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Deductible.

OUT-OF-POCKET LIMIT		
	Tier 1	**Tier 2**
Per Enrollee	~~$1,250~~[$0-$6,600]	~~$2,200~~[$0-$6,600]
Per Family	~~$2,500~~[$0-$13,200]	~~$4,400~~[$0-$13,200]

The Out-of-Pocket Limit includes all Deductibles, Copays and Coinsurance amounts You incur in a Benefit Period. The amounts paid toward the Tier 1 Out-of-Pocket Limit are concurrent with and apply toward the Tier 2 Out-of-Pocket Limit. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Out-of-Pocket Limit. Once the Enrollee and/or family Out-of-Pocket Limit is satisfied, no additional Copays/Coinsurance will be required for the Enrollee and/or family for the remainder of the Benefit Period.

Any amounts that You are responsible for paying for Health Services rendered by a Non-Participating Provider are separate from and do not apply to the Deductible and Out-of-Pocket Limits.

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Ambulance Services	~~$200 Copay per transport~~[$0-$500]Copay Per Transport	~~$200 Copay per transport~~[$0-$500] Copay Per Transport	$200 Copay per transport
Behavioral Health Services			
Inpatient Services	[0%-35%]~~5%~~ Coinsurance	~~20%~~[0%-50%] Coinsurance	Not Covered without Prior Authorization
Outpatient Services	~~$20~~[$0-$90] Copay per visit	~~$40~~[$0-$150] Copay per visit	Not Covered without Prior Authorization
Physician Home Visits & Office Services	[$0-$90] ~~$20~~ Copay per visit	$40 Copay per visit	Not Covered without Prior Authorization
Dental Services (only when related to accidental injury or for certain Enrollees requiring general anesthesia)	$100 Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	$100 Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Diabetic Equipment, Education, & Supplies	Copays / Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the "Specialty Care" or "Primary Care Provider" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.		Not Covered without Prior Authorization
Diagnostic Services			
Laboratory and Pathology Services	~~$20~~[$0-$75] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	~~$40~~[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Radiology Services including MRI, CT, PET, Ultrasound	~~$75~~[$0-$300] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	~~$150~~[$0-$400] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
X-Ray Services	~~$20~~[$0-$75] Copay per visit Copays/Coinsurance may change based on setting where the	~~$40~~[$0-$150] Copay per visit Copays/Coinsurance may change based on setting	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
	Covered Health Services are received.	where the Covered Health Services are received.	
Emergency Room Services Copay/Coinsurance is waived if You are admitted.	~~$100~~[$0-$750] Copay per visit	~~$100~~[$0-$750] Copay per visit	~~$100~~[$0-$750] Copay per visit
Home Care Services	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Annual Visit Limitation for Home Care	90 visits, combined Tier 1 and Tier 2 Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 90 visits
Annual Visit Limitation for Private-Duty Nursing	82 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 82 visits

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Lifetime Visit Limitation for Private-Duty Nursing	164 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 164 visits
Hospice Services	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Inpatient and Outpatient Professional Services	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Inpatient Facility Services	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Annual Limitation for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2 combined limitation of 60 days
Annual Limitation for Skilled Nursing Facility	90 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2 combined

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			limitation of 90 days.
Mammograms (Outpatient – Diagnostic & Routine)	For Mammogram Health Services recommended by the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF, see the "Preventive Care Services" provision in this Schedule. For all other Mammogram Health Services, see the "Diagnostic Services" provision in this Schedule.		Not Covered without Prior Authorization
Maternity Services	Copays/Coinsurance may change based on setting where the Covered Health Services are received.		Not Covered without Prior Authorization
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Participating Pharmacy)	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
	Note – Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are Covered the same as any other Medically Necessary items and Health Services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract. **Note –** If durable medical equipment or appliances are obtained through Your Primary Care Physician or another Participating Physician's office, Urgent Care Center Services, Outpatient Services, Home Care Services the Copay/Coinsurance listed above will apply		

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
	in addition to the Copay/Coinsurance in the setting where Covered Services are received.		
Outpatient Services			
Other Outpatient Services	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
	Note – Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copay/Coinsurance regardless of setting where Covered Services are received.		
Outpatient Surgery Hospital/Alternative Care Facility	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Physician Home Visits and Office Services			
Primary Medical Provider (PMP)	$~~5~~ 0 Copay per visit PMP visits are not subject to the Deductible	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any Provider that is not Your chosen (or assigned) PMP is	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any Provider that is

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
		considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.	not Your chosen (or assigned) PMP is considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.
Specialty Care Physician (SCP)	~~$20~~[$0-$90] Copay per visit	~~$40~~[$0-$150] Copay per visit	Not Covered without Prior Authorization
	Note – Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations Covered under "Preventive Care Services" in the Contract) received in a Physician's office are subject to the Other Outpatient Services Copay / Coinsurance.		
Allergy Services ~~Injections~~	[$0-$90] ~~$50~~ Copay if visit~~per injection~~	[$0-$150] ~~$50 Copay per injection~~Copay if visit	Not Covered without Prior Authorization
	[0%-35%] Coinsurance for Serum	[0%-50%] Coinsurance for Serum	Not Covered without Prior Authorization
	~~**Note –** Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations Covered under "Preventive Care Services" in the Contract) received in a Physician's office are subject to the Other Outpatient Services Copay / Coinsurance.~~ ~~The allergy injection Copay /~~Coinsurance will be applied to allergy serum when the injection(s) is billed by itself. The office visit Copay~~/Coinsurance~~ will apply if an office visit is billed with an allergy injection. No Copay if injection administered by a nurse.		
Preventive Care	No Copay	No Copay	Not Covered

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Services			without Prior Authorization
Surgical Services	[0%-35%]~~5%~~ Coinsurance	[0%-50%] ~~10%~~ Coinsurance	Not Covered without Prior Authorization
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	~~$20~~[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] ~~$40~~ Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Therapy Services	~~$20~~[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] ~~$40~~ Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
	Note – If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.		

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
Annual Visit Limitation ~~(Includes both Rehabilitative and Habilitative Services)~~			
Physical Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Occupational Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Speech Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			toward Tier 1 and Tier 2 combined limitation of 20 visits
Manipulation Therapy	12 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 12 visits
Cardiac Rehabilitation	36 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 36 visits
Pulmonary Rehabilitation	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Urgent Care Center Services	[$0-$100]~~$40~~ Copay per visit	~~$80~~[$0-$200] Copay per visit	Not Covered without Prior

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			Authorization
~~Allergy Injections~~	~~$50 Copay per injection~~	~~$50 Copay per injection~~	~~Not Covered without Prior Authorization~~
	~~**Note** – Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center are subject to the Other Outpatient Services Copay / Coinsurance.~~ ~~The allergy injection Copay / Coinsurance will be applied when the injection(s) is billed by itself. The Urgent Care Center visit Copay / Coinsurance will apply if an Urgent Care Center visit is billed with an allergy injection.~~		
Pediatric Vision			
Pediatric Eyewear	No Copay	Not Available	Not Covered without Prior Authorization
Lenses	Limit 1 pair per year.	Not Available	Not Covered without Prior Authorization
Frame	Limit 1 per year from Pediatric Exchange collection.	Not Available	Not Covered without Prior Authorization
Contact Lenses	• Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) • Monthly (six-	Not Available	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
	month supply) = 6 lenses per eye (total 12 lenses) • Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) • Dailies (one month supply) = 30 lenses per eye (total 60 lenses)		

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following.

- **Cornea and kidney transplants, and**
- **Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Enrollee cost shares.

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES		
	Participating Transplant Provider	Non-Participating Transplant Provider
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (the number of days will vary depending on the type of transplant received and the Participating Transplant	Starts one day prior to Covered Transplant Procedure and continues to the date of discharge.

	Provider Agreement. Contact the Transplant Case Manager for specific Participating Transplant Provider information) for services received at or coordinated by a Participating Transplant Provider Facility.	
Deductible	Not applicable.	Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will not apply to Your Out-of-Pocket Limit.
Covered Transplant Procedure During The Transplant Benefit Period	During the Transplant Benefit Period, No Copay/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	During the Transplant Benefit Period, You will pay 50% of the Allowed Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Participating Transplant Provider Facility will not apply to Your Out-of-Pocket Limit. If the Provider is Non-Participating Provider for this Contract, You will be responsible for the Covered Health Services which exceed Our Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
	Participating Transplant	**Non-Participating**

	Provider Professional and Ancillary (non-Hospital) Providers	Transplant Provider Professional and Ancillary (non-Hospital) Providers
Covered Transplant Procedure During the Transplant Benefit Period	No Copay/Coinsurance up to the Allowed Amount.	You are responsible for 50% of the Allowed Amount. These charges will not apply to Your Out-of-Pocket Limit.
Transportation and Lodging	[0%-35%]~~5%~~ coinsurance Covered, as approved by the Contract, up to a $10,000 benefit limit	Not Covered for Transplants received at a Non-Participating Transplant Provider Facility
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	[0%-35%]~~5%~~ Coinsurance Covered, as approved by the Contract, up to a $30,000 benefit limit	Covered, as approved by the Contract, up to a $30,000 benefit limit. You will be responsible for 50% of search charges. These charges will not apply to Your Out-of-Pocket Limit.
Live Donor Health Services	Covered as determined by the Contract.	Covered as determined by the Contract. These charges will not apply to Your Out-of-Pocket Limit.

PRESCRIPTION DRUGS	
Days Supply Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limitation and Utilization Guidelines	
Retail Pharmacy (Participating & Non-Participating)	30
Mail Service	90
~~Retail Specialty Pharmacy (Participating & Non-Participating) and Specialty Mail Service~~Tier 4 Drugs	30* *~~See additional information in Specialty Participating Retail/Specialty Mail Service Section below.~~Some Tier 4 drugs may be available in 90 day supply via mail service.
Participating Retail Pharmacy Prescription Drug Copay/Coinsurance	
~~Generic~~ Tier 1Prescription Drugs	~~$10~~[$0-$30] Copay per Prescription Order ~~*Generic~~ Tier 1 drugs are not subject to

	the Deductible
Tier 2~~Preferred Brand~~ Prescription Drugs	~~$25~~[$0-$85] Copay per Prescription Order Tier 2 drugs are not subject to the Deductible.
~~Non-Preferred Brand Prescription~~Tier 3 Prescription Drugs	~~$50 Copay~~ [0%-35%]~~___%~~ Coinsurance per Prescription Order
~~Specialty Prescription~~ Tier 4 Prescription Drugs	~~$50 Copay~~[0%-35%]~~___%~~ Coinsurance per Prescription Order; See ~~Specialty~~ Participating Retail/Specialty Mail Service Information below.
~~Specialty Participating Retail, Including Specialty Mail Service Program, Prescription Drug Copay/Coinsurance~~	
~~Level 1 Specialty Prescription Drugs~~	~~$30 Copay per Prescription Order~~ ~~*Generic drugs are not subject to the Deductible~~
~~Level 2 Specialty Prescription Drugs~~	~~$75 Copay per Prescription Order~~
~~Level 3 Specialty Prescription Drugs~~	~~$150 Copay per Prescription Order~~
~~Level 4 Specialty Prescription Drugs~~	~~$150 Copay per Prescription Order; See Specialty Participating Retail/Specialty Mail Service Information below.~~
~~***Note** –Certain Specialty Drugs in Levels 1–3 (including but not limited to oral HIV drugs and immunosuppressant drugs) may be dispensed in up to a 90-day supply, subject to the Mail Service Copays listed above. When a 30-day supply is obtained, the Copays listed below will apply. Specialty Drugs in Level 4 are limited to a 30-day supply.~~	
Non-Participating Retail Pharmacy and Non-Participating ~~Specialty~~ Pharmacy Prescription Drug Copay	
Non-Participating Retail Pharmacy and Non-Participating ~~Specialty~~ Pharmacy Prescription Drug Copay	Not Covered without Prior Authorization
Orally Administered Cancer Chemotherapy	
Orally Administered Cancer Chemotherapy	[0%-35%]~~$50 copay~~ Coinsurance for retail; [0%-35%]~~$150~~ Coinsurance for mail order

	As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to Coverage for cancer chemotherapy that is administered intravenously or by injection.

Note – Prescription Drugs will always be dispensed as ordered by Your Physician. You may request, or Your Physician may order, the ~~Preferred Brand~~ Tier 2 or ~~Non-Preferred Brand~~ Tier 3 Drug. However, if a ~~Generic~~Tier 1 Drug is available, You will be responsible for the difference in the cost between the Tier 1~~Generic~~ Drug and ~~Preferred Brand~~ Tier 2 or ~~Non-Preferred~~Tier 3 Drug. If a ~~Generic~~ Tier 1 Drug is not available, or if Your Physician writes "Dispense as Written" or "Do not Substitute" on Your Prescription, You will ~~only~~ be required to pay the applicable ~~Preferred Brand~~Tier 2 or ~~Non-Preferred Brand~~Tier 3 Copay/Coinsurance. You will not be charged the difference in cost between the ~~Generic~~Tier 1 Drug and ~~Preferred Brand~~Tier 2 or ~~Non-Preferred Brand~~Tier 3 ~~Prescription~~ Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in Our sole discretion, to remove certain higher cost Generic Drugs from this policy.

Note – No Copay/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Allowed Amount when obtained from a Participating Pharmacy. These supplies are Covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Participating Pharmacy. Diabetic test strips are Covered subject to applicable Prescription Drug Copay/Coinsurance.]

[Individual/Child-Only/On/Off Exchange] Contract

(Herein called this Contract)

issued by

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

An Indiana Not-for-Profit Health Maintenance Organization

AGREEMENT AND CONSIDERATION

[MDwise Marketplace Plan]

MDwise Marketplace, Inc. (herein referred to as MDwise, We, Us, and Our) has issued a Contract to You [to provide coverage for a Dependent]. Persons Covered under this Contract are considered to be Enrollees of MDwise. [This Contract provides Coverage only for Enrolled Dependents. The Subscriber is never Covered under this Contract.]

This Contract sets forth in detail [Your][the] rights and obligations [of the Subscriber and Dependent] as [an][the] Enrollee. It is important that You **READ THIS CONTRACT CAREFULLY.** You should familiarize Yourself with its terms and conditions before receiving Health Services.

This Contract is made in consideration of the [Subscriber's][Enrollee's] Application [submitted through the Exchange] and payment of the required Premium. The [Subscriber's][Enrollee's] Application is made a part of this Contract by this reference.

This Contract shall take effect on the date specified below. This Contract will be continued in force by the payment of the required Premium when due, subject to the termination provisions of this Contract. We shall fund all benefits payable under this Contract.

This Contract is delivered in and governed by the laws of the State of Indiana. All Coverage under this Contract shall begin at 12:00 midnight and end at 11:59:59 p.m. Eastern Standard Time.

Information regarding this Contract may be obtained by contacting Us at: [1-855-417-5615 or www.MDwisemarketplace.org]. If the Enrollee has material modifications or questions related to their health insurance coverage, contact the [Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596].

Authorized Representative

TEN-DAY FREE LOOK

The Subscriber has the right to examine this Contract for 10 days from the date You received the Contract. If, for any reason, the Subscriber does not want this Contract, he or she may return it to Us within 10 days from the date You received the Contract. The Contract will be deemed delivered when deposited in the United States mail with first class postage prepaid, or when it is personally delivered, to the address shown above. Upon return, this Contract will be deemed void and any Premium will be refunded. Any Health Services received during this 10-day period are solely the responsibility of the Subscriber if the Contract is deemed void. In making this decision, You should review the enrollment date restrictions of the Open Enrollment to identify any conditions for enrolling in a different Qualified Health Plan.

[DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for

individuals with low to modest incomes through Advance Payment Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for health insurance coverage issued through the Indiana Marketplace. Please be advised that this Contract does not qualify for these affordability programs because it is not issued through the Indiana Marketplace.]

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FOREWORD

Introduction

The [Subscriber and] Enrolled Dependents, [if any], are Enrollees of MDwise. [You][Enrollees] will be Covered as provided by this [Individual][Child-Only] Contract. (Referred to herein as this Contract.)

This Contract replaces and supersedes any Contract that We may have previously issued to the Subscriber [or Enrollee]. This Contract is an individual product and is not subject to the Employee Retirement Income Security Act of 1974, as amended.

How To Use This Contract

This Contract must be read in its entirety for a clear meaning. Many of its provisions are interrelated. You may get a false impression if You read just one or two provisions.

Certain terms used in this Contract are defined. Defined terms will be capitalized in this Contract. The meaning of defined terms should be taken into account in interpreting this Contract.

This Contract may be amended from time to time. When that happens, We will send You a new Contract or Amendment pages for this Contract. Keep this Contract in a safe place for Your future reference.

Obtaining Health Services

As an Enrollee You must obtain Health Services directly from Participating Providers. The only exceptions are those listed below.

(A) Emergency Health Services, and

~~(A)~~(B) Health Services that meet all 3 requirements below:

(1) are not available through Participating Providers

~~(1)~~(2) have been recommended by a Participating Provider, and

~~(2)~~(3) We have approved in advance through written Prior Authorization.

You are responsible for verifying the participation status of a Provider before receiving Health Services.

If You fail to check a Provider's participation status as required and as a result use a Non-Participating Provider (1) the Health Services, other than Emergency Services, will not be Covered, and (2) You will be responsible for paying for such services.

The participation status of a Provider may change from time to time. So it is important that You check the status each time before receiving Health Services.

We can give You the information You need in order to locate a Participating Provider. You can verify a Provider's participation status by contacting Us or by referencing Our provider directory at www.mdwisemarketplace.org.

Except for Emergency Health Services, Your Provider is responsible for obtaining a Prior Authorization before receiving any Health Services from a Non-Participating Provider. A Prior Authorization to a Non-Participating Provider must be initiated in writing by that Provider and approved in writing by Us prior to the time of the service. ***Your providers failure to obtain the required Prior Authorization will result in the Health Services not being Covered. You will be responsible for paying for such services. It is your responsibility to confirm that the appropriate authorization was obtained prior to services.***

Coverage for some Health Services is subject to Our prior written approval. Non participating and Participating Providers are responsible for obtaining Our Prior Authorization for such services on Your behalf.

Contact Us

Your satisfaction as an Enrollee is very important to Us. Please contact Us if You have a question or concern about Your Coverage or procedures You must follow. You can reach Our Customer Service Department during normal business hours at [1-855-417-5615, or www.MDwisemarketplace.org.]

Article 1

DEFINITIONS

This Article defines the terms used throughout this Contract. It is not intended to set forth Covered or Non-Covered Health Services.

"Adverse Benefit Determination" – a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Enrollee's eligibility to participate in the Contract, as well as any rescission of Coverage under this Contract or any decision to deny Coverage in an initial eligibility determination.

"Allowed Amount" – Reasonable and Customary Charges for Health Services incurred while Coverage is in effect.

"Affordable Care Act" or "ACA" - the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.

"Alternate Facility" - a Non-Hospital health care facility that, pursuant to the law of the jurisdiction in which treatment is received provides one of the following.

A. One (1) or more of the following on an outpatient basis surgical services, Emergency Health Services, rehab services, lab services, diagnostic services, or
B. Provides on an inpatient or outpatient basis Behavioral Health and Mental Health Services or Chemical Dependency Services, if Covered under the Contract.

An Alternate Facility may include an attachment to a Hospital but does not include a Provider's office.

"Appeal"- an oral or written request for Us to change Our decision regarding a Grievance or a claims dispute.

"Autism Spectrum Disorder" - a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Health and Mental Health" - a physical or behavioral condition having an emotional or psychological origin or effect. Behavioral Health and Mental Health includes behavioral or emotional disorders as well as chemical dependency.

"Brand Name Drug" - a prescription drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

"CMS" - the Centers for Medicare and Medicaid Services.

"Calendar Year" - January 1 through December 31 of any given year.

"Chemical Dependency" - alcoholism and chemical or drug dependency.

"Child" – child of the Subscriber or Subscriber's spouse, including the following listed below.

1) Natural child,
2) Stepchild,
3) Legally adopted child,
4) Child placed for the purpose of adoption, or
5) Child placed under legal guardianship or legal custody.

"CHIP" – the Children's Health Insurance Program, as implemented by the Federal Balanced Budget Act of 1997.

"Claim Documentation" – information required by Us to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, Explanation Of Benefit (EOB)/Explanation Of Payment (EOP) medical bills or records, other Contract information, and network repricing information.

"Coinsurance" - a percentage of the Allowed Amount that You must pay for certain covered Health Services. (See also Copay.)

"Confinement" and **"Confined"** - an uninterrupted stay following formal admission to a Hospital, Inpatient Transitional Care Unit, or Alternate Facility. Confinement and Confined refer to inpatient care.

"Contract" – this Contract that includes the Application [of the Subscriber][for Coverage] and any amendments to this Contract signed by Our executive officer. Such items constitute the entire agreement regarding the benefits, exclusions and other conditions between MDwise and the Subscriber.

"Contract Month" - calendar month.

"Copays" or **"Copay"** - a dollar amount that You must pay directly to a Provider for certain Covered Health Services. Such dollar amount is in addition to the Premium. (See also Coinsurance.)

"Cosmetic Procedures" - procedures that improve physical appearance but do not correct or materially improve a physical function. Cosmetic Procedures include, but are not limited to, drug treatment, plastic surgery, and nutritional procedures and treatments.

"Cover" - pay for Health Services to the extent they are Covered under this Contract.

"Coverage" or **"Covered"** - Your right to payment for Health Services, subject to the terms, conditions, limitations and exclusions of this Contract.

"Covered Person" or **"Enrollee"** - the Subscriber or an Enrolled Dependent, but only while the person is Covered under this Contract. References to You and Your throughout this Contract are references to a Covered Person or Enrollee.

"Custodial Care"- Non-health-related services such as assistance in activities of daily living or health-related services that do not seek to cure, are provided when the medical condition of the Enrollee is not changing, and do not require administration by skilled, licensed medical personnel.

"Deductible" - the amount an Enrollee must pay in a Calendar Year for Covered Health Services before We will pay. Copays do not apply toward the Deductible. Coinsurance does apply toward the Deductible.

"Delivery System" - a defined group of Participating Providers, linked through a contract to each Delivery System, which supply a full range of Health Services. The Delivery System contracts with Us to provide Health Services to Enrollees who have selected the Delivery System for providing and coordinating all Covered Health Services.

Your PMP's Delivery System will be Your Delivery System. Your Delivery System may be referred to throughout this Contract as "Tier 1" and the Delivery System that is not Your Delivery System, may be referred to as "Tier 2."

"Dental Care" - all services provided by or under the direction of a Dentist. Such services include preventive care and all other care of the teeth and the surrounding tissues, correction of a faulty meeting of the teeth, and surgical procedures that involve the hard or soft tissues of the mouth.

"Dentist" - any Provider, D.D.S., or medical dentistry, D.M.D., who is duly licensed and qualified to provide Dental Care under the laws of the jurisdiction in which treatment is received.

"Dependent" - a person who is [either the Subscriber's legal spouse or] a Child until he or she attains age [26][21].

"Designated Representative"- an individual You have appointed to assist or represent You with a Grievance, Appeal or External Appeal. This person may include, but not be limited to Providers, attorneys, friends or family members. You must identify Your Designated Representative to Us in writing in order to prevent the disclosure of Your medical information to unauthorized persons.

"Designated Transplant Facility" - a Hospital or Alternate Facility that has entered into an agreement with or on Our behalf to render Health Services for Covered transplants. The facility may or may not be located within Our Service Area.

"Durable Medical Equipment" or "DME" - medical equipment that meets the following requirements.

(A) Can withstand repeated use and is not disposable,
(B) Is used to serve a medical purpose,
(C) Is generally not useful to a person in the absence of a Sickness or Injury,
(D) Is appropriate for use in the home, and
(E) Is the most cost-effective type of medical apparatus appropriate for the condition.

"Effective Date"- the date when Your Coverage begins under this Contract.

"Effective Date of Termination" - the date when Your Coverage ends under this Contract.

"Eligible [Subscriber][Dependent]" – an individual who satisfies the eligibility requirements to enroll as a [Subscriber][Dependent], as set forth in Article 2 of this Contract.

"Emergency" - a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to do any of the following.

(A) Place an Enrollee's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(B) Result in serious impairment to the Enrollee's bodily functions, or
(C) Result in serious dysfunction of a bodily organ or part of the Enrollee.

"Enrolled Dependent"[or "Enrollee"] – a Dependent who is enrolled for Coverage under this Contract.

"Enrollee" – a person who is enrolled for coverage under this Contract.

"Essential Health Benefits" – those benefits identified by CMS as Essential Health Benefits and included in the benchmark plan identified by the state of Indiana.

"Experimental, Investigational or Unproven" - services, treatments, supplies, drugs, devices or procedures We have determined to be any one or more of the following at the time a Coverage determination for any particular case is made.

(A) Considered by any government agency or subdivision or the CMS Medicare Coverage Issues Manual to be experimental, investigational, not reasonable and necessary, or any similar finding. Government agencies and subdivisions include, but are not limited to the U.S. Food and Drug Administration and the Agency for Healthcare Research and Quality.
(B) Not covered under Medicare reimbursement laws, regulations, or interpretations, on the basis that such are experimental, investigational, unproven, not reasonable and necessary, or any similar finding.
(C) Not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use.
(D) Not identified as appropriate for the proposed use in the American Hospital Formulary Service, the U.S. Pharmacopoeia Dispensing Information, or the American Medical Drug Evaluations.
(E) Subject to review and approval by any institutional review board for the proposed use.
(F) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the U.S. Food and Drug Administration regulations (regardless of whether the trial is actually subject to U.S. Food and Drug Administration oversight).

(G) Not demonstrated through prevailing peer reviewed medical literature to be safe and effective for treating or diagnosing the condition for which it is proposed.

Determinations regarding whether a particular service, treatment, supply, drug, device or procedure is considered to be Experimental, Investigational or Unproven are made by Our Medical Director under Our procedural guidelines.

"External Appeal" - a voluntary Appeal process in which an Internal Review Organization reviews certain Appeal decisions We made and determines whether to uphold or reverse them.

"FDA" - the United States Food and Drug Administration.

["Federally Facilitated Exchange" or "Exchange" - the health benefit exchange established by the Affordable Care Act for the state of Indiana. You can reach the Exchange at the following toll free number, email, website or mailing address.

Health Insurance Marketplace
200 Independence Ave. SW
Washington, DC 20201
www.healthcare.gov
1-800-318-2596]

"Formulary" - a list of Prescription Drugs that We prefer for dispensing to Enrollees. We will review and change the list from time to time.

"Genetic Screening or Testing" - a laboratory test that is a direct test of a person's genes or chromosomes to detect abnormalities or defects.

"Grace Period" - applicable period of time identified in Sections 5.4 and 5.5

"Grievance" - an oral or written complaint submitted in accordance with Our formal Grievance procedure by the Enrollee or on behalf of the Enrollee regarding any aspect of Our organization relating to the Enrollee.

"Health Services" - medical or health care services, whether or not Covered under this Contract, which include but are not limited to medical evaluation, diagnosis, treatments, procedures, drugs, therapies, devices, and supplies.

"Home Health Care Services" - Health Services provided by a Home Health Agency authorized to provide such services under the law of the jurisdiction in which treatment is received.

"Hospice Care Agency" - an agency or organization that meets all of the requirements listed below.

(A) Is certified to render Hospice Care,
(B) provides twenty-four hour care, seven days a week,
(C) is under the direct supervision of a Participating Provider, and
(D) maintains written records of the services provided.

"Hospice Care or Services" - a program of care that meets all of the requirements listed below.

(A) Is provided by a licensed Hospice Care Agency,
(B) focuses on palliative rather than curative treatment, and
(C) provides supportive measures to an Enrollee with a prognosis of less than six months to live.

"Hospice Facility"– a facility that is licensed and operated in accordance with the law of jurisdiction in which treatment is received, and provides twenty-four (24) hour nursing services.

"Hospital" - an institution that meets all of the requirements listed below.

(A) Is operated under the law,
(B) is primarily engaged in providing Health Services on an inpatient basis,
(C) provides for the care and treatment of injured or sick people,
(D) has medical, diagnostic and surgical facilities,

(E) is operated by or under the supervision of a staff of Providers,
(F) has 24-hour nursing services, and
(G) is licensed as a Hospital in the jurisdiction in which it operates.

A Hospital is not primarily a place for rest, Custodial Care, or care of the aged. A Hospital is not an Inpatient Transitional Care Unit, nursing home, convalescent home or similar institution.

"Independent Review Organization or IRO" - an organization certified by the Indiana Department of Insurance to conduct External Appeals.

"Maternity Services" – all Health Services related to Pregnancy including all of the following listed below.
(A) Prenatal and postnatal care, including newborn hearing test,
(B) childbirth, and
(C) early termination of Pregnancy.

"MDwise" – MDwise Marketplace, Inc. references to We, Us, and Our throughout this Contract are references to MDwise.

"Medicaid" - Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs, as amended from time to time.

"Medical Director" - a licensed Provider of medicine or osteopathy appointed by Us to provide medical review of Health Services proposed or rendered for Enrollees.

"Medically Necessary" - Health Services that We have determined to be ***all*** of the following listed below.
(A) Medically appropriate and necessary to meet the Enrollee's basic health needs,
(B) the most cost-effective method of treatment and rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Health Service,
(C) consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and healthcare coverage organizations and governmental agencies,
(D) accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered at a frequency and duration considered by the medical community as medically appropriate,
(E) required for reasons other than the comfort or convenience of the Enrollee or his or her Provider,
(F) of a demonstrated medical value in treating the condition of the Enrollee, and
(G) consistent with patterns of care found in established managed care environments for treatment of the particular health condition.

The definition of Medically Necessary used in this Contract relates only to Coverage, and may differ from the way in which a Provider engaged in the practice of medicine may define Medically Necessary.

The fact that a Provider has performed or prescribed a Health Service does not mean that it is Medically Necessary. Nor does the fact that a particular Health Service may be the only option available for a particular condition mean that it is Medically Necessary. We retain the right to make all final decisions as to which Health Services are or were Medically Necessary, subject to the procedures specified in this Contract.

"Medicare" – the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended from time to time.

"Non-Covered" – those Health Services not Covered under the terms of this Contract.

"Non-Restorative Condition" - a condition where You will not (1) return to the state You were in prior to an Injury or an illness, or (2) achieve a state or perform a function(s) that never existed.

"Non-Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has not entered into an agreement with Your Delivery System or one of Our Delivery Systems.

“Open Enrollment" - an annual period [set by the Exchange] during which individuals eligible to enroll [in Qualified Health Plans] may enroll [in a Qualified Health Plan or may change Qualified Health Plans][in this Contract].

"Orthotic" - an appliance or apparatus used to support, align, or correct deformities or to improve the function of movable parts of the body, such as but not limited to braces or splints.

"Out-of-Pocket Limit" - the maximum amounts of Coinsurance and Copays an Enrollee must pay each Calendar Year for Covered Health Services. Once this limit is met, Coinsurance or Copays for such Services are not required for the rest of that Calendar Year. Amounts paid for Coinsurance, Copays and the Deductibles apply toward the Out-of Pocket Limit.

"Participating Pharmacy" - a pharmacy that has entered into an agreement with Us, or our Pharmacy Benefits Manager, to provide Prescription Drug services to Enrollees, and includes any subcontractors of such Participating Pharmacy

"Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has entered into an agreement with Your Delivery System or one of Our Delivery Systems, and includes any subcontractors of such Participating Providers.

Participating Providers within Your Delivery System are considered Tier 1 Participating Providers. Participating Providers that are not in Your Delivery System, but that are in one of Our Delivery Systems are considered Tier 2 Participating Providers.

"Physician" - a license medical provider, holding an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) degree.

"Post-service Grievance" - any Grievance that involves Health Services that have already been provided.

"Premium" - the fee We charge for each [Subscriber and] Enrolled Dependent Covered under this Contract. The Premium is paid in consideration for the benefits and services provided by Us under this Contract.

"Prescription Drug" - a drug that has been approved by the FDA, and under federal or state law can only be dispensed with a prescription. These are known as legend drugs. Prescription Drugs also include insulin, diabetic supplies, and inhaler aid devices.

"Pre-service Grievance" - a Grievance that must be decided before an Enrollee can obtain Health Services Covered under the Contract.

"Primary Medical Provider" or **"PMP"** – a Participating Provider in Your Delivery System practicing and duly licensed as a Physician in family practice, internal medicine, gynecology, obstetrics, or pediatrics, and who has agreed to assume primary responsibility for Your medical care under this Contract.

"Preauthorization" - the process of obtaining approval from Us that a Health Service, treatment plan, Prescription Drug, or DME is medically necessary prior to those services being rendered. "Preauthorization" may also be referred to as "Prior Authorization."

"Provider" - a Doctor, Hospital, Inpatient Transitional Care Unit, Home Health Care Agency, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

["Qualified Health Plan" - a health plan offered on the Exchange that satisfies the requirements set forth under the ACA (42 U.S.C. 18021(a)(1)).]

"Reasonable and Customary Charge" - the amount paid for a Health Service in a geographic area based on what

Providers in the area usually charge for the same or similar Health Service.

"Reconstructive Surgery" - any surgery incidental to any of the following listed below.

(A) An injury,
(B) A Sickness, or
(C) Congenital defects and birth abnormalities.

Reconstructive Surgery for congenital defects and birth abnormalities includes but is not limited to orthodontic and oral surgery involved in the management of cleft lip and cleft palate for an Enrollee.

Reconstructive Surgery includes the following reconstruction for a Covered mastectomy (1) all stages of reconstruction of the breast on which the mastectomy has been performed, and (2) surgery and reconstruction of the other breast to produce symmetry, in the manner determined by the attending Provider and the Enrollee to be appropriate, subject to the provisions of this Contract.

"Routine Care Costs" - the cost of Medically Necessary services related to the care method that is under evaluation in a clinical trial. The term does not include any of the following listed below.

(A) The health care service, item, or investigational drug that is the subject of the clinical trial.
(B) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
(C) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
(D) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
(E) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where a clinical trial is conducted.
(F) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
(G) A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.

"Routine Immunization" - an immunization administered to the age-appropriate general population and recommended by the (A) Centers for Disease Control and Prevention (CDC), (B) American Academy of Pediatrics, and (C) American Academy of Family Physicians.

"Semi-private Room" - a room with two or more beds in a Hospital, an Approved Inpatient Transitional Care Unit, or an Alternate Facility.

"Service Area" - the geographic area We serve, as defined in the Schedule of Benefits. For this product the "Service Area" may not include Our licensed Service Area in its entirety, as approved by the Indiana Department of Insurance.

"Skilled Nursing Care" - services from licensed nurses in Your own home or in a nursing home.

"Special Enrollment" - periods during which individuals eligible to enroll [under this Contract][in Qualified Health Plans] may enroll in [a Qualified Health Plan, or may change Qualified Health Plans][in this Contract], as a result of triggering events provided in Section 2.5 [and as determined by the Exchange].

"Stabilize" - to provide Health Services to an Enrollee in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the Enrollee's condition is not likely to occur.

This includes Emergency Health Services provided to an Enrollee in a Hospital's care setting throughout or during the following discharge, transfer to another health care facility, or transfer to the Hospital's inpatient setting.

"Subscriber" - an individual whose name is on the Contract and [is][has] enrolled [an Eligible Dependent] for Coverage under this Contract. [The term Subscriber does not include Enrolled Dependents][A Subscriber is the legal parent or legal guardian of the Enrolled Dependent. A Subscriber does not have Coverage under this

Contract].

"Urgent Care" - the treatment of an unexpected Sickness or Injury that is not life or limb threatening but requires prompt medical attention.

"Urgent Care Center" - a licensed medical service center that provides Urgent Care.

"Urgent Grievance" - a request for a Health Service that, if subject to the time limits applicable to Post-service Grievances or Pre-Service Grievances would do either of the following.

(A) Would seriously jeopardize Your life, health or ability to reach and maintain maximum function, or
(B) In the opinion of physicians familiar with Your condition, would subject You to severe pain that cannot be adequately managed unless We approve the Claim.

Once identified as such, an Urgent Grievance will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

Article 2

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Section 2.1 Eligibility of [the Subscriber] and Dependents. To be eligible to enroll as a [Subscriber\[Dependent], You must be all of the following listed below.

(A) Under age [65][21].
(B) Residing in Our Service Area.
(C) A legal resident of Indiana.
(D) Not eligible for or enrolled in Medicare, Medicaid or CHIP.
(E) Not covered by any other group or individual health benefit plan.
(F) [Eligible for Coverage on the Exchange]
(G) [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective].
(H)

[To be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the Exchange application completed by the Subscriber, and meet the definition of Dependent as well as all Dependent eligibility criteria established under this Contract and by the Exchange.]

We shall not require any person to submit to Genetic Screening or Testing, or use the results of such in determining eligibility for enrollment, inquire as to the results of Genetic Screening or Testing, or make an adverse decision against any person based on such results.

Section 2.2 Pre-Existing Conditions and Nondiscrimination. No Eligible Subscriber or Dependent will be refused enrollment based on health status, health care needs, expected length of life, quality of life, genetic information, previous medical information, disability or age.

Section 2.3 Enrollment and Effective Date for Coverage. Sections 2.4 through 2.5 provide information on how [an Eligible] Subscriber may enroll [an Eligible Dependent] in this Contract during the applicable enrollment periods [set by the Exchange] and the Effective Dates for Coverage for such enrollments. Regardless of how [an Eligible] Subscriber enrolls [an Eligible Dependent] in this Contract, enrollment is subject to Our receiving initial payment of Premium. No Coverage shall be Effective before this Contract takes effect. No Dependent shall be Covered until [You are Covered][enrolled for Coverage].

The Effective Date of this Contract is stated on Page 1.

Section 2.4 Annual Open Enrollment and Effective Date for Coverage. This Section 2.4 explains how an Eligible Subscriber enrolls[an Eligible Dependent] for Coverage during the Open Enrollment periods [set by the Exchange] and sets forth the Effective Date for Coverage for such enrollment.

(A) Enrollment during Open Enrollment. During an Open Enrollment period, an Eligible Subscriber can enroll for Coverage by submitting a completed application to [Us}[the Exchange] during Open Enrollment. [The Exchange will notify Us of Your selection and transmit to Us all of the information necessary to enroll You for Coverage.] If We do not receive the selection during Open Enrollment, the eligible person can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.

[If a person qualifies as a Dependent but does not enroll when the Eligible Subscriber first applies for enrollment, the Dependents can only enroll for Coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.]

[As stated in Section 2.1, to be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the application completed by the Subscriber and submitted to [Us][the Exchange], and meet all Dependent eligibility criteria established by Us.]

(B) Effective Dates for Coverage during Annual Open Enrollment. For applications received during any annual Open Enrollment period, Coverage will be effective [according to the dates listed below][on the date identified by the Exchange].

(1) If the selection is received by [Us][the Exchange] between the first and the fifteenth day of the Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or the first day of the following month.

(2) If the selection is received by [Us][the Exchange] between the sixteenth and the last day of the Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or the first day of the second following month.

Section 2.5 Special Enrollment and Effective Date for Coverage. This Section 2.5 explains how an Eligible Subscriber may enroll for Coverage during a Special Enrollment period [set by the Exchange] and sets forth the Effective Date for Coverage for such enrollment.

Special Enrollment period Effective Dates for Coverage depend on the type of event, the date of request for a special enrollment period, and the date of plan selection. [CMS][We] will determine enrollee eligibility for all special enrollment periods.

[For additional information on Special Enrollment period set by the Exchange and how to enroll in or change Qualified Health Plans during a Special Enrollment period, You may contact the Exchange at [1-800-318-2596] or visit the Exchange website at [www.healthcare.gov.]

(A) [Special Enrollment Triggering Events.

(1) Loss of Minimum Essential Coverage.

(2) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.

(3) Obtaining status as a United States citizen, national, or lawfully present individual.

(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.

(5) Violation of a Qualified Health Plan of a material provision of its contract.

(6) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(7) Relocation to a new service area of the Exchange.

(8) An Indian, as defined in Section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(9) Demonstration to the Exchange, in accordance with the guidelines established by the United States Department of Health and Human Services, that You or Your Dependent satisfy other exceptional circumstances provided by the Exchange.

(10) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

(A) [Special Enrollment Triggering Events.

(1) Involuntary loss of Minimum Essential Coverage for any reason other than fraud, failure to pay Premium, or misrepresentation of material fact.

(2) Loss of Minimum Essential Coverage due to dissolution of marriage.

(3) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.

(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.

(5) Violation of a Qualified Health Plan of a material provision of its contract.

(6) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(7) Relocation to a new service area of the Exchange.

(8) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

(B) New Dependents as a Result of Marriage or Loss of Essential Minimum Coverage. If [You have][the Subscriber has] a new Dependent as a result of marriage, or due to [Your][the] Dependent's loss of essential minimum coverage, [You][the Subscriber] may elect to enroll [Your][the new] Dependent in this Contract, provided [You request][the Subscriber requests] enrollment within 60 days of the date of marriage or loss of essential minimum coverage. The Effective Date for Coverage will be on the first day of the month following the date of marriage or loss of essential minimum coverage. If We receive [an application form][notification from the Exchange] to add [Your][the new] Dependent more than 60 days after this qualifying event, We will not be able to enroll that person until the next Open Enrollment period.

(C) New Dependents as a Result of Birth, Adoption, or Placement for Adoption. If You have a new Dependent as a result of birth, adoption, or placement for adoption, Your new Dependent will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption or placement for adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for Your Dependent beyond 31 days, provided You submit [an application form to Us][a form through the Exchange] to add Your Dependent to the Contract and pay the required premium. The form must be submitted to [Us][the Exchange] within 60 days after the date of birth or adoption. If the form is not submitted to [us][the Exchange] within 60 days after the date of birth or adoption, Coverage will cease on the expiration of the 31 day period provided above.

[If an Enrolled Dependent has a child as a result of birth, adoption, or placement for adoption, the Enrolled Dependent's child will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption, or placement for adoption or date of entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for the Enrolled Dependent's child beyond 31 days, provided: (1) the child is placed under legal guardianship or legal custody of the Subscriber or the Subscriber's spouse and the child otherwise satisfies the eligibility requirements to enroll as a Dependent as set forth in this Article 2; (2) the Subscriber submits a form [to Us][through the Exchange] to add the child to the Contract within 60 days after the date of birth or adoptions; and (3) the Subscriber pays the required premium.]

(D) [CHIP. Eligible Dependents may also enroll under either of the two additional circumstances identified in (1) and (2).

(1) The Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility.

(2) The Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

You must request Special Enrollment for Your Dependent within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive notification to add Your Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, We will not be able to enroll that person until the next Open Enrollment period.]

(E) Other Qualifying Events. For all other Special Enrollment qualifying events[identified by the Exchange], the Effective Date for Coverage for [You and Your] Enrolled Dependents, [if any], is determined based on the date [We receive][the Exchange] receives Your selection according to the applicable timeframes listed below.

(1) If the selection is received [by Us] [by the Exchange] between the first and the fifteenth day of the month, the Effective Date for Coverage will be of the first day of the following month.

(2) If the selection is received by [Us}][the Exchange] between the sixteenth and the last day of the month, the Effective Date for Coverage will be of the first day of the second following month.

Section 2.6 Notify Us [or the Exchange] of Eligibility Changes. The Subscriber is responsible for notifying Us [or the Exchange] in writing of any change in eligibility that affects [the Subscriber or the][any] Enrolled Dependents. We [or the Exchange] must be notified no later than 30 days from the date of the event. We have the right to bill the Subscriber for the cost of any Health Services We have paid during the period of time the person was not enrolled under the Contract.

A change in the eligibility [of the Enrolled Dependent] may be any of the following listed below.

(A) [A determination of ineligibility made by the Exchange.]
(B) [Any change with respect to the eligibility standards specified by the Exchange for which You are required to notify the Exchange.]
(C) Address change.
(D) [Marriage.
(E) Divorce.]
(F) Death.
(G) [Birth of a Dependent].
(H) [Change in disability status of a Dependent.]
(I) Dependent Child] is no longer eligible because they have reached the limiting age.

Section 2.7 Service Area Requirements. [Subscribers][Dependents] must live in Our Service Area.

Article 3

BENEFITS AND COVERED HEALTH SERVICES

Subject to the Exclusions sets forth in this Contract and the terms and conditions of this Contract, We will Cover the following Medically Necessary Health Services [for an Enrolled Dependent].

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copay, and Benefit Limitation information.

You are responsible for any fees incurred for Non-Covered Health Services.

Section 3. 1 Ambulance Services. Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians, paramedics, or other certified medical professionals from or between any of the following listed below.

- From Your home, scene of accident or medical Emergency to a Hospital,
- Between Hospitals,
- Between a Hospital and Skilled Nursing Facility, or
- From a Hospital or Skilled Nursing Facility to Your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when You are not transported will be Covered if Medically Necessary.

Ambulance services are a Covered Health Service only when Medically Necessary, except when ordered by an employer, school, fire or public safety official and the Enrollee is not in a position to refuse, or when an Enrollee is required by Us to move from a Non-Participating Provider to a Participating Provider.

Ambulance trips must be made to the closest local facility that can give Covered Health Services appropriate for Your condition. If none of these facilities are in Your local area, You are Covered for trips to the closest facility outside Your local area.

Non-Covered Services for Ambulance include any of the following.

- Trips to a Physician's office or clinic, or a morgue or funeral home.
- Ambulance usage when another type of transportation can be used without endangering the Enrollee's health.
- Ambulance usage for the convenience of the Enrollee, family or Provider.

Section 3.2 Behavioral Health and Mental Health Services.

- Inpatient services. Medical management, individual or group psychotherapy, psychological testing, family counseling with family members to assist in Your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
- Observation stays. Overnight stays in behavioral health hospital facilities that do not meet inpatient levels of Medical Necessity, but do meet observation level based on nationally accepted criteria.
- Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
- Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.

- Outpatient Treatment or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

To assist You in obtaining appropriate and quality care, We will ask Your Provider to submit a treatment plan to Us within 48 hours of an inpatient or observation level of care, or after You have had an initial outpatient evaluation and nine (9) subsequent visits in an outpatient setting. We may discuss the goals of treatment and changes in the treatment plan, including alternative courses of treatment, with Your Provider in order to manage Your benefits effectively and efficiently.

Non-Covered Behavioral Health Services include all of the following.

- Supervised living or halfway houses.
- Health Services or care provided by a residential treatment center, school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, outward bound programs, even if psychotherapy is included.
- Health Services related to non-compliance of care if the Enrollee ends treatment for Substance Abuse against the medical advice of a Provider.

Section 3.3 Dental Health Services Related to Accidental Injury. Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are Covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Treatment for pain is only Covered if it is the result of an accidental injury. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Health Services for Accidental Dental include, but are not limited to all of the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia.

Section 3.4 Other Dental Health Services. Anesthesia and Hospital charges for dental care, for an Enrollee less than 19 years of age or an Enrollee who is physically or mentally disabled, are Covered if the Enrollee requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Enrollee's condition under general anesthesia. This Coverage does not apply to treatment for temporal mandibular joint disorders (TMJ). Extraction of teeth to prepare the jaw for radiation treatment or neoplastic disease is Covered.

Routine dental care is not a Covered Health Service under this Contract.

Section 3.5 Diabetic Equipment, Education and Supplies. Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when all of the following requirements listed below are met.

- Ordered in writing by a Physician or a podiatrist.
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Health Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes pursuant to Sections 3.13, 3.16, and 3.17.

Section 3.6 Diagnostic Health Services. Diagnostic Health Services are tests or procedures performed when You have specific symptoms, to detect or monitor Your condition. Coverage for Diagnostic Health Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to those listed below.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- Computer Tomography and Computer Axial Tomography Scans (CAT).
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Health Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy necessary (e.g. intravenous dye) to perform tests are Covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Diagnostic Breast Cancer Screening Mammography. The following breast cancer screening mammography Health Services are Covered Diagnostic Health Services.

- If the female Enrollee is at least 35 years of age, she may have one (1) Covered baseline breast cancer screening mammography performed before she becomes 40 years of age.
- If the Enrollee is less than 40 years of age and is high risk, she may have one (1) breast cancer screening mammography performed every year.
- Any additional mammography views that are required for proper evaluation..
- Ultrasound services, if determined Medically Necessary by the physician treating the Enrollee.

A woman is considered "high risk" if she meets at least one (1) of the following.

(1) Has a personal history of breast cancer.
(2) Has a personal history of breast disease proven benign by biopsy.
(3) Has a mother, sister, or daughter who has had breast cancer.
(4) Is at least 30 years of age and has not given birth.

Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Diagnostic Health Service for an Enrollee under the age of fifty (50) if the Enrollee is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and

laboratory tests for cancer for any nonsympomatic Enrollee, in accordance with the current American Cancer Society guidelines.

Diagnostic Prostate Cancer Screening. If an Enrollee is at least 50 years of age, one (1) prostate specific antigen test is Covered annually. If an Enrollee is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test is Covered annually.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Section 3.7 Emergency Health Care Services. Benefits for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever You are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copay/Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, Your Physician or the Inpatient facility must seek authorization for your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, Your Provider will be notified whether the Inpatient setting is appropriate and considered Medically Necessary.If Prior Authorization is not obtained within 48 hours of your admission You may be financially responsible for Your Inpatient care.

Care and treatment provided once You are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or Stabilize Your condition in an Emergency may be Covered if We authorize the continuation of care and it is Medically Necessary. Transfer to a Participating Provider will be made available to persons receiving post-stabilization care in a Non-Participating Provider facility.

Section 3.8 Urgent Care Center Services. An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital.

Section 3.9 Home Care Services. Health Services performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Enrollee must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Health Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Services.
- Nutritional Guidance.
- Home Health Aide Services. The Enrollee must be receiving skilled nursing or therapy. Health Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Massage, Music, and Manipulation Therapy which will not be Covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

Non-Covered Home Health Care Services include the following.

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services as such services are Covered under Therapy Services.

- Helpful environmental materials such as hand rails, bath stools ramps, telephones, air conditioners, and similar services, appliances and devices.
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if Your Provider obtains prior approval from Our Home Infusion Therapy Administrator. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Section 3.10 Hospice Services. Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician and hospice medical director. Covered Health Services will continue if the Enrollee lives longer than six months, provided the hospice medical director or other hospice doctor recertifies that You are terminally ill.

Covered Hospice Services include the following list.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

Non-Covered Hospice Services include services provided by volunteers and housekeeping services.

Section 3.11 Inpatient Services. Inpatient Services include all of the following.

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for Room, Board and General Nursing Services,
- Ancillary (related) services, and
- Professional Health Services from a Physician while an Inpatient.

<u>Room, Board, and General Nursing Services</u>

- A room with two or more beds.
- A private room if it is Medically Necessary that You use a private room. You will be required to supplement the difference in cost if a private room is desired, but not Medically Necessary.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive Health Services for intensive care of critically ill patients.

<u>Ancillary (Related) Services</u>

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and Health Services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Health Services.
- Therapy Services.

Professional Health Services

Medical care visits limited to one visit per day by any one Physician.

- Intensive medical care for constant attendance and treatment when Your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a Physician who is not Your surgeon while You are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of Your condition requires the skills of separate Physicians.
- Consultation which is a personal bedside examination by another Physician when ordered by Your Physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

When an Enrollee is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copay per admission in the Schedule of Benefits is waived for the second admission.

Section 3.12 Maternity Services. Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. Maternity Services are used for normal or complicated pregnancy and ordinary routine nursery care for a healthy newborn. In order to aid in facilitating a pregnant Enrollee's prenatal care, she is required to notify Us of her pregnancy within 7 days of the date that she becomes aware that she is pregnant.

If the Enrollee is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider to have Covered Maternity Services paid at the Delivery System level. If the Enrollee is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Delivery System level if the Enrollee is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date.

Covered Maternity Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period.

If a newborn child is required to stay as an Inpatient past the mother's discharge date, the Health Services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copay.

Coverage for the Inpatient postpartum stay for You and Your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care and Postnatal Care.

Covered Maternity Services include post-delivery care visits at Your residence by a Physician or Nurse performed no later than 48 hours following You and Your newborn child's discharge from the Hospital. Coverage for this visit includes all of the following listed below.

1. Parent education,
2. Assistance and training in breast or bottle feeding, and
3. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

We will Cover an examination given at the earliest feasible time to Your newborn child for the detection of the following disorders.

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia.
- Galactosemia.
- Maple Syrup urine disease.

- Homocystinuria.
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
- Physiologic hearing screening examination for the detection of hearing impairments.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.
- HIV testing in infants exposed to HIV/AIDS.
- Pulse oximetry screening examination for the detection of low oxygen levels.

Section 3.13 Medical Supplies, Durable Medical Equipment and Appliances.

- Medical and surgical supplies –Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera and Remicade. Covered Health Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.
    - Covered Health Services include the following.
        1. Allergy serum extracts
        2. Chem strips, Glucometer, Lancets
        3. Clinitest
        4. Needles/syringes
        5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Health Services
        6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.
    - Non-Covered Health Services include the following.
        1. Adhesive tape, band aids, cotton tipped applicators
        2. Arch supports
        3. Doughnut cushions
        4. Hot packs, ice bags
        5. vitamins
        6. medijectors

- Durable Medical Equipment - The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Contract will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Health Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Enrollee, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is Covered.

    - Covered Health Services include the following.
        1. Hemodialysis equipment
        2. Crutches and replacement of pads and tips
        3. Pressure machines
        4. Infusion pump for IV fluids and medicine
        5. Glucometer
        6. Tracheotomy tube
        7. Cardiac, neonatal and sleep apnea monitors

8. Augmentive communication devices are Covered when We approve based on the Enrollee's condition.
9. CPAP machines when indicated for sleep apnea.

- Non-Covered items include the following.
  1. Air conditioners
  2. Ice bags/coldpack pump
  3. Raised toilet seats
  4. Rental of equipment if the Enrollee is in a Facility that is expected to provide such equipment
  5. Translift chairs
  6. Treadmill exerciser
  7. Tub chair used in shower.

- Prosthetics – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Health Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are Covered.

  - Covered Health Services include, the following.
    1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
    2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
    3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
    4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
    5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Enrollee selects eyeglasses and frames, then reimbursement for both lenses and frames will be Covered.
    6. Cochlear implant.
    7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
    8. Restoration prosthesis (composite facial prosthesis).
    9. Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Benefit Period).

  - Non-Covered Prosthetic appliances include the following.
    1. Dentures, replacing teeth or structures directly supporting teeth.

2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

- Orthotic Devices – The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered. The casting is Covered when an orthotic appliance is billed with it, but not if billed separately.

  - Covered Health Services for Orthotic Devices include the following.
    1. Cervical collars.
    2. Ankle foot orthosis.
    3. Corsets (back and special surgical).
    4. Splints (extremity).
    5. Trusses and supports.
    6. Slings.
    7. Wristlets.
    8. Built-up shoe.
    9. Custom made shoe inserts.
  - Orthotic appliances may be replaced once per year per Enrollee when Medically Necessary in the Enrollee's situation. However, additional replacements will be allowed for Enrollees under age 18 due to rapid growth, or for any Enrollee when an appliance is damaged and cannot be repaired.
  - Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.
  - Non-Covered Health Services for Orthotic Devices include the following.
    1. Orthopedic shoes (except therapeutic shoes for diabetics).
    2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
    3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
    4. Garter belts or similar devices.

- Prosthetic limbs & Orthotic custom fabricated brace or support –
  - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be Covered if they satisfy both requirements listed below.
    1. Determined by Your Physician to be Medically Necessary to restore or maintain Your ability to perform activities of daily living or essential job related activities, and
    2. Not solely for comfort or convenience.
  - Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the Coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.
  - Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are Covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract.

Replacements and Repairs. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be Covered, as approved by Us.

The repair, adjustment or replacement of the purchased equipment, supply or appliance is Covered if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be Covered if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

Section 3.14 Outpatient Services. Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Contract. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us.

When Diagnostic Health Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copay is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these Health Services.

Section 3.15 Autism Spectrum Disorder Services.
Coverage is provided for the treatment of Autism Spectrum Disorders. Treatment is limited to Health Services prescribed by Your Physician in accordance with a treatment plan.

- Autism Spectrum Disorder, as defined in the definition section of the Policy, means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Coverage for Health Services will be provided as prescribed by Your treating Physician in accordance with the treatment plan.
- Any exclusion or limitation in this Contract in conflict with the Coverage described in this provision will not apply.
- Coverage for Autism Spectrum Disorders will not be subject to dollar limits, Deductibles, Copay or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copays or Coinsurance provisions that apply to physical illness under this Contract.

Section 3.16 Physician Home Visits and Office Services. Covered Health Services include care provided by a Physician in their office or Your home. Refer to the Sections 3.2, 3.9, 3.12, and 3.17 for Health Services Covered by the Contract. For Emergency Care refer to Sections 3.7 and 3.8.

- Office Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copay is required.

- Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in Your home.

- Diagnostic Health Services when required to diagnose or monitor a symptom, disease or condition.

- Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

- Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Section 3.17 Preventive Care Services. Preventive Care Services include, Outpatient services and Office Services. Screenings and other Health Services are Covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

- Enrollees who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Health Services benefit.

- Preventive Care Services in this section shall meet requirements as determined by federal and state law.

- Health Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF.

Section 3.18 Routine Care Costs as Part of a Cancer or Other Life-Threatening Disease or Condition Clinical Trial. Routine Care Costs as part of an Approved Clinical Trial if the Health Services are otherwise Covered Health Services under this Contract.

An Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

1. The trial is approved or funded by one, or a combination, of the following:
    - A National Institutes Health institute.
    - A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center.
    - The United States Food and Drug Administration.
    - The United States Department of Veterans Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
    - The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
    - The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).
    - The Centers of Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare and Medicaid Services.
    - The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 C.F.R. 146.103.
    - A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.
    - A qualified non-governmental research entity in guidelines issued by the National Institutes of health for center support grants.
2. A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.
3. A study or investigation done for drug trials which are exempt from the investigational new drug application.

Your PMP must provide Us with written authorization for Your participation in a Cancer Clinical Trial.

Routine Costs as part of an Approved Clinical Trial does not include any of the following.

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial,
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.
- Transportation, lodging, food, or other expense for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the cancer clinical trial.
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient.
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

The term "life threatening condition" means any disease or condition from which death is likely unless the disease or condition is treated.

Section 3.19 Surgical Services. Coverage for Surgical Services when provided as part of Physician Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to the list below.

- Performance of accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary.
- Usual and related pre-operative and post-operative care.
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

- Covered Surgical Services include the following.
    - Operative and cutting procedures.
    - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
    - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

<u>Reconstructive Services</u>. Certain Reconstructive Services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are Covered. Reconstructive Services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract. Covered Reconstructive Services are limited to the following list.

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further Coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or Younger.
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia.
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect.
- Tongue release for diagnosis of tongue-tied.
- Congenital disorders that cause skull deformity such as Crouzon's disease.
- Cleft lip.
- Cleft palate.

<u>Mastectomy Notice.</u> An Enrollee who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive Coverage for all of the following listed below.

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Section 3.20 Sterilization. Sterilization is a Covered Service.

Section 3.21 Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder. Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders if provided within Our guidelines.

Section 3.22 Therapy Services. When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, Coverage for these Therapy Services is limited to the following list.

- Physical Medicine Therapy Services. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.
    - Physical Therapy Services including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Physical Therapy Services include but are not limited to maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness, repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients), range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities, general exercise programs, diathermy, ultrasound and heat treatments for pulmonary conditions, diapulse, work hardening.
    - Speech Therapy Services for the correction of a speech impairment.
    - Occupational Therapy Services for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Occupational Therapy Services include but are not limited to supplies (looms, ceramic tiles, leather, utensils), therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again, general exercises to promote overall fitness and flexibility, therapy to improve motivation, suction therapy for newborns (feeding machines), soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial, adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
    - Manipulation Therapy Services includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy Services as specified in the Schedule of Benefits. Manipulation Therapy Services rendered in the home as part of Home Care Services are not Covered.
- Other Therapy Services
    - Cardiac Rehabilitation Services to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not Covered.
    - Pulmonary Rehabilitation Services to restore an individual's functional status after a pulmonary or cardiac event, or to improve respiratory capacity in persons with chronic lung conditions.
    - Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
    - Dialysis Treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of Coverage the Contract will not require You to

receive dialysis treatment at a Participating Provider dialysis facility if that facility is further than 30 miles from Your home. If You require dialysis treatment and the nearest Participating Provider dialysis facility is more than 30 miles from Your home, the Contract will allow You to receive treatment at a Participating Provider dialysis facility nearest to Your home as Covered Health Service.

- Radiation Therapy Services for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, treatment planning.
- Inhalation Therapy Services for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Inhalation Therapy Services include but are not limited to, introduction of dry or moist gases into the lungs, nonpressurized inhalation treatment, intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive airway pressure ventilation (CPAP), continuous negative pressure ventilation (CNP), chest percussion, therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers, broncho-pulmonary drainage and breathing exercises.
- Pulmonary Rehabilitation Services to restore an individual's functional status after an illness or injury. Covered Pulmonary Rehabilitation Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also Covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary Rehabilitation Services in the acute Inpatient rehabilitation setting is not a Covered Health Service.
- Nutritional Counseling Services that are Medically Necessary or that are ordered by a Participating Provider. Limit of twelve (12) sessions annually.

Section 3.23 Physical Medicine and Rehabilitation Services. A structured therapeutic program under the supervision of a physical medicine and rehabilitation specialist and developed treatment plan of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical Medicine and Rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Long term rehabilitation for longer than 60 days in an inpatient setting is not a Covered Service.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Health Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Health Service.

Section 3.24 Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services. The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Enrollee cost shares.

Covered Transplant Procedure. Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period**.** Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Transplant Provider agreement. Contact the Case Manager for specific Participating Transplant Provider information for Health Services received at or coordinated by a Participating Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Transplant Provider Facility.

Prior Approval and Precertification. In order to maximize Your benefits, We strongly encourage You to call Our transplant department to discuss benefit Coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We may require additional work-ups and/or treatments before determining eligibility for the transplant benefit (e.g. psychotherapy). We will assist You in maximizing Your benefits by providing Coverage information, including details regarding what is Covered and whether any clinical Coverage guidelines, medical policies, Participating Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of Your I.D. Card. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are Covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging. The Contract will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Enrollee receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Enrollee must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed.

Non-Covered Services for transportations and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by Us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Section 3.25 Prescription Drug Benefits.

Pharmacy Benefits Manager**.** The pharmacy benefits available to You under this Contract are managed by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which We contract to manage Your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, and provides clinical management services. The management and other services the PBM provides include, among others, making recommendations to, and updating, the Covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and, operating a Mail Service pharmacy. The PBM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, Drug interactions or Drug/pregnancy concerns.

You may request a copy of the Covered Prescription Drug list by calling the Customer Service telephone number on the back of Your I.D. Card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage. You may request a list of Pharmacies in the PBM network by calling the customer service number listed on the back of Your I.D. Card.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Health Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Contract can determine Medical Necessity. The Contract may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Health Services will be limited based on Medical Necessity, quantity and/or age limits established by the Contract, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit Coverage. At the time You fill a prescription, the Participating Pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee which is reviewed and adopted by Us. We, or the PBM may contact Your Provider if additional information is required to determine whether Prior Authorization should be granted. We communicate the results of the decision to both You and Your Provider.

If Prior Authorization is denied, You have the right to appeal through the appeals process outlined in Article 8.

For a list of the current Drugs requiring Prior Authorization, please contact the Pharmacy Customer Service telephone number on the back of Your I.D. card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage under Your Contract. Refer to the Prescription Drug benefit sections in this Contract for information on Coverage, limitations and exclusions. Your Participating Provider or Participating Pharmacist may check with Us to verify Covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Contract.

- Therapeutic Substitution of Drugs is a program approved by Us and managed by the PBM. This is a voluntary program designed to inform Enrollees and Physicians about possible alternatives to certain prescribed Drugs. We, or the PBM, may contact You and Your prescribing Physician to make You aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only You and Your Physician can determine whether the therapeutic substitute is appropriate for You. For questions or issues involving therapeutic Drug substitutes, call the Customer Service telephone number on the back of Your I.D. card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

- Step Therapy. Step therapy protocol means that an Enrollee may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Enrollees access high quality yet cost effective Prescription

Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Participating Pharmacies**.** The PBM's Participating Pharmacies are available to Enrollees who use medically necessary drugs

Participating mail service pharmacies have toll free access to registered pharmacists to answer your questions. Participating specialty pharmacies have dedicated patient care coordinators to help You manage Your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists.

You may obtain a list of the Participating Pharmacies, and Covered Drugs, by calling the Customer Service telephone number on the back of Your ID card, or review the lists on Our website at *www.mdwisemarketplace.org*.

Covered Prescription Drug Benefits include the following.

- Prescription Legend Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are Covered when obtained through an eligible Pharmacy.
- If certain supplies, equipment or appliances are not obtained by Mail Service or from a Participating Pharmacy then they are Covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits and may be subject to applicable DME Copays or Coinsurance.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Non-Covered Prescription Drug Benefits

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by Us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for Coverage under the Medical Supplies benefit, they are Covered Health Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.

- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Health Services.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Refills of lost or stolen medications.
- Refills earlier than 72 hours before Your next refill is due.
- Refills on expired Prescription Drugs.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, are not Covered, unless otherwise required by law or approved by Us. "Clinically equivalent" means Drugs that, for the majority of Enrollees, can be expected to produce similar therapeutic outcomes for a disease or condition.

Deductible/Coinsurance/Copay. Each Prescription Order may be subject to a Deductible and Coinsurance/Copay. If the Prescription Order includes more than one Covered Drug, a separate Coinsurance/Copay will apply to each Covered Drug.

Days Supply. The number of days supply of a Drug which You may receive is limited. The days supply limit applicable to Prescription Drug Coverage is shown in the Schedule of Benefits. If You are going on vacation and You need more than the days supply allowed for under this Contract, You should ask Your Pharmacist to call the PBM and request an override for one additional refill. This will allow You to fill Your next prescription early. If You require more than one extra refill, please call the Pharmacy Customer Service telephone number on the back of Your I.D. Card.

Prescription Drug Classifications. Your Copay/Coinsurance amount may vary based on whether the Prescription Drug has been classified by Us as a Tier 1, Tier 2, Tier 3, or Tier 4 Prescription Drug. The determination of Prescription Drug class is made by Us based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, and where appropriate certain clinical economic factors.

- Tier 1Drugs have the lowest Copay. This class will contain low cost and preferred medications that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs will have a higher Copay than Tier 1 Prescription Drugs. This class will contain preferred medications that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3Prescription Drugs will have a required Coinsurance payment after You have hit your Deductible. This class will contain non-preferred and high cost medications. This will include medications considered Generic, single source brands, and multi-source brands.
- Tier 4 Prescriptions are subject to a day supply limit for Retail and Mail Service, and are subject to the applicable Coinsurance shown in the Schedule of Benefits. Coinsurance payment will occur after You have hit your Deductible. Tier 4 Drugs are Prescription Legend Drugs which are any of the following listed below.
    - Are only approved to treat limited patient populations, indications or conditions, or
    - Are normally injected, infused or require close monitoring by a physician or clinically trained individual, or
    - Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Class and Formulary Assignment Process. We have established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of Prescription Drug class assignments and formulary inclusion are made by Us based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, generic availability, the degree of utilization of one Drug over another in Our patient population, and where appropriate, certain clinical economic factors.

We retain the right at Our discretion to determine Coverage for dosage formulations in terms of Covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may Cover one form of administration and exclusion or place other forms of administration in another tier.

Special Programs. From time to time We may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Tier 1 Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copays or Coinsurance for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program. The Half-Tablet Program will allow Enrollees to pay a reduced Copay on selected "once daily dosage" medications. The Half-Tablet Program allows an Enrollee to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Enrollee's decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of Your I.D. Card.

Section 3.26 Payment of Prescription Drug Benefits. The amount of benefits paid is based upon whether You receive the Covered Health Services from a Participating Pharmacy, a Non-Participating Pharmacy, or the PBM's Mail Service Program. It is also based upon how We have classified the Prescription Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The amounts for which You are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copay/Coinsurance for which You are responsible.

Your Copay(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Contract from Drug manufacturers or similar vendors. For Covered Health Services provided by a Participating Pharmacy or through the PBM's Mail Service, You are responsible for all Deductibles and/or Copay/Coinsurance amounts.

For Covered Health Services provided by a Non-Participating Pharmacy, You will be responsible for the amount(s) shown in the Schedule of Benefits.

How to Obtain Prescription Drug Benefits. How You obtain Your benefits depends upon whether You go to a Participating or a Non-Participating Pharmacy.

- Participating Pharmacy – Present Your written Prescription Order from Your Physician, and Your I.D. Card to the pharmacist at a Participating Pharmacy. The Pharmacy will file Your claim for You. You will be charged at the point of purchase for applicable Deductible and/or Copay/Coinsurance amounts. If You do not present Your I.D. Card, You will have to pay the full retail price of the prescription. If You do pay the full charge, ask Your pharmacist for an itemized receipt and submit it to Us with a written request for refund.
- Tier 4 Drugs - You or Your Physician can order Your Tier 4 Drugs directly from a Participating Pharmacy, simply call the Pharmacy Customer Service telephone number on the back of Your ID card.
- Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy. You must submit a Prescription Drug claim form for reimbursement consideration. These forms are available from Us, the PBM, or from the Group. You must complete the top section of the form and ask the Non-Participating Pharmacy to complete the bottom section. If for any reason the bottom

section of this form cannot be completed by the pharmacist, You must attach an itemized receipt to the claim form and submit to Us or the PBM. The itemized receipt must show all of those items listed below.
  - Name and address of the Non-Participating Pharmacy.
  - Patient's name.
  - Prescription number.
  - Date the prescription was filled.
  - Name of the Drug.
  - Cost of the prescription.
  - Quantity of each Covered Drug or refill dispensed.
- You are responsible for the amount shown in the Schedule of Benefits.
- The Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from Your Physician, or have Your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copay amounts to the Mail Service when You request a prescription or refill.

Drug Exception Program. This is a program designed to allow Enrollees to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. The Drug Exception Program is separate from and in addition to the Grievance Procedures set forth in Article 8. Please call the Customer Service number on the back of your I.D. Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary.

Section 3.27 Pediatric Vision Benefits. Pediatric vision services are Covered under this Contract for Enrollees under the age of 19. Adult eyewear is not Covered under this Contract.

- A complete pediatric eye exam, including dilation if professional indicated
- One pair of eyeglass lenses. Lenses include single vision, bifocal, trifocal or lenticular. You may choose plastic or polycarbonate lenses and scratch resistant coating.
- One pair of eyeglass frames.
- Contact lenses in lieu of eyeglasses.
- Low vision services including a comprehensive low vision exam, optical/non-optical aids, and supplemental testing.

Please refer to the Schedule of Benefits for detailed information.

Article 4

EXCLUSIONS

Section 4.1 We do not provide Coverage for any of the following.

1. Health Services that are not Medically Necessary.
2. Health Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available for a condition will not make it eligible for Coverage if We deem it to be Experimental/Investigative.
3. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
4. Health Services that are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

5. Any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
6. A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
7. Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
8. Court ordered testing or care unless Medically Necessary.
9. Health Services for which You have no legal obligation to pay in the absence of this or like Coverage.
10. Physician or Other Practitioners' charges for consulting with Enrollees by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Enrollee except as otherwise described in this Contract.
11. Surcharges for furnishing and/or receiving medical records and reports.
12. Charges for doing research with Providers not directly responsible for Your care.
13. Charges that are not documented in Provider records.
14. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
15. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
16. Health Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
17. Health Services prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
18. Completion of claim forms or charges for medical records or reports unless otherwise required by law.
19. Mileage, lodging and meals costs, and other Enrollee travel related expenses, except as authorized by Us or specifically stated as a Covered Health Service.
20. Health Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Enrollee had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.
21. Charges in excess of Our Allowed Amounts.
22. Health Services incurred prior to Your Effective Date.
23. Health Services incurred after the termination date of this Coverage except as specified elsewhere in this Contract.
24. Any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts) or for the removal of tattoos. Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not Covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Enrollee was Covered by another carrier/self funded plan prior to Coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.
25. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
26. Custodial Care, convalescent care or rest cures.
27. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Enrollee's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

28. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
29. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a
30. Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
31. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
32. Wilderness camps.
33. Routine foot care (including the cutting and removal of corns and calluses), Nail trimming, cutting and debriding, Hygienic and preventive maintenance foot care, including, but not limited to the following list.
    1. Cleaning and soaking the feet.
    2. Applying skin creams in order to maintain skin tone.
    3. Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
34. Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses.
35. Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including, but not limited to the list below.
    1. Extraction, restoration and replacement of teeth.
    2. Medical or surgical treatments of dental conditions.
    3. Services to improve dental clinical outcomes.
36. Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Health Service.
37. Dental implants.
38. Dental braces.
39. Dental x-rays, supplies and appliances and all associated expense, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following listed below.
    1. Transplant preparation.
    2. Initiation of immunosuppresives.
    3. Direct treatment of acute traumatic injury, cancer or cleft palate.
40. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
41. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as Covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
42. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not Covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Contract or any previous [MDwise Contract], and it applies if the surgery was performed while the Enrollee was Covered by a previous carrier/self funded plan prior to Coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to myocardial infarction, excessive nausea/vomiting, pneumonia, and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.
43. Marital counseling.
44. Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

45. Vision orthoptic training.
46. Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.
47. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
48. Services to reverse voluntarily induced sterility.
49. Diagnostic testing or treatment related to infertility.
50. Personal hygiene, environmental control, or convenience items including but not limited to the following list.
    1. Air conditioners, humidifiers, air purifiers,
    2. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals,
    3. Charges for non-medical self-care except as otherwise stated,
    4. Purchase or rental of supplies for common household use, such as water purifiers,
    5. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds,
    6. Infant helmets to treat positional plagiocephaly,
    7. Safety helmets for Enrollees with neuromuscular diseases, or
    8. Sports helmets.
51. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
52. Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Contract.
53. Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.
54. Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
55. Self-help training and other forms of non-medical self care, except as otherwise provided in this Contract.
56. Examinations relating to research screenings.
57. Stand-by charges of a Physician.
58. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
59. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
60. Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility, Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
61. Manipulation Therapy services rendered in the home as part of Home Care Services.
62. For any new FDA Approved Drug Product or Technology **(including but not limited to medications, medical supplies, or devices)** available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
63. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
64. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
65. Abortion, except in the following cases.

1. The pregnant woman became pregnant through an act of rape or incest.
2. An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

66. Any services or supplies provided to a person not Covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
67. Surgical treatment of gynecomastia.
68. Treatment of hyperhidrosis (excessive sweating).
69. Any service for which You are responsible under the terms of this Contract to pay a Copay, Coinsurance or Deductible, and the Copay, Coinsurance or Deductible is waived by any Participating Provider.
70. Human Growth Hormone for children born small for gestational age. It is only a Covered Health Service in other situations when allowed by Us through Prior Authorization.
71. Complications directly related to a service or treatment that is a Non-Covered Health Service under this Contract because it was determined by Us to be Experimental/Investigational or non Medically Necessary. Directly related means that the Health Service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
72. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
73. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
74. Treatment of telangiectatic dermal veins (spider veins) by any method.
75. Reconstructive Health Services except as specifically stated in Section 3.19 of this Contract, or as required by law.
76. Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
77. Non-preventive medical nutritional therapy from a Non-Participating Provider.
78. Health Services from a Non-Participating Provider, except as specified elsewhere in this Contract.

Section 4.2 Experimental/Investigative Health Services Exclusion. We do not provide Coverage for any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the Health Service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply satisfies any or all of the following listed below.

- Cannot be legally marketed in the United States without the final approval of the FDA, or other licensing or regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any Health Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Health Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

- The scientific evidence is conclusory concerning the effect of the Health Service on health outcomes,
- The evidence demonstrates the Health Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects,
- The evidence demonstrates the Health Service has been shown to be as beneficial for the total population for whom the Health Service might be proposed as any established alternatives, and
- The evidence demonstrates the Health Service has been shown to improve the net health outcomes of the total population for whom the Health Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

Off-Label Drug Treatment. Coverage for a Drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

~~(8)~~(1) The Drug is recognized for treatment of the indication in at least one standard reference compendium.

~~(9)~~(2) The Drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the Drugs' use to be contraindicated or the Drug has not been approved by the FDA for any indication.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof, or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Documents of an IRB or other similar body performing substantially the same function, or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Medical records, or
- The opinions of consulting Providers and other experts in the field.

Article 5

PREMIUM PAYMENT

Section 5.1 Premium Rate. Your Premium rate is determined using the following acceptable rating factors: age, tobacco use, family size, and geography.

[Your][An Enrollee's] tobacco use impacts the determination of [Your][the] Premium rate. Upon enrollment, You will attest to [Your][an Enrollee's] tobacco use. If You report false or incorrect information to Us [or the Exchange] about [Your][an Enrollee's] tobacco use upon enrollment, We may retroactively apply the appropriate tobacco rating factor to [Your][the] Premium as if the correct information had been accurately reported from the Effective Date for Coverage.

Section 5.2 Payment of Premium. The Subscriber is responsible for paying the Premium to Us on a monthly

basis. The first Premium is due and payable on the Effective Date of this Contract. Subsequent Premium payments are due and payable on or before the first day of each month thereafter that this Contract is in effect. Payment must be made on or before each due date. Even if You have not received a bill from Us, You are still obligated to pay, at a minimum, the amount of the prior bill. A service charge in the maximum allowable amount under law will be charged for any non-sufficient check used to pay the Premium.

Section 5.3 Adjustments to Premium. We reserve the right to change the Premium annually. You will receive 30 days notice of any change in Premiums.

Section 5.4 General Grace Period. Following payment of the initial Premium, a Grace Period of one (1) month shall be granted for the payment of any Premium. This Grace Period shall not extend beyond the date this Contract terminates. During the one (1) month Grace Period this Contract shall continue in force.

Any claims incurred and submitted during the grace period will not be considered for payment until Premium is received. If Premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of Coverage.

[Section 5.5 Three-Month Grace Period for Subscribers Receiving Advance Payments of the Premium Tax Credit.
For [a Subscriber][or Enrollee] receiving advance payments of the premium tax credit who has previously paid at least one full month's premium during the benefit year, a Grace Period of three (3) consecutive months shall be granted for the payment of any Premium.

During this 3-month Grace Period, We shall do all of the following listed below.

(1) Pay all claims for Covered Emergency and Health Services rendered to [the Subscriber][an Enrolled Dependent] during the first month of the Grace Period and may pend claims for Covered Emergency and Health Services rendered to the Subscriber in the second and third months of the Grace Period.
(2) Notify the Department of Health and Human Services of such non-payment.
(3) Notify Participating Providers of the possibility for denied claims when a Subscriber is in the second and third months of the Grace Period.

During this 3-month Grace Period, We shall do all of the following listed below.

(1) Continue to collect advance payments of the premium tax credit on behalf of the Subscriber from the Department of Treasury.
(2) Return advance payments of the premium tax credit on the behalf of the Subscriber for the second and third months of the Grace Period if the Subscriber exhausts the grace period.]

Section 5.6 Payment upon Termination. If Premium has been paid for any period of time after the termination date, We will refund that Premium to You. The refund will be for the period of time after Your Coverage ends. Also, if an [Enrollee][Enrolled Dependent] dies while this Contract is in force, We will refund the Premium paid for any period after the month of the [Enrollee's][Enrolled Dependent's] death to You or Your estate for that [Enrollee][Enrolled Dependent].

Article 6

PROCEDURES FOR OBTAINING HEALTH SERVICES

Our authorization does not guarantee Coverage for the Health Service or procedure reviewed. Benefits of this Contract are determined in accordance with all of the terms, conditions, limitations, and exclusions.

Section 6.1 Selection of a Primary Medical Provider. We require the designation of a Primary Medical Provider (PMP). You have the right to designate any PMP who is a Participating Provider in Your Service Area and who is available to accept [You and Your Enrolled Dependents][an Enrollee]. Until You make this designation, We will

designate a PMP for You. For information on how to select a PMP, and for a list of PMPs in Your Delivery System, contact the customer service telephone number on the back of your I. D. Card or refer to the provider directory on Our website, www.mdwisemarketplace.org. [For Children, you][You] may designate a pediatrician as the PMP.

[You do][An Enrollee does] not need Preauthorization or a referral from Us or from any other person (including a PMP) in order to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetrics or gynecology. The Participating Provider, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services or following a pre-approved treatment plan. For a list of Participating Providers who specialize in obstetrics or gynecology, contact the customer service telephone number on the back of your I.D. Card or refer to Our website, www.mdwisemarketplace.org.

Section 6.2 Preauthorization. The Health Services listed below do not require Preauthorization.

(A) Emergency Services.
(B) Preventive Services provided by a Participating Provider.

A Provider that provides [You][an Enrollee] with Emergency Services may not charge You except for an applicable Copay or Deductible.

All other Health Services must be made through Your PMP. [Your][An Enrollee's] PMP will determine whether Preauthorization is required. The following is a list of Health Services that require Preauthorization. This list is not exhaustive.

(A) Elective/Urgent Inpatient Admissions.
    (1) Medical.
    (2) Surgery.
    (3) Sub-acute rehabilitation and skilled nursing facility.
    (4) Inpatient behavioral health and substance abuse.
(B) Observation stay.
(C) Skilled nursing facility services.
(D) Hospice Care – Inpatient and Outpatient.
(E) Hysterectomy.
(F) Transplantation evaluations and procedures/surgery.
(G) Reduction mammoplasty surgery
(H) Reconstructive services/plastic surgery/potentially Cosmetic Procedures.
(I) Home Health Care Services.
(J) MRI, MRA, CT scans and PET scans.
(K) All Non-Participating Provider services.
(L) Durable Medical Equipment and supplies greater than $500 (total per claim) per rental or purchase.
(M) Prosthetics greater than $500/per prosthetic.
(N) Pharmacy Services, including,
    (1) Biotech Injectables
    (2) Enteral Products
    (3) As otherwise specified on the MDwise preferred drug list.
(O) Occupational Therapy (authorization required after the initial evaluation).
(P) Physical Therapy (authorization required after the initial evaluation).
(Q) Speech Therapy (authorization required after the initial evaluation).
(R) Transportation – non-emergent.
(S) Certain mental disorders/substance abuse.
(T) Outpatient services, including outpatient surgical procedures and certain other procedures.
(U) Pain management programs.

Section 6.3 Health Services by Participating Providers. Health Services rendered by Participating Providers are Covered if the Health Services meet all of the following conditions.

(A) Are ordered by a Participating Provider (including Health Services performed at Participating facilities),
(B) Provided by or under the direction of a Participating Provider,
(C) Medically Necessary, and
(D) Specified as Covered by this Contract.

Section 6.4 Verification of Participation Status. You must confirm that the Provider is a Participating Provider and whether the Participating Provider is a Provider in Tier 1 or Tier 2 before receiving Health Services. This is important since this Contract is aimed at providing Coverage for Health Services rendered by Participating Providers.

You must show the Participating Provider Your I.D. card before receiving Health Services.

If You do not identify [Yourself][an Enrolled Dependent] to the Participating Provider as an Enrollee within 90 days from the date Health Services are incurred a Participating Provider may bill You for Your Health Services, and You shall be responsible for 100% of the cost of Your Health Services.

The Provider needs to know that [You are][an Enrolled Dependent] an Enrollee in order to follow Our procedures, such as Prior Authorization. If failure to show Your I.D. card results in non-compliance with Our required procedures and Coverage is denied, You shall be responsible for 100% of the cost of Your Health Services.

Section 6.5 Health Services by a Non-Participating Provider. Non-Emergency Health Services rendered by a Non-Participating Provider will be Covered in the following circumstances only.

(A) Referral to Non-Participating Providers. The Allowed Amounts of non-Emergency Health Services provided by a Non-Participating Provider shall be Covered if all of the following conditions listed below are satisfied.

(1) The specific Health Services cannot be provided by or through Participating Providers,
(2) The services are Medically Necessary, and
(3) Your PMP referred You to the Non-Participating Provider.

The Non-Participating Provider must obtain written approval from US, in the form of a Prior Authorization,before You receive non-Emergency Health Services by a Non-Participating Provider. If Your Non-Participating Provider does not receive Prior Authorization, You will be responsible for all costs associated with those Health Services. Additional Health Services not authorized in the original request require a new authorization.

(B) National Committee for Quality Assurance (NCQA). Continuity of care with the Non-Participating Provider is required under current NCQA standards.

Section 6.6 Emergency Health Services. We will Cover Allowed Amounts for Emergency Health Services rendered by Participating or Non-Participating Providers. Such services must meet the requirements listed below.

(A) Provided during the course of the Emergency,
(B) Medically Necessary for evaluating and treating an Emergency condition, up to the point of Stabilization, and
(C) Provided by or under the direction of a Provider.

Health Services are not Covered if We determine that the situation was not an Emergency, as defined by this Contract.

Subsequent follow-up care by Non-Participating Providers after the condition is no longer an Emergency is not Covered without Our prior written approval.

Section 6.7 Inpatient Emergency Health Services by Non-Participating Providers. If [You are][an Enrollee is] hospitalized in a Non-Participating facility due to an Emergency, You must notify Us within 48 hours after Emergency Health Services are initially provided or as soon thereafter as is reasonably possible. You must make available full details of the Emergency Health Services received, at Our request.

Any continued stay in a Non-Participating facility after the condition is Stabilized and is no longer an Emergency (1) requires coordination by a Participating Provider, and (2) requires Our prior written authorization. We may elect to transfer You to a Participating Hospital once it is medically appropriate to do so.

Health Services rendered by Non-Participating Providers are not Covered if You (1) fail to notify Us within 48 hours of the initiation of Emergency Health Services or as soon as reasonably possible thereafter, or (2) choose to remain in a Non-Participating facility after We have notified You of the intent to transfer You to a Participating facility.

Section 6.8 Access to Health Services. Additional information on access to Health Services can be obtained through any means listed below.

(A) Our Participating Provider Directory.
(B) Our Enrollee newsletter.
(C) Our Customer Service Department at the number or website below.
1-855-417-5615www.mdwisemarketplace.org

Article 7

PROCEDURES FOR REIMBURSEMENT OF ALLOWED AMOUNTS

Section 7.1 Identification Card ("I.D. Card").

The Subscriber[, and spouse, if applicable,] will receive an I.D. Card. The I.D. Card will identify [any Dependents that are][each Dependent] Covered under the Contract. You may be charged a fee for additional or replacement cards.

Information on Your I.D. Card is needed for the Participating Provider to bill Us. *You must show Your I.D. Card every time You request Health Services[for an Enrolled Dependent]*. If You do not show the I.D. Card, Participating Providers have no way of knowing that [You are][the Dependent is] an Enrollee.

When failure to show an I.D. Card results in non-compliance with required procedures, Coverage may be denied.

Section 7.2 Participating Provider Services. We pay [Your] Participating Providers for [Your][an Enrollee's] Covered Health Services. You may be responsible for paying the Participating Provider for any applicable Copays, Coinsurance, or Deductibles included under this Contract. Please refer to the Schedule of Benefits for any applicable Deductible, Coinsurance or Copay information.

Section 7.3 Procedures for Health Services Received from Non-Participating Providers. If [You receive][an Enrollee receives] Health Services from a Non-Participating Provider, the rules below apply for claims submitted by You or by a Non-Participating Provider on Your behalf.

Claim Forms. You can locate Our claim forms on Our website, www.mdwisemarketplace.org, or You can notify us of a claim and We will mail You Our claim forms. If You do not receive Our usual claim forms within fifteen (15) days of this request, You may file a claim without them. The claims must contain written Claim Documentation.

Notice of Claim**.** You must inform Us of the claim within thirty (30) days of the date the Covered Health Service began or as soon as reasonably possible.

Claim Documentation. You must send Us written Claim Documentation within one hundred and eighty (180) days of the date the Covered Health Service began or as soon as reasonably possible. Claim Documentation furnished more than one (1) year late will not be accepted, unless You had no legal capacity in that year.

Cooperation By You. You or Your representative must fully cooperate with Us in determining Our rights and obligations under this Contract. You must cooperate as often as may be reasonably necessary. This means You or Your representative must do all of the following items, as requested.

(1) Sign, date and deliver to Us authorization to obtain any medical or other information, records, or documents We deem relevant from any person or entity.
(2) Give Us, or Our representatives, any medical or other information, records or documents We deem relevant.
(3) Answer, under oath or otherwise, any questions We deem relevant, which We or Our representative may ask.
(4) Furnish any other information, aid or assistance that We may require, including without limit, assistance in communicating with any person or entity (including requesting any person or entity to promptly give Us, or Our representative, any information, records or documents requested by Us).

If You or Your representative fails to give any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by Us unless and until We receive the item or information or You do the action We have requested, subject to the terms and conditions of this Contract.

In addition, failure on Your part or on the part of Your representative, to give Us any of the items or information requested or to take any action requested may result in the denial of Your claims.

Payment of Claims. Any payment made by Us in good faith under this Section shall fully discharge Our obligation to the extent of the payment. We reserve the right to deduct any overpayment made under this Contract from any future benefits payable under this Contract.

Foreign Claims Incurred for Emergency Care. Claims incurred outside the United States for Emergency Care and treatment must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper Claim Documentation.

Assignment. We will reimburse a Hospital or Provider if You assign in writing [Your][an Enrollee's] health insurance benefits, and We approve the assignment. Any assignment to a Hospital or Provider providing treatment, whether with or without Our approval, shall not confer upon such Hospital or Provider any right or privilege granted to You under this Contract except for the right to get benefits, if any, that We have determined are due and payable.

Physical Examination and Autopsy. We shall have the right and opportunity to examine [You][an Enrollee} while a claim is pending or while a dispute over a claim is pending. These examinations are made at Our expense and as often as We may reasonably require. We also have the right to have an autopsy made where the law does not prohibit it.

Legal Action. You may not bring any suit on a claim until at least sixty (60) days after the required Claim Documentation is given. You may not bring any suit more than three (3) years after the date Claim Documentation is required.

Section 7.4 Filing a Claim for Non-Participating Provider Services. If You need to file a claim under the procedures identified in Section 7.3, submit Your claim to the address below. The claim forms are available on our website, www.mdwisemarketplace.org.

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

Be sure Your claim includes all of the information listed below.
(A) Your name and address.
(B) Patient's name, date of birth, and Enrollee I.D. number (shown on Your I.D. card).
(C) Name and address of the Non-Participating Provider of services.
(D) Diagnosis from the Provider.
(E) Bill which gives a CPT code, or description of each charge.
(F) Date the Injury or Sickness began.

Some claims may require more information before being processed. Benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

Section 7.5 Coverage through Non-custodial Parent. Whenever a Child under the age of 18 is an Enrolled Dependent under this Contract through a [Subscriber that is a] non-custodial parent, We shall, upon the custodial parent's written request do all of the following.

(A) Provide any information to the custodial parent that is necessary for the child to obtain benefits through this Contract.
(B) Permit the custodial parent, or the Provider with the custodial parent's approval, to submit claims for Covered Health Services without the non-custodial parent's approval.
(C) Pay claims submitted by the custodial parent or the Provider in accordance with (B) above, directly to the custodial parent or Provider.

Section 7.6 Payment of Claims. We shall pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for Your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. Claims submitted by Providers are also governed by Indiana Code § 27-13-36.2.

Article 8

GRIEVANCE PROCEDURES

Section 8.1 Who May File. You or Your Designated Representative may file any of the following.

(A) A Grievance.
(B) An Appeal.
(C) A request for an External Appeal.

In each of these review processes, Your notice to Us is considered to be filed on the date We first receive it orally or in writing.

Detailed information on how to submit all of the above may be found in this Contract, on Our website, in newsletters, and in medical management determination letters sent to Enrollees when a Health Service is denied. At least annually in a newsletter, We notify Enrollees about the Grievance and Appeal process and the availability of External Appeals.

Neither You nor Your Designated Representative will be subject to retaliation from Us for exercising Your rights to any of the review processes described in this Article. Also, We may not take any action against a Provider solely on the basis that the Provider represents You in any of the review processes described in this Article.

Section 8.2 Internal Grievance Procedure. The MDwise Customer Service Department is responsible for the processing of Grievances. All Grievances are thoroughly researched and documented, and as necessary, are referred for resolution beyond the Customer Services Department. You may file a Grievance in writing or by calling MDwise Customer Service directly and a Customer Service representative will assist You in filing the Grievance.

We must receive Your request to initiate the Grievance process within 180 days from the date We provide You an initial notice of denial. We will acknowledge Your Grievance, orally or in writing, within three business days of Our receipt of it.

In Your Grievance, You should express Your concerns in detail and provide copies of any supporting documents. You should provide us with the following information:

(A) Your Name [and the patient's name]
(B) [The patient's] Date of Birth
(C) Date of Grievance
(D) Type of Grievance
(E) Summary of the substance of the Grievance
(F) Summary of the actions taken.

We will document the substance of the Grievance and any actions taken.

You are permitted to review the Grievance claim file and to present evidence and testimony as part of the internal claims and appeals process.

The MDwise Customer Service Representative appointed to Your Grievance will conduct a thorough investigation of the facts of Your Grievance, including any aspects involving critical care, and make a decision regarding it. Other Providers or individuals We employ may be consulted before the decision is made.

Our decision regarding Your Grievance must be made as soon as possible. We will notify you in writing no later than

(A) 15 days after the date Your Grievance was filed, for a Pre-service Grievance, and
(B) 20 business days after Your Grievance is filed, for a Post-service Grievance,

when the issue is resolved and inform You of Your right to Appeal Our decision. If Your Grievance is considered an Urgent Grievance or Concurrent Care Claim, We will follow the timing requirements outlined in Sections 8.3 and 8.4 respectively.

If We are not able to make a decision by the applicable deadline due to reasons beyond Our control We will notify You in writing of the reason for the delay not more than 14 days after the date Your Grievance was filed, for a Pre-service Grievance, and not more than 19 business days after Your Grievance is filed, for a Post-service Grievance. We shall also issue You a written notification of the resolution of Your Grievance not more than 10 business days after notifying You of the reason for delay.

If We do not receive from You all of the information necessary to complete the review of Your Grievance, You will be afforded an extension of at least 45 days within which to provide Us with the specified information. We will resolve Your Grievance not more than 10 business days after We receive such necessary information.

We will provide You with any new or additional evidence considered, relied upon, or generated by Us in connection with the claim, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date. Before We issue a final decision based on a new or additional rationale, We will provide You with the rationale, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date.

We will notify You in writing of the resolution of the grievance within 5 business days after the resolution.

If You are not satisfied with Our decision regarding Your Grievance, You have the right to file an Appeal with Us as set forth in Section 8.5 of this Contract.

Section 8.3 Urgent Grievance Procedure. If You are not satisfied with a decision We made either before or after You have filed a Grievance and Your situation meets the requirements of an Urgent Grievance, You have the right to use this Urgent Care procedure. Once identified as such, an Urgent Grievance will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

Your Urgent Grievance may be expressed to Us orally or in writing and should set forth all issues, comments, or other documented evidence that support it. We will treat Your Urgent Grievance pursuant to the procedure described in Section 8.2 and Section 8.4, except that We will shorten the time limits as follows.

We will acknowledge Your Urgent Grievance within 24 hours (and include any request for additional information, if appropriate).

We will decide Your Urgent Grievance as soon as possible, but no later than 72 hours after the receipt of the initial request for the Urgent Grievance. You will receive written or electronic notification of Our decision. We may notify You of Our decision orally, provided that a written or electronic notification is furnished to You no later than 3 days after the oral notification.

If You do not provide sufficient information for Us to determine whether or to what extent the benefits You seek are Covered or payable under the Contract, We will notify You within 24 hours of the specific information that You must submit for Us to answer Your Claim.

If You are notified that You need to provide additional information, You will have at least 48 hours in which to provide the additional information. We shall notify You of Our decision no later than 48 hours after We receive the requested information. If You do not provide the requested information, We shall notify You of Our decision no later than 48 hours after the end of the time that You were given to provide the information.

Section 8.4 Concurrent Care Procedure. If We reduce or terminate a Concurrent Care plan or course of treatment (other than by amending the Contract) before the end of the originally approved period of time or number of treatments, You will be notified sufficiently in advance of the reduction or termination to allow You to file a Grievance and Appeal of the decision before the benefit is reduced or terminated.

If Your request to extend a particular course of treatment beyond the period of time or number of treatments involves an Urgent Grievance,

(A) We will notify You of Our decision as soon as possible, taking into account the medical exigencies, and
(B) We will notify You of Our determination, whether adverse or not, within 24 hours of Our receipt of Your request, provided that Your request was made to Us at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Section 8.5 Internal Appeal Procedure. If You are not satisfied with Our decision regarding Your Grievance, You have the right to submit an Appeal to Us within 180 days of Our decision regarding Your Grievance. You may file an appeal in writing or You may call MDwise Customer Service directly and a Customer Service Representative will assist You in filing the Appeal. We will acknowledge Your Appeal, orally or in writing, within three business days of Our receipt of it.

We will continue to provide You with Coverage under this Contract pending the outcome of the Appeal.

You may request continuation of Health Services during the Appeal process if an authorized Health Service is being terminate, reduced or suspended before the expiration of the original authorization date. Pre-service authorization requests and re-authorization request after a number of approved number of days, services, or visits expired do not apply. In the event of request for Concurrent Care Claim reviews beyond original authorization, You and Your provider will be notified of the Appeals process, as indicated in Section 8.4.

We will document the substance of the Appeal and the actions taken.

Your representative may act on Your behalf with respect to requesting an Appeal and the procedures involved. We allow You the opportunity for representation by anyone You choose, including a provider or attorney. For Urgent Grievance Appeals, a health care practitioner with knowledge of Your condition may act as Your representative.

We will investigate the substance of the Appeal, including any aspects of clinical care involved.

Our Appeal Committee (the Committee) will resolve the Appeal. The Committee shall be comprised of qualified individuals who were not involved in the investigation or resolution of the Grievance or involved in the matters giving rise to it. If the Appeal concerns health care procedures, treatments, or services that have been proposed, refused, or delivered, the Committee shall include one or more individuals who meet all of the following requirements

(A) Have knowledge of the Health Services at issue.
(B) Are in the same licensed profession as the Provider who proposed, refused or delivered the Health Service at issue.
(C) Are not involved in the matter giving rise to the appeal or the previous Grievance process.
(D) Do not have a direct business relationship with You or with the Provider who recommended the Health Service at issue.

You or Your Designated Representative may (A) appear in person before the Committee, or (B) communicate with the Committee through appropriate other means, if unable to attend in person.

You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

To support Your Appeal, You should submit to the Committee any written issues, arguments, comments, or other documented evidence. The Committee shall review all findings and pertinent documents, including any aspects of clinical care, whether or not We have considered them previously. The Committee will not afford any special deference to the original denial of Your Grievance. In no event shall Your claim that was previously denied under the terms of the Contract and upheld by an Appeals ruling be reconsidered by the Committee for review.

The Committee's decision regarding Your Appeal will be made as soon as possible and with regard to the clinical urgency of the Appeal, but not later than

(A) 30 days after the Appeal was filed, for Pre-Service Grievances.
(B) 45 days after the Appeal was filed, for Post-Service Grievances.

The Committee's decision regarding Your Appeal of an adverse benefit determination for an Urgent Grievance will be made not later than 72 hours after the receipt of Your request for review.

Section 8.6 External Review of Grievances. You may pursue an External Appeal if You are not satisfied with Our Appeal decision. An Independent Review Organization ("IRO") is available for Appeals that involve an Adverse Determination of the following:

(A) a Medically Necessary Service,
(B) a Utilization Review Determination, or
(C) the experimental or investigational nature of a proposed Health Service, or
(D) a decision to rescind Your Contract

If Your Appeal did not involve one of the above three areas, You are not entitled to an External Appeal. Requests for excluded benefits or exceeded benefits are not eligible for External Appeal. [Also, if You are a Medicare recipient and have a right to an external review under Medicare (42 U.S.C. 1395 *et seq.*, as amended from time to time), there is no right to request an External Appeal.]

If Your situation qualifies, You or Your representative must file a written request for an External Appeal with Us no later than 120 days after You receive notice of the Appeal decision.

You may not file more than one External Review appeal grievance.

You shall not be subject to retaliation for exercising Your right to an External Review.

You are permitted to utilize the assistance of other individuals, including providers, attorneys, friends, and family members throughout the External Review process.

You are permitted to submit additional information relating to the proposed Health Service as issue throughout the External Review process.

You are required to cooperate with the IRO by providing or authorizing the release of any necessary medical information that We have not already provided.

We shall cooperate with the selected IRO by promptly providing any information requested by the IRO.

You may request an Expedited Appeal if Your External Review is of a Grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize Your life or health, or Your ability to reach and maintain maximum function. If You request an Expedited Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 72 hours after Your Expedited Appeal is filed, and
(B) notify You within 24 hours of after making the determination.

If Your External Review is a Standard Grievance Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 15 business days after the Standard Grievance Appeal, and
(B) notify You within 72 hours of making the determination.

An Expedited External Review can occur concurrently with the Appeals process for Urgent Care and Concurrent Care Claims.

When making its determination, the IRO shall apply,

(A) standards of decision making that are based on objective clinical evidence, and
(B) the terms of Your Contract.

You shall not pay any of the costs associated with the services of an IRO. All of the costs must be paid by Us.

We shall notify You of the IRO's decision within 2 business days of receiving it, including the basis/rationale for the decision.

The IRO’s decision in an External Appeal is binding on Us, but You may have other legal remedies.

After You have received notification of the IRO’s determination regarding Your External Review, You may request the IRO provide You with all information reasonably necessary to enable You to understand the,

(A) effect of the determination on You, and
(B) manner in which We may be expected to response to the IRO’s determination.

We will authorize or provide disputed services promptly, and as expeditiously as Your health condition requires if the services were not furnished while the Appeal was pending and at any level reverses a decision to deny, limit or delay services.

Section 8.7. Suspension of the External Review Process. The External Appeal process will be suspended if the information You submit during the External Appeal is relevant to Our decision, and was not previously reviewed by Us during the Grievance or Appeal stages.

During the suspended External Review process, We will reconsider the new information You presented to Us and notify You of Our decision within the relevant timeframe listed below.

(A) 15 business days after the new information is provided to Us for a Standard Grievance Appeal, or
(B) 72 hours after the new information is provided to Us for an Expedited Appeal Grievance.

If We uphold the Grievance Appeal decision, You may request that the External Appeal resume.

Section 8.8 Contact Us. Questions regarding Your policy or Coverage should be directed to Our address, telephone number or website listed in this Section.

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423
www.mdwisemarketplace.org
1-855-417-5615

Section 8.9 Indiana Department of Insurance. If You need the assistance of the governmental agency that regulates insurance, or have a complaint You have been unable to resolve with Your insurer, You may contact the Department of Insurance by mail, telephone or email the Indiana Department of Insurance at the contact information provided for in this Section.

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

Consumer Hotline – (800) 622-4461, (317) 232-2395

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

Section 8.10 Indiana Medical Malpractice Act. The review procedures described in this Article do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

Article 9

RENEWABILITY AND TERMINATION

Section 9.1 Renewability and Termination of Contract. We must renew or continue in force this Contract at Your option. We may terminate or refuse to renew this Contract only for the following reasons.

(A) Non-payment of premium, subject to the notice and Grace Periods defined in this Contract.
(B) We rescind coverage based upon fraud or an intentional misrepresentation of material fact made by You under the terms of the Contract.
(C) We receive a written request from You to terminate this Contract as provided in Section 9.6.
(D) [We receive notice from the Exchange that] [You][all Enrolled Dependents] are no longer eligible for coverage [under this Contract][through the Exchange].
(E) You obtain coverage from another [Qualified Health Plan through the Exchange][health plan] during an Open Enrollment period or a Special Enrollment period.
(F) [Our status as a Qualified Health Plan for the Exchange is terminated by the Exchange.]
(G) You no longer reside or live in Our Service Area.
(H) Death [of the Subscriber].

Section 9.2 Discontinuance of a Particular Type of Contract. We may discontinue a particular contract if We do all of the following.

(A) We provide You with written notice at least 90 days before the date the contract form will be discontinued.
(B) We offer You the option to purchase any other individual contract We currently offer.
(C) We act uniformly without regard to any health status-related factor of Enrollees or [Dependents of Enrollees] that may become eligible for Coverage.

Section 9.3 Discontinuance of All Coverage. We may discontinue all contracts in the individual market in Indiana if We do all of the following.

(A) We provide You and the Indiana Department of Insurance with written notice at least 180 days before the date Your Coverage will expire.
(B) We discontinue and do not renew all Contracts We issue or deliver for issuance in the State of Indiana in the individual market.
(C) We act uniformly without regard to any health status-related factor of Enrollees or Dependents of Enrollees that may become eligible for Coverage.

Section 9.4 Exception for Uniform Modification of Coverage. We may, at the time of renewal, modify this Contract if the modification is consistent with the laws of the state of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

Section 9.5. Notice and Effective Date of Termination. We shall provide You with written notice of our intent to terminate or not renew this Contract. This notice will identify the date upon which Your Coverage will cease. This date will be referred to as the "Effective Date of Termination".

Our notice to the Subscriber shall be deemed as notice to [the Subscriber's Enrolled Dependents][each Enrolled Dependent] and is sufficient if mailed to the Subscriber's address as it appears in Our records. Notice is effective when deposited in the United States mail with first class postage prepaid.

Termination of this Contract shall not prejudice any claim for Health Services rendered before the Effective Date of Termination. All requests for reimbursement, however, must be furnished as provided in Article 7.

Section 9.6 Process for Termination of Coverage By Written Request of Subscriber. You may terminate this Contract or Coverage for an Enrollee under this Contract with reasonable notice to [the Exchange or] Us. Reasonable notice is defined as fourteen (14) days prior to the requested Effective Date of Termination.

If You provide reasonable notice, the Effective Date of Termination is the date specified in Your notice. If You do not provide reasonable notice, the Effective Date of Termination is fourteen (14) days after We receive Your termination request, or an earlier date specified by Us if we are able to effectuate termination in fewer than fourteen (14) days.

If an Enrollee is newly eligible for Medicaid, the Children's Health Insurance Program for the state of Indiana, or the Basic Health Plan for state of Indiana (if such a plan is implemented), the Effective Date of Termination is the day before such coverage begins.

Section 9.7 Process for Termination of Coverage [Due to Loss of Eligibility].

~~(D)~~**(A) [Process for Termination of Coverage] When the [Enrolled Dependent] [Subscriber] is No Longer Eligible for Coverage [Under this Contract][Through the Exchange].** In the case of termination due to a [Subscriber][an Enrolled Dependent] no longer being eligible for Coverage [under this Contract][through the Exchange], the Effective Termination Date is the last day of the month following the month in which [the Subscriber loses eligibility][notice is sent to Us by the Exchange], unless the [Subscriber][Enrolled Dependent] requests an earlier Effective Termination Date.

~~(E)~~**(B) [Process for Termination of Coverage When a Dependent is No Longer Eligible Under the Contract**. In the case of termination due to a Dependent no longer being eligible for Coverage under this Contract, the Effective Termination Date is the last day of the month following the day in which the Dependent loses eligibility.]

Section 9.8 Process for Termination of Coverage Due to Non-Payment of Premiums. In the case of termination due to non-payment of premiums by a Subscriber subject to the general Grace Period identified in Section 5.3 of this Contract, the Effective Date of Termination will be the earliest date of the last paid date of Coverage if (1) the Grace Period expires and any Premiums remain unpaid, or (2) We receive written notice of termination from the Subscriber during the Grace period

[In the case of termination due to non-payment of premiums by a Subscriber subject to the 3-month Grace Period identified in Section 5.4 of this Contract, the Effective Date of Termination will be on the last day of the first month of the three-month Grace Period. The [Subscriber][Enrolled Dependent] will receive notice of termination of Coverage no later than thirty (30) days prior to this Effective Date of Termination.]

Section 9.9 Process for Termination of Coverage When the [Subscriber][Enrolled Dependent] Changes to Another [Qualified Health Plan][Health Plan] During an Open Enrollment Period or Special Enrollment Period. In the case of termination due to a [Subscriber][Enrolled Dependent] changing to another [Qualified Health Plan][health plan] during an Open Enrollment period or Special Enrollment period, the Effective Date of Termination under the Contract shall be the day before the Effective Date of coverage in the [Subscriber's][Dependent's] new [Qualified Health Plan][health plan].

Section 9.10 Continued Inpatient Hospital Benefits. We will continue inpatient Hospital benefits for [a Covered Person][an Enrollee] if (1) We terminate this Contract, and (2) [the Covered Person][an Enrollee is hospitalized for a medical or surgical condition on the Effective Date of Termination. Such continued benefits shall end on the earliest of the dates specified in (A) through (E) below.

(A) The date [the Covered Person][an Enrollee] is discharged from the Hospital.
(B) The date [the Covered Person][an Enrollee] is covered under other health coverage if that coverage covers the inpatient hospital benefits.
(C) Sixty (60) days after the date this Contract ends.
(D) The last day the required Premium has been paid, if the grace period expires and the Subscriber has not made the required payment.
(E) The date the Subscriber terminates Coverage for the Subscriber and any Enrolled Dependents.

This section does not apply if this Contract ends due to Our receivership.

[Section 9.11. Extended Coverage for Disabled Children. Coverage for a Child may continue beyond age 26 if all of the following factors exist.

(A) The Child is incapable of self-sustaining employment due to a mental or physical disability.
(B) The Child is primarily dependent upon the Subscriber for support and maintenance.
(C) We receive written proof of such incapacity and dependency from a Participating Provider, that is acceptable to Us, within 120 days of the Child reaching the age of 26.

This extended Coverage will continue so long as the Child remains so incapacitated and dependent, unless Coverage is otherwise ended by the terms of this Contract.

We may require proof from a Participating Provider that is satisfactory to Us of the Child's continued incapacity and dependency.]

Section 9.12 Reinstatement. If [Your][this] Contract was terminated for non-payment of Premium, You may request reinstatement of the Contract from [Us][the Exchange] within 30 days of the Effective Date of Termination. You must remit all premium that was due for the Coverage upon reinstatement. Upon receipt of the outstanding Premium [and notice from the Exchange][or Us,] We will reinstate Coverage as of the Effective Date of Termination.

Article 10

RECOVERY SOURCE/SUBROGATION

Section 10.1 Recovery Source. The following persons or entities are collectively referred to as a Recovery Source or Recovery Sources.

(A) Any person alleged to have caused the Enrollee to suffer Sickness, Injuries or damages,
(B) The employer of the Enrollee, or

(C) Any person or entity obligated to provide benefits or payments to the Enrollee. This includes, but is not limited to, underinsured or uninsured motorist protection and liability insurance.

Section 10.2 Recovery. An amount owed by a Recovery Source pursuant to a settlement, judgment, or otherwise.

Section 10.3 Our Rights to Reimbursement, Recovery, and Subrogation. If You obtain a Recovery from a Recovery Source for a Sickness or Injury or other condition for which You have received Health Services, then We will not Cover such Health Services to the extent of such recovery. However, if We Covered such Health Services the conditions listed below apply.

(A) You shall reimburse Us immediately from a collected Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) Other costs incurred in obtaining or collecting the Recovery,
  regardless of whether or not that collected amount fully compensates You.

(B) For a Recovery not yet collected, You grant to Us a first priority lien against such Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) other costs incurred in obtaining and eventually collecting the Recovery,
  regardless of whether or not the Recovery fully compensates You. We may give notice of such lien to the Recovery Source. You also assign to Us any benefits that You may have under any car insurance policy or other sources in order to enforce Our rights under this Article.

(C) We are subrogated to Your rights to seek a Recovery from a Recovery Source under any legal or equitable theory that You could assert against that Recovery Source. At Our option, We may bring a lawsuit against the Recovery Source in Your name or take, in Our sole discretion, such other necessary and appropriate action to preserve or enforce Our rights under this Article.

(D) You grant to Us a first priority lien against any Recovery We obtain under this subsection, whether or not You are fully compensated by the Recovery, to the extent of 100% of the Covered Health Services and Our reasonable costs, including attorneys fees, of pursuing and collecting the Recovery.

All Recoveries will be deemed as compensation for Covered Health Services regardless of how the Enrollee or the Enrollee's legal representative defines it.

We shall be responsible only for those legal fees and expenses relative to Your Recovery to which We agree in writing.

If the Sick or Injured Enrollee is a minor, any Recovery shall be subject to this Article to the extent permitted by applicable law, regardless of whether such Enrollee's parent, trustee, guardian, or other representative has access to or control of the Recovery.

The Enrollee agrees that acceptance of Covered Health Services is constructive notice of this Article in its entirety and constitutes full consent to it.

Section 10.4 Your Full Cooperation Required. In order to protect Our rights under this Article, You shall cooperate by doing all of the actions listed below.

~~(B)~~(A) Hold any collected Recovery in trust for Our benefit under this Article.

~~(C)~~(B) Notify Us of a claim or suit against a Recovery Source within 60 days of the action and of a proposed settlement at least 30 days before it is entered. You shall not, without Our written approval, accept any settlement that does not fully compensate or reimburse Us. If You fail to notify Us in accordance with this section, We shall not be obligated to cover the Health Services that provide a basis for the claim, suit or settlement.

~~(D)~~(C) Execute and deliver such documents as We may reasonably request including, but not limited to, documents to protect and perfect Our liens, to affect an assignment of benefits, and to release records.

~~(E)~~(D) Provide Us, or any party acting on Our behalf, any facts We need to subrogate the claim in a timely manner, but not more than one year after Our initial request for information or You will be responsible for any incurred claims.

~~(F)~~(E) Provide such other cooperation and information as We may reasonably request including, but not limited to, responding to requests for information about an accident, Sickness or Injuries and making court appearances.

~~(G)~~(F) Not prejudice Our rights.

Article 11

Coordination of Benefits

Section 11.1 Applicability. This Coordination of Benefit ("COB") section applies when an Enrollee has Coverage for Health Services under more than one "Plan," as defined below. The Order of Benefit Rules in Section 11.3 determines whether the benefits of this Contract are determined before or after those of another Plan. If the Order of Benefit Rules determines that this Contract is the "Primary Plan," as defined below, then the benefits of this Contract will not be reduced. If the Order of Benefit Rules determines that this Contract is the "Secondary Plan," as defined below, then the benefits of this Contract may be reduced.

Section 11.2 Definitions. The following definitions apply throughout this Article 11, but do not apply to the rest of the Contract:

(A) "**Allowable Expense**" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(B) "**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this COB provision or a similar provision takes effect.

(C) "**Plan**" means this Contract and any of the following arrangements that provide benefits or services for, or because of, medical or dental care or treatment:

(1) Employer insurance or Employer-type coverage, whether insured or uninsured. This includes prepayment, Employer practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
(3) Each arrangement described in (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(D) "**Plan Year**" means, for the initial Plan Year, the twelve-month period commencing with the date that Employer's coverage under this Contract becomes effective. Thereafter, it means the twelve-month period commencing on the anniversary of Employer's Coverage under this Contract.

(E) "**Primary**" or "**Primary Plan**" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If this Contract is Primary to another Plan, this Contract's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(F) "**Secondary**" or "**Secondary Plan**" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If this Contract is Secondary to another Plan, this Contract's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

Section 11.3 Order of Benefit Rules.

General. If there is a basis for benefits under this Contract and another Plan, this Contract is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those of this Contract, and (2) the rules of this Contract and the other Plan require this Contract to be the Primary Plan.

Specific Rules. The following rules will be applied in the order they appear to determine whether this Contract is Primary or Secondary to another Plan:

(1) Non-Dependent or Dependent. The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) Dependent Child or Parents not Separated or Divorced. If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(3) Dependent Child or Separated or Divorced. If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:
   a. the Plan of the parent with custody of the Child is Primary;
   b. the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and
   c. the Plan of the parent without custody of the child is the last Plan to be Primary.

   If a QMCSO states that a parent is responsible for the health care expense of a child, that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(4) Joint Custody. If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph (2), Dependent Child or Parents not Separated or Divorced will apply.

(5) Active or Inactive Employee. A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(6) Dependent of Active or Inactive Employee. A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) Continuation Coverage. If an individual has Continuation Coverage under this Contract and also has coverage under another Plan as an employee or dependent, the other Plan is Primary to this Contract. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) Longer or Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

Section 11.4 Effect on the Benefits of this Contract. Section 11.4 applies when the Order of Benefit Rules in Section 11.3 determine that this Contract is Secondary to one or more other Plans.

This Contract's benefits will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under this Contract in the absence of this COB provision; and
(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of COB provisions like this Contract's COB provisions, whether or not a claim is made.

The benefits of this Contract will be reduced so that they and the benefits payable under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this Contract.

Section 11.5 Facility of Payment. If another Plan provides a benefit that should have been paid or provided under this Contract, We may reimburse the Plan for the benefit. We may then treat the amount as if it were a benefit provided under this Contract and will not be responsible for providing that benefit again. This provision applies to the payment of benefits as well as to providing services. If services are provided, then We will reimburse the other Plan for the reasonable cash value of those services.

Section 11.6 Right of Recovery. If this Contract provides a benefit that exceeds the amount of benefit it should have provided under the terms of these COB provisions, We may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following.
(1) The individuals We have paid or for whom We have provided the benefit;
(2) Insurance Companies; or
(3) Other Organizations.

Article 12

GENERAL PROVISIONS

Section 12.1 Entire Contract. The Contract, the Appendix, and any Amendments make up the entire Contract of Coverage between You and Us.

All statements made by the Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce Coverage under this Contract or be used in defense of a legal action unless it is contained in the Application.

Section 12.2 Limitation of Action. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought unless brought within 3 years from the date the cause of action first arose.

[The Enrollee's][Your] damages shall be limited to recovery of actual benefits due under the terms of this Contract. [The Enrollee waives][You waive] any right to recover any additional amounts or damages including, but not

limited to, punitive and/or exemplary damages.

Section 12.3 Amendments and Alterations. No agent has authority to change this Contract or to waive any of its provisions. No person has authority to make oral changes to this Contract.

We will give You 60 days advance notice before any material modifications to this policy, including changes in preventive benefits.

Section 12.4 Relationship Between Parties. The relationships between MDwise and Participating Providers are ***solely*** contractual relationships between a payor (MDwise) and independent contractors (Participating Providers). Non-Participating Providers have no contractual relationship with Us, nor are they Our independent contractors.

Providers are not Our agents or employees. We and Our employees are not employees or agents of Providers.

The relationship between a Provider and any Enrollee is that of Provider and patient. The Provider is ***solely*** responsible for the services provided to any Enrollee. The Participating Pharmacy is ***solely*** responsible for the pharmacy services provided to any Enrollee.

Section 12.5 Second Opinion Policy. A second opinion may be required at Our discretion prior to the scheduling of certain Health Services. We will advise You if a proposed Health Service is subject to the second opinion policy. If so, You must consult with a second Participating Provider prior to the scheduling of the service.

You must (1) contact Us to obtain a list of Participating Providers who are authorized to render a second opinion, and (2) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider.

You must obtain the second opinion within 31 days of the first opinion or as soon thereafter as is reasonably possible. Second opinions We have arranged as described above are provided at no cost to You.

A second opinion may also be obtained at the request of an Enrollee, subject to separate benefit restrictions and/or Copays/Coinsurance described elsewhere in this Contract.

Section 12.6 Wellness and Cost Containment Programs. We may implement wellness or cost containment programs for Enrollees. Such programs may Cover services and supplies that would not otherwise be Covered. Such programs are in Our sole discretion. They may be discontinued at any time without prior approval from other parties.

Section 12.7 Confidentiality of Non-Public Personal Information. As required by the Gramm-Leach-Bliley Financial Services Modernization Act of 1999, We provide You with notice that We protect the nonpublic personal information that We receive about You and Your Dependents. We obtain certain nonpublic information about You through this Contract. This includes information from You on Applications or other forms, and information about Your transactions with Us, Our affiliates, or others. We have always been committed to maintaining the confidentiality of Your information and we take the following steps to protect our nonpublic personal information

(A) We restrict access to information to authorize individuals who need to know this information in order to provide services and products to You or relating to Your Contract.
(B) We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard Your information.
(C) We do not disclose this information about You or any former customers, except as permitted by law.
(D) We make disclosures to affiliates, as applicable, as permitted by law.

Section 12.8 Confidentiality of Medical Information

By accepting Coverage, You authorize and direct any person or institution that has attended, examined, or treated You to furnish Us any and all related information and records. Such must be provided to Us at any reasonable time, upon Our request.

We and Our designees have the right to any and all records concerning Health Services as necessary to accomplish

any of action listed below.

(A) To implement and administer the terms of this Contract,
(B) For appropriate medical review or other quality assessment, or
(C) For purposes of health care research.

Any information We obtain that pertains to Your diagnosis, treatment or health is confidential. We shall not disclose such information to any person except to fulfill Our obligations as described above, or as required by state or federal law.

Examples of when We may release such information as required by law are listed below.

(A) Upon Your express written consent.
(B) When a Child under the age of 18 is an Enrolled Dependent through a custodial parent, non-custodial parent, step-parent or legal guardian, except when the minor child has lawfully obtained Covered Health Services without the consent or notification of a parent or legal guardian.
(C) Under a statute or court order for the protection of evidence or the discovery of evidence, in the event of litigation between You and MDwise in which the information is pertinent.

We may claim any legal right against disclosure of the information that the Provider who supplied it may claim.

Section 12.9 Records. The Subscriber shall furnish Us with all information and proof that We may reasonably require with regard to any matters pertaining to this Contract.

The following items shall be open for Our inspection at any reasonable time (1) all documents furnished by an Enrollee in connection with the Coverage, and (2) any other records pertinent to Coverage under this Contract.

Both MDwise and Participating Providers may charge You reasonable fees to cover costs for completing medical abstracts or for other forms which You request.

Section 12.10 Examination of Enrollees. We may reasonably require that You be examined if a question or dispute about the provision of or payment for Health Services arises. The exam will be performed by a Participating Provider acceptable to Us. We will pay for the exam.

Section 12.11 Typographical or Administrative Error. Typographical or administrative errors shall not deprive an Enrollee of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

Section 12.12 Right of Recovery. If We pay for Health Services or benefits that, according to the terms of the Contract, should not have been paid, We reserve the right to recover such amounts from [You}[an Enrollee], the Provider to whom they have been paid, or any other appropriate party.

Section 12.13 Notice. Our notice to the Subscriber is deemed notice to all Enrolled Dependents. Such notice includes notice of termination of this Contract.

Our notice is sufficient if mailed to the Subscriber's address shown in Our records at the time of the mailing. Notice is deemed delivered when deposited in the United States mail with first class postage prepaid, unless otherwise stated in this Contract.

Any notice from You concerning this Contract must be sent to Our address listed in this Section.

MDwise Marketplace, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

Section 12.14 Contract is Not Worker's Comp Insurance. The Coverage provided under the Contract does not replace, supplement or provide a substitute for benefits to which an Enrollee is entitled under worker's comp, occupational disease, and similar laws.

The Contract does not Cover Health Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's comp, occupational disease and similar laws, even when the circumstances below are present.

~~(E)~~(A) If the Enrollee's employer is not properly insured or self-insured under such laws.

~~(F)~~(B) When an Enrollee refuses to use his or her employer's designated Provider.

~~(G)~~(C) When an Enrollee has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

An Enrollee must contact his employer or its worker's comp or occupational disease insurer for the provision or payment of such Health Services and expenses.

Section 12.15 Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on its Effective Date shall apply.

Any Contract provision which, on this Contract's Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

Section 12.16 Non-Discrimination. In compliance with state and federal law, We shall not discriminate on the basis of age, gender, color, race, disability, marital status, sexual preference, religious affiliation, or public assistance status.

We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care.

We shall not, with respect to any person and based upon any health factor or the results of Genetic Screening or Testing (1) refuse to issue or renew Coverage, (2) cancel Coverage, (3) limit benefits, or (4) charge a different Premium.

Section 12.17 General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within Our control (1) We will Cover Health Services as provided in this Contract to the extent that facilities and personnel are then available, and (2) We shall have no liability or obligation for delay or failure to provide Health Services due to lack of available facilities or personnel.

[Section 12.18 Medicare. Any Health Services Covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare, We will calculate benefits as if they had enrolled.

The benefits under this Contract for Enrollees age 65 and older or Enrollees otherwise eligible for Medicare do not duplicate any benefit for which Enrollees are entitled under Medicare, except when federal law requires Us to be the primary payor.

Where Medicare is the primary payor, all sums payable by Medicare for Health Services provided to Enrollees shall be reimbursed by or on behalf of the Enrollees to Us to the extent We have made payment for such Health Services.]

MDwise [BENEFIT PLAN] Schedule of Benefits

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copays, maximums and other limits that apply when You receive Covered Health Services from a Provider. Please refer to the "Benefits and Covered Health Services" article of this Contract for a more complete explanation of the specific Health Services Covered by the Contract. All Covered Health Services are subject to the conditions, exclusions, limitations, terms and provisions of this Contract including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Enrollee's responsibility for Covered Health Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Health Services must be provided by a Participating Provider. Services provided by Non-Participating providers are Not Covered and the cost of services will be Your responsibility unless otherwise specified in this Contract.

Coinsurance and Deductibles, as well as any maximums, are calculated based upon the Allowed Amount, not the Provider's charge.

Under certain circumstances, if We pay the Provider amounts that are Your responsibility, such as Deductibles, Copays or Coinsurance, We will collect such amounts directly from the Provider who will in turn collect them from you. You agree that the Provider has the right to collect such amounts from You.

Essential Health Benefits provided within this Contract are not subject to lifetime or annual dollar limitations. Certain non-Essential Health Benefits, however, may be subject to either lifetime and/or annual dollar limitations.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories.

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services and chronic disease management, and
- Pediatric vision services.

Such benefits shall be consistent with those set forth under the ACA and any regulations issued pursuant thereto.

BENEFIT PERIOD – Calendar Year
DEPENDENT AGE LIMIT – Until the Child attains age 26
CONTRACT SERVICE AREA: _____

MDWISE MARKETPLACE [BENEFIT PLAN]

DEDUCTIBLE		
	Tier 1	**Tier 2**
Per Enrollee	[$0-$5,500]	[$0-$6,600]
Per Family	[$0-$11,000]	[$0-$13,200]

The amounts paid toward the Tier 1 Deductible are concurrent with and apply toward the Tier 2 Deductible. The Deductible applies to all Covered Health Services except for office visits for primary care physicians and , Generic drugs, and preventive care. Copays do not apply toward the Deductible. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Deductible.

OUT-OF-POCKET LIMIT		
	Tier 1	**Tier 2**
Per Enrollee	[$0-$6,600]	[$0-$6,600]
Per Family	[$0-$13,200]	[$0-$13,200]

The Out-of-Pocket Limit includes all Deductibles, Copays and Coinsurance amounts You incur in a Benefit Period. The amounts paid toward the Tier 1 Out-of-Pocket Limit are concurrent with and apply toward the Tier 2 Out-of-Pocket Limit. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Out-of-Pocket Limit. Once the Enrollee and/or family Out-of-Pocket Limit is satisfied, no additional Copays/Coinsurance will be required for the Enrollee and/or family for the remainder of the Benefit Period.

Any amounts that You are responsible for paying for Health Services rendered by a Non-Participating Provider are separate from and do not apply to the Deductible and Out-of-Pocket Limits.

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Ambulance Services	[$0-$500]Copay Per Transport	[$0-$500] Copay Per Transport	$200 Copay per transport
Behavioral Health Services			
Inpatient Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Outpatient Services	[$0-$90] Copay per visit	[$0-$150] Copay per visit	Not Covered without Prior Authorization
Physician Home Visits & Office Services	[$0-$90] Copay per visit	$40 Copay per visit	Not Covered without Prior Authorization
Dental Services (only when related to accidental injury or for certain Enrollees requiring general anesthesia)	$100 Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	$100 Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Diabetic Equipment, Education, & Supplies	Copays / Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the "Specialty Care" or "Primary Care Provider" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.		Not Covered without Prior Authorization
Diagnostic Services			
Laboratory and Pathology Services	[$0-$75] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Radiology Services including MRI, CT, PET, Ultrasound	[$0-$300] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$400] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
X-Ray Services	[$0-$75] Copay per visit Copays/Coinsurance may change based on setting where the	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
	Covered Health Services are received.	where the Covered Health Services are received.	
Emergency Room Services Copay/Coinsurance is waived if You are admitted.	[$0-$750] Copay per visit	[$0-$750] Copay per visit	[$0-$750] Copay per visit
Home Care Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Annual Visit Limitation for Home Care	90 visits, combined Tier 1 and Tier 2 Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 90 visits
Annual Visit Limitation for Private-Duty Nursing	82 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 82 visits

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Lifetime Visit Limitation for Private-Duty Nursing	164 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 164 visits
Hospice Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Inpatient and Outpatient Professional Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Inpatient Facility Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Annual Limitation for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2 combined limitation of 60 days
Annual Limitation for Skilled Nursing Facility	90 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2 combined

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			limitation of 90 days.
Mammograms (Outpatient – Diagnostic & Routine)	For Mammogram Health Services recommended by the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF, see the "Preventive Care Services" provision in this Schedule. For all other Mammogram Health Services, see the "Diagnostic Services" provision in this Schedule.		Not Covered without Prior Authorization
Maternity Services	Copays/Coinsurance may change based on setting where the Covered Health Services are received.		Not Covered without Prior Authorization
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Participating Pharmacy)	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
	Note – Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are Covered the same as any other Medically Necessary items and Health Services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract. **Note –** If durable medical equipment or appliances are obtained through Your Primary Care Physician or another Participating Physician's office, Urgent Care Center Services, Outpatient Services, Home Care Services the Copay/Coinsurance listed above will apply		

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
	in addition to the Copay/Coinsurance in the setting where Covered Services are received.		
Outpatient Services			
Other Outpatient Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
	Note – Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copay/Coinsurance regardless of setting where Covered Services are received.		
Outpatient Surgery Hospital/Alternative Care Facility	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Physician Home Visits and Office Services			
Primary Medical Provider (PMP)	$0 Copay per visit PMP visits are not subject to the Deductible	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any Provider that is not Your chosen (or assigned) PMP is	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any Provider that is

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
		considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.	not Your chosen (or assigned) PMP is considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.
Specialty Care Physician (SCP)	[$0-$90] Copay per visit	[$0-$150] Copay per visit	Not Covered without Prior Authorization
	Note – Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations Covered under "Preventive Care Services" in the Contract) received in a Physician's office are subject to the Other Outpatient Services Copay / Coinsurance.		
Allergy Services	[$0-$90] Copay if visit	[$0-$150] Copay if visit	Not Covered without Prior Authorization
	[0%-35%] Coinsurance for Serum	[0%-50%] Coinsurance for Serum	Not Covered without Prior Authorization
	Coinsurance will be applied to allergy serum when the injection(s) is billed by itself. The office visit Copay will apply if an office visit is billed with an allergy injection. No Copay if injection administered by a nurse.		
Preventive Care Services	No Copay	No Copay	Not Covered without Prior Authorization
Surgical Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Therapy Services	[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
	Note – If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.		
Annual Visit Limitation			
Physical Therapy (Limits apply separately to	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
Rehabilitative and Habilitative Services)			Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Occupational Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Speech Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Manipulation Therapy	12 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			approved apply toward Tier 1 and Tier 2 combined limitation of 12 visits
Cardiac Rehabilitation	36 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 36 visits
Pulmonary Rehabilitation	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Urgent Care Center Services	[$0-$100] Copay per visit	[$0-$200] Copay per visit	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Pediatric Vision			
Pediatric Eyewear	No Copay	Not Available	Not Covered without Prior Authorization
Lenses	Limit 1 pair per year.	Not Available	Not Covered without Prior Authorization
Frame	Limit 1 per year from Pediatric Exchange collection.	Not Available	Not Covered without Prior Authorization
Contact Lenses	• Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) • Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) • Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) • Dailies (one month supply) = 30 lenses per eye (total 60 lenses)	Not Available	Not Covered without Prior Authorization

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following.

- **Cornea and kidney transplants, and**
- **Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Enrollee cost shares.

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES		
	Participating Transplant Provider	**Non-Participating Transplant Provider**
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (the number of days will vary depending on the type of transplant received and the Participating Transplant Provider Agreement. Contact the Transplant Case Manager for specific Participating Transplant Provider information) for services received at or coordinated by a Participating Transplant Provider Facility.	Starts one day prior to Covered Transplant Procedure and continues to the date of discharge.
Deductible	Not applicable.	Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will not apply to Your Out-of-Pocket Limit.
Covered Transplant Procedure During The Transplant Benefit Period	During the Transplant Benefit Period, No Copay/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending	During the Transplant Benefit Period, You will pay 50% of the Allowed Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Participating Transplant Provider Facility will not apply to Your Out-of-Pocket Limit.

	where the service is performed.	If the Provider is Non-Participating Provider for this Contract, You will be responsible for the Covered Health Services which exceed Our Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
	Participating Transplant Provider Professional and Ancillary (non-Hospital) Providers	**Non-Participating Transplant Provider Professional and Ancillary (non-Hospital) Providers**
Covered Transplant Procedure During the Transplant Benefit Period	No Copay/Coinsurance up to the Allowed Amount.	You are responsible for 50% of the Allowed Amount. These charges will not apply to Your Out-of-Pocket Limit.
Transportation and Lodging	[0%-35%]coinsurance Covered, as approved by the Contract, up to a $10,000 benefit limit	Not Covered for Transplants received at a Non-Participating Transplant Provider Facility
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	[0%-35%]Coinsurance Covered, as approved by the Contract, up to a $30,000 benefit limit	Covered, as approved by the Contract, up to a $30,000 benefit limit. You will be responsible for 50% of search charges. These charges will not apply to Your Out-of-Pocket Limit.
Live Donor Health Services	Covered as determined by the Contract.	Covered as determined by the Contract. These charges will not apply to Your Out-of-Pocket Limit.

PRESCRIPTION DRUGS
Days Supply

Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limitation and Utilization Guidelines	
Retail Pharmacy (Participating & Non-Participating)	30
Mail Service	90
Tier 4 Drugs	30* *Some Tier 4 drugs may be available in 90 day supply via mail service.
Participating Retail Pharmacy Prescription Drug Copay/Coinsurance	
Tier 1Prescription Drugs	[$0-$30] Copay per Prescription Order Tier 1 drugs are not subject to the Deductible
Tier 2Prescription Drugs	[$0-$85] Copay per Prescription Order Tier 2 drugs are not subject to the Deductible.
Tier 3 Prescription Drugs	[0%-35%] Coinsurance per Prescription Order
Tier 4 Prescription Drugs	[0%-35%]Coinsurance per Prescription Order; See Participating Retail/Specialty Mail Service Information below.
Non-Participating Retail Pharmacy and Non-Participating Pharmacy Prescription Drug Copay	
Non-Participating Retail Pharmacy and Non-Participating Pharmacy Prescription Drug Copay	Not Covered without Prior Authorization
Orally Administered Cancer Chemotherapy	
Orally Administered Cancer Chemotherapy	[0%-35%]Coinsurance for retail; [0%-35%]Coinsurance for mail order As required by Indiana law, benefits for

	orally administered cancer chemotherapy will not be less favorable than the benefits that apply to Coverage for cancer chemotherapy that is administered intravenously or by injection.

Note – Prescription Drugs will always be dispensed as ordered by Your Physician. You may request, or Your Physician may order, the Tier 2 or Tier 3 Drug. However, if a Tier 1 Drug is available, You will be responsible for the difference in the cost between the Tier 1 Drug and Tier 2 or Tier 3 Drug. If a Tier 1 Drug is not available, or if Your Physician writes "Dispense as Written" or “Do not Substitute” on Your Prescription, You will be required to pay the applicable Tier 2 or Tier 3 Copay/Coinsurance. You will not be charged the difference in cost between the Tier 1 Drug and Tier 2 or Tier 3 Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in Our sole discretion, to remove certain higher cost Generic Drugs from this policy.

Note – No Copay/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Allowed Amount when obtained from a Participating Pharmacy. These supplies are Covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Participating Pharmacy. Diabetic test strips are Covered subject to applicable Prescription Drug Copay/Coinsurance.]

State: *Indiana* **Filing Company:** *MDwise Marketplace, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *MDwise Marketplace*
Project Name/Number: *MDwise Marketplace/62033IN001*

Rate Information

Rate data applies to filing.

Filing Method: Review/Approval
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision: 01/01/2014
Filing Method of Last Filing: SERFF HIOS

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
MDwise Marketplace, Inc.	New Product	%	%				%	%

State: *Indiana* **Filing Company:** *MDwise Marketplace, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *MDwise Marketplace*
Project Name/Number: *MDwise Marketplace/62033IN001*

Rate Review Detail

COMPANY:

Company Name: MDwise Marketplace, Inc.
HHS Issuer Id: 62033

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
MDwise Marketplace	62033IN001	62033-326741	1

Trend Factors: SEE ACTUARIAL MEMORANDUM

FORMS:

New Policy Forms: 62033-2015-1
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 694,058
Benefit Change: None
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium: 336,308,624.00
Projected Incurred Claims: 258,367,891.00
Annual $: Min: 125.19 Max: 1,697.53 Avg: 484.49

State: *Indiana* **Filing Company:** *MDwise Marketplace, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *MDwise Marketplace*
Project Name/Number: *MDwise Marketplace/62033IN001*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Actuarial Memorandum	62033-2015-1	New		Actuarial Memorandum MDwise Issuer 62033 (Wakely 7-25-2014).pdf,

Actuarial Memorandum

MDwise Issuer #62033

Individual Health Insurance Exchange Premium Rate Filing

July 25, 2014

Developed By:

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1. EXECUTIVE SUMMARY

This memorandum documents the development of individual rates for MDwise. These rates will be offered inside of the State of Indiana's health insurance exchange, which is being operated by the federal government.

MDwise is a not-for-profit corporation that purchased 100% of the stock in IU Health Plan, Inc., a fully licensed HMO, (IUHP) on December 29, 2006. IUHP was merged into MDwise, Inc. as of January 1, 2007. MDwise remains a fully licensed Indiana domestic HMO. MDwise is jointly controlled by Indiana University Health, Inc. and Health & Hospital Corporation of Marion County Indiana. The two parent companies are not-for-profit, are incorporated in the State of Indiana, and are provider delivery system companies.

Beginning January 1, 2011, MDwise was granted a four-year contract with the State of Indiana (the "State"), through the Family and Social Service Administration ("FSSA") and Office of Medicaid Policy and Planning ("OMPP"), to arrange for and administer two risk-based managed care programs ("Hoosier Healthwise" and "Healthy Indiana Plan") for certain Indiana Medicaid enrollees. MDwise contracts with various delivery networks. The delivery networks accept the medical service risk for enrollees who choose a primary care provider after selecting the MDwise network. There were approximately 280,000 members enrolled in the Hoosier Healthwise and Healthy Indiana Plan products at December 31, 2013.

Under an Accountable Care Organization model, MDwise contracts with several integrated delivery systems to provide medical services and claims administration under risk contracts for their current business. MDwise has operated under this model since its inception.

MDwise is offering two individual health insurance products in the Bronze and Silver metal tiers and one individual health insurance product in the Gold metal tier. Being a non-profit health plan focused on low income individuals, MDwise expects most enrollment to be in the Silver plan, for individuals eligible for premium tax credits and cost sharing reductions. MDwise's mission is to provide health care services to the lower income population. One of the primary reasons that MDwise is entering the individual market within the health insurance exchange is to provide its Medicaid members with an MDwise product offering if they lose Medicaid eligibility.

MDwise has applied for a new HMO license in the State of Indiana (MDwise Marketplace). Our filing is in the review process. MDwise anticipates it to be active in time for 2015 Open Enrollment season. MDwise has applied and received a new HIOS ID number of 62033.

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2. GENERAL INFORMATION

Company Legal Name: MDwise Marketplace, Inc.

State: Indiana

HIOS Issuer ID: 62033

Market: Individual Market

Effective Date: January 1, 2015

Company Contact Information

Primary Contact Name: Elizabeth Eichhorn

Primary Contact Telephone Number: 317-822-7232

Primary Contact Email Address: Eeichhorn@mdwise.org

3. PROPOSED RATE INCREASES

MDwise began selling individual policies with effective dates beginning January 2014. They did not previously participate in the individual market. The effective rate increase is 8.8% for 2015 for all proposed individual policies. This large increase is driven primarily by Indiana's transition from a 209(b) state to a 1634 state and the associated population expected to enroll in the individual market because of this change.

4. EXPERIENCE PERIOD PREMIUM AND CLAIMS, BENEFIT CATEGORIES AND PROJECTION FACTORS

MDwise began selling individual policies with effective dates beginning January 2014. The effective rate increase for 2015 is 8.8% for all proposed individual policies.

Because they did not participate in the individual or small group markets prior to 2014 and 2014 experience is not yet credible, the rate development is based entirely on a manual rate.

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5. MANUAL RATE DEVELOPMENT

The basic manual rate development methodology is unchanged from the 2014 premium rate development. Updated market experience was not available at a sufficient level of detail to justify redeveloping the manual rate. Instead, we reflected emerging demographic and risk adjustment information in our morbidity assumptions and updated other assumptions that were different from 2014 including trend, the impact of reinsurance, benefit changes, leveraging of fixed cost sharing items and the addition of individuals expected to enroll in the Individual market starting in 2014 because of Indiana's transition from a 209(b) state to a 1634 state.

The approach to premium rate development is as follows:

1. Paid and/or allowed PMPM medical costs were developed using market information including competitor rate filings, premium rates, and financial filings. If historic experience net of member cost sharing was used, paid to allowed ratios were estimated using the Wakely pricing model. Table C-1 in Appendix C shows the various sources used for the small group source development.

2. Allowed PMPMs were adjusted for trend and ACA changes and requirements including EHB, pent up demand, morbidity changes between pre and post ACA enrollment and others described below.

3. The Wakely pricing model was calibrated to the adjusted allowed PMPMs and used to estimate paid to allowed ratios. Within a benefit plan offering, a consumer may choose to use providers in a preferred network of providers and receive reduced cost sharing, represented by Tier 1. If a consumer chooses instead to use non-preferred providers, the cost sharing is greater, represented by Tier 2. They have been blended with a 90% weighting on Tier 1 and 10% on Tier 2, reflective of MDwise's expectations on actual utilization. The pricing by tier and blended result is shown in Appendix A.

4. Administrative costs and regulatory fees and taxes, along with contribution to surplus were added.

Appendix C, Table C-2 shows the components of the starting allowed PMPM shown in Appendix A. A comparison to the 2014 development is also provided.

Source and Appropriateness of Experience Data Used

The allowed PMPM target for post reform experience was developed using pre-reform small group market information.

Even though the goal is to price individual products post reform, the post reform individual market may look more like the pre-reform small group market than the pre-reform individual market. Therefore, we reviewed rate filings and financial reports for Indiana small group products. We made adjustments for trend, benefit design, and others to adjust the allowed PMPM to the midpoint of the rating period.

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Population Changes

The manual rate incorporates results from the SOA study[1] (performed by Optum/Lewin) to estimate changes in morbidity from the Indiana pre-ACA market to that enrolled in Indiana post ACA. Results from other states and analyses, including those performed by Wakely were also reviewed, but the Lewin model framework was used. Wakely has performed detailed studies on behalf of individual states with broad health plan participation and detailed data collection. We have found some of the values provided by the health plans, high risk pool, and the state differ (sometimes significantly) from the values presented in the SOA study, which is reasonable given the different data sources used and differences in judgment likely between actuaries performing this type of modeling. We made adjustments and applied judgment with input from the health plan in developing the final estimates of how the post reform market would compare to the pre-reform market. The primary changes were to decrease the number of previously uninsured entering the market and to increase their assumed health status since the SOA values are targeted once the ACA has been fully implemented.

Wakely also reviewed emerging results from the Wakely National Risk Adjustment Reporting study. This study included participation from Indiana issuers, including MDwise. The issuers reported claims and demographic based risk adjustment information through February 2014. The project will include updated information throughout 2014 which we will be reviewing as it becomes available. Emerging Indiana information caused us to increase our morbidity assumption by 2%. This is primarily driven by a higher age distribution than originally anticipated. This adjustment captures expected morbidity over and above allowable rating variation.

An additional adjustment of 1.5% is made to account for the transition of individuals that had been covered under Indiana's Medicaid Spend-down program. In developing an assumption for the impact of this population on the market, Wakely considered information provided by the state regarding the population and emerging enrollment of this population into the exchange.

The components of the Morbidity Adjustment are shown in Appendix C, Table C-2.

Appendix F provides the detail behind the base SOA tables and our adjustments to the SOA tables to develop the final morbidity adjustment factor in Appendix C (1.0039).

Pent up demand and the 2014 strategic renewal impact adjustments are described in more detail below.

Cost Adjustments

We have made two adjustments to account for cost variances.

- Smoking Load – We adjusted the base period data by a factor of 0.9874 to create an index rate that is reflective of a non-smoking population.

[1] Web link (as of 4-4-2013): http://www.soa.org/NewlyInsured/

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- Bad Debt – To account for the likelihood that some policy holders will not pay premiums within the grace period, we have increased rates by a factor of 1.00275. This is calculated assuming a 15% rate of non-payment of one out of twelve months on about 22% of premium, after considering federal subsidies (.15 x .224 x 1/12 = .00275).

Trend Factors (cost / utilization)

We assumed PMPM medical costs would increase by 8% annually from 2012 to 2015 due to ongoing increases in utilization, unit costs and technology. This assumption is based on review of rate filings for Indiana and other states, national publicly available trend surveys, and judgment. These trends do not include the effect of demographics or benefits because those adjustments are included elsewhere.

Essential Health Benefits (EHB)

We adjusted the allowed claims sources in the manual rate development for expected changes in covered benefits due to EHB requirements, specific to individual and small group market starting cost sources. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

Adjustments for changing demographics, changes in benefits, and others were separately addressed and included in the premium rate development.

To incorporate these adjustments we increased the small group market source by 2%.

Provider Reimbursement Adjustment

MDwise provided Wakely with provider contracting targets by plan (based on service area) for inpatient facility, outpatient facility and professional categories of service. Wakely analyzed these targets and compared them to market information regarding current commercial reimbursement rates. We assumed provider volume by provider system would be consistent with current MDwise Medicaid volume by provider system. The total adjustments to allowed cost varied by plan and are reflected in the geographic factors.

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Strategic Renewal Impact

Many health plans were working to provide communication and incentive for individual policyholders to renew on 12/1/2013, 1/1/2014, or at their scheduled renewal. This type of strategic approach has been used in the past as states have implemented different state based reforms. This approach likely increased the average morbidity of individuals included in the risk adjustment pool in 2014. The healthy individuals will get a smaller rate increase under pre-ACA policies due to rating for health status while the sicker individuals would get a better rate on ACA policies since they do not rate for health status. For 2015, the impact of strategic renewal would have disappeared but the administration allowed states to continue renewing these policies on pre-ACA products and Indiana has allowed such policies (referred to as a transitional or "grandmothering").

We have been informed by the State of Indiana that approximately 20% or less of the market will renew transitional policies. We have included a 1% adjustment (1.01 factor) within our manual rate development for this (part of morbidity adjustment in Appendix C, Table C-2).

Pent Up Demand

In 2014, there were many new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services.

We expect very little remaining pent up demand in 2015. Therefore, we have removed the pent up demand effect and used a factor of 1.0 in Appendix C, Table C-2.

Inclusion of Capitation Payments

While MDwise will pay the Delivery Systems a global cap rate (percentage of premium), the State of Indiana has required MDwise to report the underlying provider payments as the true medical costs to provide coverage in MDwise's financial statements. This is because the Delivery Systems are delegated a portion of the administrative costs associated with their members. Therefore, the capitation paid to the delivery systems is meant to cover direct medical costs, and provider overhead. Based on discussions between MDwise, CCIIO and the state of Indiana, we understand that this treatment will continue in 2014 and beyond. This is important because of the risk corridor protection and minimum loss ratio treatment, which affect the relative level of risk inherent in the premium rate development and overall delivery system payment amounts.

6. CREDIBILITY OF EXPERIENCE

MDwise began operating in the individual market in 2014 and that experience is not yet credible. Per request from the State of Indiana Department of Insurance, we have entered projected 2014 information from last year's rate filing in the "Experience Period" section of Worksheet 1 of the URRT. However, the

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projection factors (cells J24:M29 on Worksheet 1) have been left blank. The service category PMPMs shown in the "Credibility Manual" section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

7. PAID TO ALLOWED RATIO

The Wakely pricing model uses a nationally-representative detailed medical and pharmacy claim and enrollment data (Truven MarketScan) for over 40 million lives to develop paid to allowed pricing estimates for final rate development (as opposed to metal tier categorization). The model uses actuarially sound pricing methods to value the impact of deductibles, copays, coinsurance and maximum out of pocket cost sharing parameters. We calibrated the utilization and unit cost assumptions by category of service in the model to the allowed cost estimates underlying the manual rate and/or experience rate, including adjustments for EHB, trend, provider reimbursement changes by service category, average expected demographics and other adjustments discussed elsewhere in this report.

8. RISK ADJUSTMENT AND REINSURANCE

Projected Risk Adjustments PMPM

We have developed manual rates for a 1.0 average statewide risk and assumed that MDwise would enroll average risk individuals. Therefore, no risk adjustment PMPM payment is assumed in 2015.

Reinsurance

The presence of the Federal reinsurance program will reduce costs for issuers in the individual market. This adjustment is intended to capture the portion of costs that will be reimbursed to health plans for reinsurance. The reinsurance payment parameters for 2015 were originally announced as an attachment point of $70,000, a reinsurance cap of $250,000, and a target coinsurance rate of 50%. In final regulations published in late May, CMS stated its intent to lower the 2015 attachment point to $45,000 and suggested the possibility of an adjustment to the 2015 target coinsurance rate. In rates developed for this filing, an attachment point of $45,000 has been assumed. We have assumed no change to the target coinsurance rate of 50%.

To estimate the impact of reinsurance, we reviewed several claims probability distributions (CPDs) from different sources, adjusted to our estimated allowed PMPMs. To estimate the impact of moving from allowed to paid continuance, we increased the attachment and maximum values from the federal parameters by the MOOP for various plans, since the vast majority of individuals would have already reached their MOOP when costs reach the reinsurance attachment point. Our estimates are very sensitive to the shape of the CPD, the overall allowed cost PMPM that the CPD is calibrated to, as well as the MOOP and underlying Actuarial Value of the plan. Based on sensitivity testing, we have assumed that the average reinsurance impact will be a 9.6% reduction to net allowed claims costs (11.1% to paid claims). This adjustment was applied uniformly across all benefit plan packages. We have assumed that the allocated

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federal reinsurance dollars will be sufficient to fund the federal reinsurance program in 2015, which is not guaranteed.

9. NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load

MDwise developed expected administrative costs based on current administrative costs for their Medicaid line of business, adjusted to reflect any differences in functions or level of effort for the commercial product. MDwise assumed a 50% of administrative expenses would increase by 3% from 2014 on a PMPM basis while 50% would increase with premium rates. For the small service areas, the PMPM component was increased to spread fixed costs across a small member cohort.

Contribution to Surplus & Risk Margin

Three percent (3%) of premiums has been allocated to contribution to surplus.

Taxes and Fees

Taxes and regulatory fees include the following:

1. PCORI Fee = $0.17 PMPM
2. Issuer Fee = It is not clear if MDwise will be exempt from the issuer fee in 2015. We have assumed they will be subject to the fee in this filing at 2.0%.
3. Health Insurance Exchange Fee = 3.5% of premium for products sold through the Exchange. MDwise expects the vast majority of their business to be sold through the exchange and we have included the full 3.5% load in premium rate development.

Please note that in the URRT taxes and fees section, the risk adjustment and reinsurance fees have been excluded.

Reinsurance and Risk Adjustment Fees

The following fees were netted out of the experience in the URRT.

1. Reinsurance Charge = $3.67 PMPM
2. Risk Adjustment User Fee = $1.00 PMPY ($0.08 PMPM)

10. PROJECTED LOSS RATIO

Wakely's estimates indicate projected MLRs for the individual line of business of 82.0% for 2015. Consistent with the MLR and Risk Corridor calculations, regulatory fees and taxes were excluded from premium in the calculation of this value.

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11. SINGLE RISK POOL

MDwise has established a single risk pool for all of its individual business. Since MDwise did not participate in the individual market prior to 2014, all of its individual business is non-grandfathered, non-transitional, and ACA-compliant.

12. INDEX RATE

Index Rate for Projection Period

The starting allowed claim index of $650.20 is developed from the historical claim index rate of the Indiana Small Group Market. Appendix C, Table C-2 illustrates this development. The bullet points below briefly describe specific line items in Table C-2. For comparative purposes, the adjustment for average percentage of smokers has been retained in the table. Per CCIIO instructions, the adjustment for the smoker load should not be included in the starting allowed claim cost, so to calculate the $650.20 the factor is excluded.

- Base Period Allowed PMPM – These historical claim index rates are developed from publicly available information.
- Cost Adjustment – This adjustment accounts for cost differences between the base period and projected period and include an adjustment for the expected bad debt that is introduced by the grace period.
- Benefit Adjustment – This adjustment accounts for differences between the base period benefits and those offered under the exchange as essential health benefits.
- Morbidity Adjustment – This adjustment accounts for differences in the morbidity of the population underlying the base period allowed PMPM and the population expected in the exchange market. Included in this adjustment are considerations for morbidity and demographic differences, pent-up demand, and the impact of transitional policies.
- Trend factor – We used an assumed trend of 8.0% over 30 months to trend the base period data to a midpoint of 7/1/2015.
- Allowed Claim Index Rate by Source – The allowed claim index rate is calculated as the product of the historical claim index rate and all the factors listed above in this section.

Market Adjusted Index Rate

We included the impact of reinsurance and risk adjustment and the exchange user fee to the index rate for the projection period to develop the market adjusted index rate.

The development of this index rate can be seen in Appendix A, item g.

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Plan Adjusted Index Rate

To bring the experience used in the manual rating to a "non-tobacco" basis, a downward adjustment is applied using a factor of 0.9874. Among the items contemplated when setting this assumption were the rates of tobacco use in Indiana as well as the proportion of people who will self-report as "Smokers."

We multiplied the market adjusted rate by provider contracting discounts, the actuarial value and the federal induced demand factors.

We then included the admin, commissions, ACA fees, tax, and profit margin.

The development of this index rate can be seen in Appendix A, item v.

Calibration

To bring the experience to age 21 rate, we divided the plan adjusted index rate by the weighted average age factor. The age factor was calculated as the weighted average of ACA age factors and the 2015 expected individual enrollment by age. The average age is approximately 50 years.

The development of this index rate can be seen in Appendix A, item w.

Consumer Adjusted Index Rate

The consumer adjusted index rates are calculated by multiplying the calibrated plan adjusted index rates by the consumer's specific age factor, area, and tobacco status. As last year's restrictions on the smoker load (limiting smoker loaded rates to the same 3:1 limit as non-smoker rates) have been removed, the loads have been change and are shown in Appendix D.

Using the age factors and smoking load Area Factors in Appendix D, one can take the index rate from Appendix A and develop the rates for each product and age combination. Two examples are provided in Appendix E.

13. AV METAL LEVELS

The Federal AVC was used without modification to generate the AV metal tier (column b on Appendix A). The Federal AVCs were as follows:

Bronze A	61.8%
Silver A (base)	71.9%
Silver A (73% CSR)	73.9%
Silver A (87% CSR)	87.7%
Silver A (94% CSR)	94.8%
Gold A	80.5%
Bronze B	58.3%
Silver B (base)	68.1%
Silver B (73% CSR)	73.8%

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Silver B (87% CSR)	86.1%
Silver B (94% CSR)	93.0%

14. AV PRICING VALUES

The reference plan underlying our pricing was a Silver plan. From this base PMPM, we applied benefit richness utilization adjustments to stratify this PMPM to levels suitable for each of the metal tiers. We used the following values which are equal to the Federal values published in the Federal Register payment notice, normalized to the silver benefit level:

Bronze = 1.00 / 1.03 = 0.9709

Silver = 1.03 / 1.03 = 1.0000

Gold = 1.08 / 1.03 = 1.0485

MDwise is not offering Platinum or Catastrophic plans.

The adjustment factors above are shown in Appendix A, column o.

The same underlying cost distribution and cost level was used. The only adjustment before determining AV pricing values was benefit richness utilization differences using Federal adjustment factors. **Therefore, differences in expected morbidity across metal tiers were not included in the pricing development for each metal tier plan.**

These adjustments do not incorporate a selection bias due to health status. Rather, they represent an adjustment due to any particular individual utilizing services differently when they have a richer or less rich benefit design.

The pricing AVs are higher than the Federal AVCs primarily because the estimated allowed PMPMs are higher than those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements like copays, deductibles and MOOPs. This effect is more pronounced in 2015 than it was in 2014 because of the morbidity increases assumed due to the addition of the high risk population (conversion from 209(b) to 1634) and the higher age distribution.

15. MEMBERSHIP PROJECTIONS

The membership projections for 2015 were developed by Wakely in consultation with MDwise based on emerging enrollment and expected new enrollment for 2015.

Appendix B shows estimates of the Cost Sharing Reduction by Silver base and Silver variant level. We used the Federal formula shown in the Advance Payment Notice, which is equal to the difference in AVC

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multiplied by the allowed cost PMPM for each base plan, increased by 1.12 for cost sharing utilization for the 87% and 94% variants.

16. TERMINATED PRODUCTS

MDwise began selling individual policies with effective dates beginning January 1, 2014. They have no prior products to terminate.

17. PLAN TYPE

MDwise is filing HMO products.

18. URRT WARNINGS

There were no warnings in the URRT.

19. RELIANCE

Wakely Consulting Group, Inc., 9777 Pyramid Ct, Suite 260, Englewood, CO 80112 relied on information provided by MDwise to develop the 2014 individual premium rates. This information includes, but is not limited to the following:

- Provider contracting levels, including descriptions of the relationship between the Delivery systems and MDwise
- Administrative cost projections
- Projected enrollment figures by QHP
- Product design information
- Provider network information including discount data
- CCIIO and the State of Indiana regulatory and compliance interpretations and rulings
- Commercial rate filings and financial reports of carriers participating in the pre-ACA market.

20. ACTUARIAL CERTIFICATION

I, Ross Winkelman, am a Fellow in the Society of Actuaries (FSA) and a member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

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The submission is in compliance with all applicable laws, regulations, and guidance of the Federal government and the state of Indiana as of July 25, 2014. The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

ASOP No. 5, Incurred Health and Disability Claims

ASOP No. 8, Regulatory Filings for Health Plan Entities

ASOP No. 12, Risk Classification

ASOP No. 23, Data Quality

ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

ASOP No. 41, Actuarial Communication

In my opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are not excessive nor deficient although actual experience may vary from the estimates inherent in the premium rate development.

The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs.

The Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

Electronic Signature

Ross Winkelman, FSA, MAAA
Managing Director
(720) 226-9801
RossW@Wakely.com

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Appendix A
Wakely Mdwise Premium Rate Development
Individual Market Premium Rates (Non-Smoker, 1.0 HHS Age Factor, by Metal Tier and Plan ID)

Plan ID (a)	Metal Tier (b)	Starting Allowed (c)	Impact of Reinsurance (% allowed) (d)	Impact of Risk Adjustment (e)	Exchange User Fee Adjustment (f)	Market Adjusted Index Rate (g)=(c)*(d)*(e)	Provider Contracting Adjustment (h)	Tobacco Adjustment (non-tobacco rates) (i)	Cost Sharing Utilization (j)	Tier 1 AV (k)	Tier 2 AV (l)	Tier 1 PMPM (m)=(g)*(h)*(i)*(j)*(k)	Tier 2 PMPM (n)=(g)*(h)*(i)*(j)*(l)	AV (o)	Composite PMPM* (p)=(g)*(h)*(i)*(j)*(o)
62033IN0010001	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010002	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010003	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010004	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010005	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
62033IN0010006	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010007	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010008	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010009	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010010	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
62033IN0010011	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010012	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010013	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010014	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010015	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
62033IN0010016	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010017	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010018	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010019	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010020	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
	Total/Average								1.0011	75.4%	73.5%	$373.20	$363.74	75.2%	$372.26

Plan ID (a)	Metal Tier (b)	Fixed Admin (q)	Variable Admin (r)	PMPM Regulatory Fees (s)	Other Regulatory Fees (t)	Contribution to Surplus (u)	Plan Adjusted Index Rates (v)=(p)+(q)+(r)+(s)+(t)+(u)	Average Age Factor (w)	Calibrated Plan Index Rate (1.0 HHS Factors) (x)=(v)/(w)	Target Loss Ratio (y)=(p)/[(v)-(s)-(t)]	Projected Member Months (z)	PMPM Impact of Reinsurance (aa)
62033IN0010001	Bronze	$32.94	$28.47	$3.36	$23.00	$12.54	$418.11	**1.75**	$238.92	81.1%	3,289	$36.09
62033IN0010002	Silver	$32.94	$33.04	$3.92	$26.78	$14.61	$486.86	1.75	$278.21	82.3%	235,181	$43.32
62033IN0010003	Gold	$32.94	$39.68	$4.48	$32.24	$17.59	$586.21	1.75	$334.98	83.6%	28,008	$53.79
62033IN0010004	Bronze	$32.94	$27.25	$3.36	$21.98	$11.99	$399.55	1.75	$228.31	80.7%	29,603	$34.12
62033IN0010005	Silver	$32.94	$31.53	$3.92	$25.51	$13.92	$463.84	1.75	$265.05	82.0%	53,995	$40.87
62033IN0010006	Bronze	$35.54	$28.47	$3.36	$23.15	$12.63	$420.96	1.75	$240.55	80.6%	1,328	$36.09
62033IN0010007	Silver	$35.54	$33.04	$3.92	$26.93	$14.69	$489.71	1.75	$279.84	81.9%	82,805	$43.32
62033IN0010008	Gold	$35.54	$39.68	$4.48	$32.40	$17.67	$589.06	1.75	$336.60	83.2%	9,456	$53.79
62033IN0010009	Bronze	$35.54	$27.25	$3.36	$22.13	$12.07	$402.39	1.75	$229.94	80.1%	11,956	$34.12
62033IN0010010	Silver	$35.54	$31.53	$3.92	$25.67	$14.00	$466.69	1.75	$266.68	81.5%	18,994	$40.87
62033IN0010011	Bronze	$35.54	$28.47	$3.36	$23.15	$12.63	$420.96	1.75	$240.55	80.6%	1,074	$36.09
62033IN0010012	Silver	$35.54	$33.04	$3.92	$26.93	$14.69	$489.71	1.75	$279.84	81.9%	85,906	$43.32
62033IN0010013	Gold	$35.54	$39.68	$4.48	$32.40	$17.67	$589.06	1.75	$336.60	83.2%	9,912	$53.79
62033IN0010014	Bronze	$35.54	$27.25	$3.36	$22.13	$12.07	$402.39	1.75	$229.94	80.1%	9,666	$34.12
62033IN0010015	Silver	$35.54	$31.53	$3.92	$25.67	$14.00	$466.69	1.75	$266.68	81.5%	19,745	$40.87
62033IN0010016	Bronze	$36.94	$28.47	$3.36	$23.24	$12.67	$422.49	1.75	$241.42	80.3%	797	$36.09
62033IN0010017	Silver	$36.94	$33.04	$3.92	$27.02	$14.74	$491.24	1.75	$280.71	81.6%	64,417	$43.32
62033IN0010018	Gold	$36.94	$39.68	$4.48	$32.48	$17.72	$590.59	1.75	$337.48	83.0%	5,928	$53.79
62033IN0010019	Bronze	$36.94	$27.25	$3.36	$22.22	$12.12	$403.93	1.75	$230.81	79.8%	7,171	$34.12
62033IN0010020	Silver	$36.94	$31.53	$3.92	$25.75	$14.05	$468.22	1.75	$267.56	81.2%	14,827	$40.87
	Total/Average	$34.41	$32.78	$3.91	$26.65	$14.54	$484.55	1.75	$276.89	82.0%	694,058	$42.90

* The exchange user fee was excluded in this column and re-included in column (t).
**[(c)*(h)*(i)*(j)*(o)] - [(c)*(h)*(i)*(j)*(o)-(d)] - 3.67

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Appendix B
Wakely Mdwise Cost Sharing Reduction Estimates and Justification
(based on a 1.0 Area Factor)

Base Silver Plan	No CSR Allowed PMPM	Federal AVCs for Base and CSR Silvers				87% and 94% Utilization	CSR Advance Payments by Level			Weighted Average PMPM*
		Base Silver	73% Silver	87% Silver	94% Silver		73% Silver	87% Silver	94% Silver	
62033IN0010002	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010005	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010007	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010010	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010012	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010015	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010017	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010020	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38

* See Actuarial Memo, Assumes 23.3% No CSR, 34.9% at 73% Silver, 15.7% at 87% Silver, and 26.1% at 94% Silver.

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Appendix C

Table C-1

Small Group Source Starting Allowed PMPM Development

Source	Allowed PMPM	Weight
Anthem SG Financial	$352.41	25.0%
UHLC Rate Filing	$421.71	25.0%
AWLP SG Rate Filing	$405.76	25.0%
ADVA Rate Filing	$480.85	0.0%
Plan Finder 1) Anthem PPO	$412.45	4.2%
Plan Finder 2) Anthem Lumenos	$334.88	4.2%
Plan Finder 3) United ChoicePlus	$430.98	4.2%
Plan Finder 4) Humana IN Copay 10	$367.33	4.2%
Plan Finder 5) All Savers Group	$343.55	4.2%
Plan Finder 6) Aetna PPO	$422.90	4.2%
Total / Weighted Average	**$391.31**	**100.0%**

Table C-2

Average Allowed PMPM Development for Appendix A from Starting Allowed PMPM

Item	Description	Small Group
(a)	Base Period Allowed PMPM (Small Group)	$391.31
	Cost Adjustment	
(b)	Bad Debt	1.0028
(c)	Benefit Adjustment	1.0200
	Morbidity Adjustment	
(d)	Morbidity	1.0190
(e)	Demographic - Age Gender (Outside of allowable age rating)	1.0589
(f)	Pent Up Demand	1.0000
(g)	2014 Strategic Renewal Impact	1.0100
(h)	Trend Factor to 7/1/2015	1.2122
(i)	Market Demographic (Allowable age rating)	1.2298
(j)	Allowed Claim Index Rate (product of all figures above)	$650.20

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Appendix D
Age Factors, Smoker Loads, and Area Factors

Demographics	HHS Factor	Smoker Load	Non-Smoker Load
Children 00-20	**0.635**	**1.000**	**1.000**
Ages 21	1.000	1.050	1.000
22	1.000	1.061	1.000
23	1.000	1.071	1.000
24	1.000	1.082	1.000
25	1.004	1.093	1.000
26	1.024	1.104	1.000
27	1.048	1.114	1.000
28	1.087	1.125	1.000
29	1.119	1.136	1.000
30	1.135	1.146	1.000
31	1.159	1.157	1.000
32	1.183	1.168	1.000
33	1.198	1.179	1.000
34	1.214	1.189	1.000
35	1.222	1.200	1.000
36	1.230	1.211	1.000
37	1.238	1.221	1.000
38	1.246	1.232	1.000
39	1.262	1.243	1.000
40	1.278	1.254	1.000
41	1.302	1.264	1.000
42	1.325	1.275	1.000
43	1.357	1.286	1.000
44	1.397	1.296	1.000
45	1.444	1.307	1.000
46	1.500	1.318	1.000
47	1.563	1.329	1.000
48	1.635	1.339	1.000
49	1.706	1.350	1.000
50	1.786	1.361	1.000
51	1.865	1.371	1.000
52	1.952	1.382	1.000
53	2.040	1.393	1.000
54	2.135	1.403	1.000
55	2.230	1.414	1.000
56	2.333	1.425	1.000
57	2.437	1.436	1.000
58	2.548	1.446	1.000
59	2.603	1.457	1.000
60	2.714	1.468	1.000
61	2.810	1.478	1.000
62	2.873	1.489	1.000
63	2.952	1.500	1.000
64 and Older	3.000	1.500	1.000

Rating Area	Area Factor
1	1.0000
2	0.9713
3	1.0748
4	0.9814
5	1.0082
6	1.0243
7	1.0761
8	1.0748
9	1.0261
10	1.0785
11	1.0748
12	1.0691
13	1.0823
14	N/A
15	1.0823
16	0.8636
17	1.1179

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Appendix E
Sample Rate Calculations

Example 1

Sample Plan:	62033IN0010001		
Metal Level:	Bronze		
Effective Date:	1/1/2015		
Rating Area:	2		
Age:	42		
Smoker Status:	Non-Smoker		
Calculation of Monthly Premium:			
Base Rate:		$238.92	Appendix A
Area Factor:		0.971	Appendix D
Age Factor:		1.325	Appendix D
Smoker/Non-Smoker Load:		1.000	Appendix D
Monthly Premium:		$307.48	Product of numbers above

Example 2

Sample Plan:	62033IN0010002		
Metal Level:	Silver		
Effective Date:	1/1/2015		
Rating Area:	5		
Age:	35		
Smoker Status:	Smoker		
Calculation of Monthly Premium:			
Base Rate:		$278.21	Appendix A
Area Factor:		1.008	Appendix D
Age Factor:		1.222	Appendix D
Smoker/Non-Smoker Load:		1.200	Appendix D
Monthly Premium:		$411.31	Product of numbers above

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Appendix F - SOA Values, Including Adjustments to SOA Values and Final Morbidity Adjustment

	OPTUM VALUES								Adjusted Values							
Figure 1- Changes in Sources of Coverage under the ACA in Selected State in 2014																HOME
Baseline Coverage	Total	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	768,681	200,861	43,675	493,581	556	2	23,974	6,032	768,681	200,861	10,919	526,337	556	2	23,974	6,032
Employer 51-100	149,666	27,449	6,762	113,722	13	-	1,204	516	149,666	27,449	6,762	113,722	13	-	1,204	516
Employer 101+	2,358,762	-	55,065	2,253,680	1,217	157	39,491	9,152	2,358,762	-	13,766	2,294,979	1,217	157	39,491	9,152
High Risk Pool	10,969	185	8,662	526	-	-	1,595	-	10,969	185	8,662	526	-	-	1,595	-
Other Non-Group	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093
Retiree	81,477	-	-	68,081	-	-	13,395	-	81,477	-	-	68,081	-	-	13,395	-
TRICARE	84,044	-	-	-	-	84,044	-	-	84,044	-	-	-	-	84,044	-	-
Medicare	815,120	-	-	-	-	815,120	-	-	815,120	-	-	-	-	815,120	-	-
Dual Eligible	138,231	-	-	-	-	138,231	-	-	138,231	-	-	-	-	138,231	-	-
Medicaid/CHIP	945,008	5,410	6,128	16,018	38	62	917,352	-	945,008	5,410	6,128	16,018	38	62	917,352	-
Uninsured	922,141	32,591	202,697	93,143	1,816	-	291,966	299,929	922,141	32,591	50,674	93,143	1,816	-	291,966	451,952
% of Currently Uninsured	-	3.5%	22.0%	10.1%	0.2%	0.0%	31.7%	32.5%	-							
Total	**6,452,541**	**270,394**	**407,586**	**3,050,802**	**55,807**	**1,037,616**	**1,302,613**	**327,723**	**6,452,541**	**270,394**	**181,508**	**3,124,857**	**55,807**	**1,037,616**	**1,302,613**	**479,745**

Elasticity Model - Lewin Baseline ACA model

	OPTUM VALUES								Adjusted Values							
Figure 1A- Changes in Morbidity under the ACA in Selected State in 2014																
Baseline Coverage	Pre-ACA PMPM	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15
Employer 51-100	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08
Employer 101+	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92
High Risk Pool	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00
Other Non-Group	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32
Retiree	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00
TRICARE	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00
Medicare	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00
Dual Eligible	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00
Medicaid/CHIP	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00
Uninsured	$222.21	$369.76	$362.84	$627.13	$4,084.72	$0.00	$555.17	$125.31	$222.21	$369.76	$453.55	$627.13	$4,084.72	$0.00	$555.17	$125.31
Total	**$555.38**	**$481.18**	**$448.93**	**$518.34**	**$500.79**	**$1,097.05**	**$492.28**	**$133.45**	$557.04	$481.18	$456.37	$517.80	$500.79	$1,097.05	$492.28	$130.87

	Pre-ACA		Post ACA W/out Changes		Post ACA W/ Changes		Post ACA Modified / Original	
	Members	PMPM	Members	PMPM	Members	PMPM	Members	PMPM
Individual	178,442	$331.56	463,393	$455.18	237,315	$466.81	0.5121	1.0256
Small Group	768,681	$464.98	694,442	$454.86	727,198	$453.99	1.0472	0.9981

Post ACA PMPM / Pre-ACA PMPM (This is Morbidity Change Only)

1.4079 Individual to Individual
1.0039 Small Group to Individual
0.9764 Small Group to Small Group

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State: Indiana **Filing Company:** MDwise Marketplace, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: MDwise Marketplace
Project Name/Number: MDwise Marketplace/62033IN001

Supporting Document Schedules

Bypassed - Item:	10 Individual Checklist (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	12 Individual HMO Checklist (Accident & Health)
Bypass Reason:	Filing a non-grandfathered major medical on the Health Exchange.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	20(C) Out of State Association/Trust Products Checklist (Accident & Health)
Bypass Reason:	Not filing out of state
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	12(A) Individual HMO Checklist (Accident & Health)
Comments:	
Attachment(s):	MDwise Marketplace HMO Checklist 12(A) 62033-2015-1.pdf
Item Status:	
Status Date:	

Bypassed - Item:	4.1 Individual New Rate/Form Requirements (Accident & Health)
Bypass Reason:	We are filing a product for the Health Care Exchange.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0 Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	filing for QHP (see below)
Attachment(s):	
Item Status:	
Status Date:	

State: Indiana **Filing Company:** MDwise Marketplace, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: MDwise Marketplace
Project Name/Number: MDwise Marketplace/62033IN001

Satisfied - Item:	4.1(A) QHP Individual New Rate/Form Requirements (Accident & Health)
Comments:	See the Actuarial Memorandum attached under the Acturial Memorandum Section. See the Unified Rate Review Template under the Unified Rate Review Template Section. See the Rate Review Detail in Schedule on Rate/Rule Tab.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(A) QHP Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	We are filing a new product.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.1(B) EHB Individual New Rate/Form Requirements (Accident & Health)
Comments:	See the Actuarial Memorandum attached under the Acturial Memorandum Section. See the Unified Rate Review Template under the Unified Rate Review Template Section. See the Rate Review Detail in Schedule on Rate/Rule Tab.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(B) EHB Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	New Product
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	09 SERFF Data Field Guide (Accident & Health)
Comments:	MDwise has reviewed the SERFF Data Field Guide.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Initial submission
Attachment(s):	
Item Status:	
Status Date:	

State: *Indiana* **Filing Company:** *MDwise Marketplace, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *MDwise Marketplace*
Project Name/Number: *MDwise Marketplace/62033IN001*

Satisfied - Item:	04 Major Medical Experience Workbook (Accident & Health)
Comments:	
Attachment(s):	MDwise 62033 2015 Major_Medical_Experience_Workbook (7-25-2014).xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Actuarial Memorandum MDwise Issuer 62033 (Wakely 7-25-2014).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	MDwise 2015 URRT 62033 Resubmission 20140725 external.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	03 PPACA Uniform Compliance Summary
Comments:	
Attachment(s):	PPACA Uniform Compliance Summary 62033-2015-1.pdf
Item Status:	
Status Date:	

Satisfied - Item:	EHB Crosswalk Tool
Comments:	
Attachment(s):	EHB Crosswalk Tool MDwise Marketplace 62033-2015-1.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	Statement of Variability MDwise Marketplace, Inc 62033-2015-1.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Response on 6.6.14 to Rate Objection Letter 5.23.14

State: *Indiana* **Filing Company:** *MDwise Marketplace, Inc.*
TOI/Sub-TOI: *HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO*
Product Name: *MDwise Marketplace*
Project Name/Number: *MDwise Marketplace/62033IN001*

Comments:	
Attachment(s):	62033_Rate_Objection_Response_dated_05232014_RESPONSE.pdf Rate objection letter #1 demographic attachment.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	AV Calculator Screen Shots
Comments:	
Attachment(s):	62033 Benefits Plan A 2015 050914.pdf 62033 Benefits Plan B 2015 050914.pdf
Item Status:	
Status Date:	

Attachment MDwise 62033 2015 Major_Medical_Experience_Workbook (7-25-2014).xlsx is not a PDF document and cannot be reproduced here.

Attachment MDwise 2015 URRT 62033 Resubmission 20140725 external.xlsm is not a PDF document and cannot be reproduced here.

Attachment Rate objection letter #1 demographic attachment.xlsx is not a PDF document and cannot be reproduced here.

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name MDwise Marketplace, Inc. **NAIC #** _____

Form number(s) 62033-2015-1 **Filing date** 05/11/2014

Product Type: ☑ **Major Medical** ☐ **Pediatric Stand-Alone Dental**

Exchange Participation: ☑ **Off-Exchange** ☑ **On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

A. General Filing Requirements 2
B. Required Provisions 4
C.HMO Individual A&H Policies *must provide* 7
D. General Regulatory Issues 9
E. HMO Individual A&H must cover 10
F. ACA Must Provide 11
G. Specific Requirements for Qualified Health Plans 26
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan 28

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.	Y	
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.	Document is compliant with State	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm	Yes - we have completed the templates for the 5/11 filing and will complete the remaining templates before their respective State and Federal deadlines.	
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.	Yes we acknowledge.	
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.	Yes we acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.	Yes we acknowledge.	
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*	Yes we acknowledge.	
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.	Yes we acknowledge.	
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**	Yes - Page 1	
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**	Yes - Article 2 - Begins page 12.	
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**	Yes - Article 3 - Page 15.	
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**	Yes - Section 3.7 - Page 19.	
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**	Yes - Section 6.5 - 6.7 - page 43	
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**	Yes - Article 3- Begins page 16.	
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**	Yes - Article 4 - Begins page 35.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**	Yes - Article 9 - Begins page 51.	
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**	Yes - Section 9.12 - Page 53.	
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**	Yes - Page 45-46.	
IC 27-13-36.2	**CLEAN CLAIMS**	Yes - Section 7.6 - Page 46.	
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**	Yes - Article 8 - Begins Page 46.	
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**	Yes - Page 56.	
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**	N/A - MDwise does not offer Gro	
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**	Yes - Section 9.10 - Page 53.	
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**	Yes - Article 11 - Begins page 55.	
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**	Yes - Article 10 - Begins page 53	
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**	Yes - Pages 11 & 15.	
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**	Yes - Section 12.1 - Page 57.	
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**	Yes - Page 61 (first page of SOB	
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**	Yes - Page 9.6 - Page 52.	
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**	Yes - Article 9 - Beginning on Pa	
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**	Yes - Section 9.12 - Page 53.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.	Yes - Sections 5.4 & 5.5 - Page 41.	
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**	Yes - Section 12.1 - Page 60.	
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))	Yes - Section 9.1 - Page 51	
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.	Yes - Definitions of Dependent - Page 6.	
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision	Yes - Page 1.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.	Yes - Article 8 - Beginning on Page 46.	
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance	Yes - Section 8.9 - Page 51.	
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits	Yes - Section 3.2 - Pages 16-17.	
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)	Yes - Section 9.11 - Page 53.	
IC 27-8-5-21	**ADOPTED CHILDREN**	Yes - Definitions - Page 5.	
IC 27-8-5.6-2(b)	**NEWBORNS**	Yes - Section 3.12 - Begin Page 2	
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**	Yes - Section 3.5 - Page 17.	
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**	Yes - Pages 32, Page 40.	
IC 27-8-24	**MINIMUM MATERNITY STAYS**	Yes - Pages 21.	
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**	Yes - MDwise does not use rating	
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**	Yes - Section 3.12 - Page 21.	
IC 27-8-26	Individuals without regard to **GENETIC TESTING**	Yes - Page 12, Page 40.	
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**	Yes - Page 56.	
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**	Yes - Sections 3.3 & 3.4 - Page 1	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:**-Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727	Yes - Definition of Reconstructive Surgery - Page 11. Pages 27.	
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136	Yes - Page 16-17	
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage	Yes - Page 31-35	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug	Yes - Page 31-35	
Bulletin 172	**CHEMOTHERAPY PARITY**	Yes - Schedule of Benefits	
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**	Y - SECTION 4.1 IS LIST OF EX	
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**	N/A - MDwise does not offer Employer Coverage.	
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.	Y - QUESTIONS NOT A PART OF APPLICATION PROCESS	
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.	Y - NOT MENTIONED AS REQURIED IN OUR POLICY	
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.	Y - NO ENDORSEMENTS.	
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.	Y - NO ENDORSEMENTS	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.	Y - NO PROHIBITED PROVISIONS	
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.	Y - NO APPLICATION FEES	
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.	Y - PRE-EXISTING CONDITION PROVISIONS ARE INCLUDED IN THE FORM.	
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.	Y - Form is compliant.	
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.	Y - Form is compliant.	
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.	Y - SECTION 3.15 PAGE 25	
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)	Y - PAGE 18	
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)	Y - 19 SECTION 3.6	
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**	Y - PAGE 18 SECTION 3.6	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**	NA: NOT MANDATED BY THE EXCHANGE	
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**	Y - PAGE 32 / SECTION 3.25	
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130	Y - SCHEDULE OF BENEFITS (SOB)	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit **– PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302	Y - SCHEDULE OF BENEFITS (SOB)	
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760	Yes - PAGE 58-59 Sec 12.3	
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145	N/A - MDwise does not contract directly with an institution of higher learning.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)	Y - MDwise does not include any of these as Essential Health Benefit.	
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126	Y - MDwise does not impose limits on dollar value (annual or lifetime) of Essential Health Benefits, except for services according to Bulletin 198.	
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)	Yes - MDwise will meet the EHB Formulary Requirements Provided.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715	Yes. MDwise will reflect the covered EHB, CS and AV that the final approved rates and forms permit.	
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108	Yes - Section 2.2 (Page 12)	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)	MDwise acknowledges that it will comply with applicable state laws and regs regarding marketing practices and benefit designs.	
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125	Yes - Section 2.2 (Page 12)	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)	Yes we acknowledge.	
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Yes - Section 2.4 page 12-13	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410	Yes - section 2.5, page 13-14	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)	Yes - Section 2.5, page 13-15	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)	Yes we acknowledge.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)	Yes we acknowledge.	
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)	Yes we acknowledge. See Article 9 (pages 51-53)	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)	Yes - Section 9.1 (Page 51)	
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)	Yes - Section 9.2, page 51	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)	Yes - section 9.3, page 51	
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)	N/A	
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)	Yes - we are compliant.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138	Yes - Section 6.2 & Schedule of Benefits.	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155	N/A - MDwise does not offer catastrophic coverage	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)	Yes we acknowledge.	
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)	Yes - Section 5.4 & 5.5 page 41	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)	Yes - Section 5.5, page 41	
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)	N/A - MDwise only provides coverage for abortion services in situations of rape, incest, and life of mother, page 38-39	
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)	N/A - MDwise only provides coverage for abortion services in situations of rape, incest, and life of mother, Page 38-39	

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)	Yes - Schedule of Benefits.	
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330	Yes we acknowledge	
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.	N/A - We are not offering SADP	

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: TLCole

Printed Name: TERRY L COLE

Title: CFO

Company: MDWISE MARKETPLACE, INC.

Date: 5/10/14

Actuarial Memorandum

MDwise Issuer #62033

Individual Health Insurance Exchange Premium Rate Filing

July 25, 2014

Developed By:

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1. EXECUTIVE SUMMARY

This memorandum documents the development of individual rates for MDwise. These rates will be offered inside of the State of Indiana's health insurance exchange, which is being operated by the federal government.

MDwise is a not-for-profit corporation that purchased 100% of the stock in IU Health Plan, Inc., a fully licensed HMO, (IUHP) on December 29, 2006. IUHP was merged into MDwise, Inc. as of January 1, 2007. MDwise remains a fully licensed Indiana domestic HMO. MDwise is jointly controlled by Indiana University Health, Inc. and Health & Hospital Corporation of Marion County Indiana. The two parent companies are not-for-profit, are incorporated in the State of Indiana, and are provider delivery system companies.

Beginning January 1, 2011, MDwise was granted a four-year contract with the State of Indiana (the "State"), through the Family and Social Service Administration ("FSSA") and Office of Medicaid Policy and Planning ("OMPP"), to arrange for and administer two risk-based managed care programs ("Hoosier Healthwise" and "Healthy Indiana Plan") for certain Indiana Medicaid enrollees. MDwise contracts with various delivery networks. The delivery networks accept the medical service risk for enrollees who choose a primary care provider after selecting the MDwise network. There were approximately 280,000 members enrolled in the Hoosier Healthwise and Healthy Indiana Plan products at December 31, 2013.

Under an Accountable Care Organization model, MDwise contracts with several integrated delivery systems to provide medical services and claims administration under risk contracts for their current business. MDwise has operated under this model since its inception.

MDwise is offering two individual health insurance products in the Bronze and Silver metal tiers and one individual health insurance product in the Gold metal tier. Being a non-profit health plan focused on low income individuals, MDwise expects most enrollment to be in the Silver plan, for individuals eligible for premium tax credits and cost sharing reductions. MDwise's mission is to provide health care services to the lower income population. One of the primary reasons that MDwise is entering the individual market within the health insurance exchange is to provide its Medicaid members with an MDwise product offering if they lose Medicaid eligibility.

MDwise has applied for a new HMO license in the State of Indiana (MDwise Marketplace). Our filing is in the review process. MDwise anticipates it to be active in time for 2015 Open Enrollment season. MDwise has applied and received a new HIOS ID number of 62033.

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2. GENERAL INFORMATION

Company Legal Name: MDwise Marketplace, Inc.

State: Indiana

HIOS Issuer ID: 62033

Market: Individual Market

Effective Date: January 1, 2015

Company Contact Information

Primary Contact Name: Elizabeth Eichhorn

Primary Contact Telephone Number: 317-822-7232

Primary Contact Email Address: Eeichhorn@mdwise.org

3. PROPOSED RATE INCREASES

MDwise began selling individual policies with effective dates beginning January 2014. They did not previously participate in the individual market. The effective rate increase is 8.8% for 2015 for all proposed individual policies. This large increase is driven primarily by Indiana's transition from a 209(b) state to a 1634 state and the associated population expected to enroll in the individual market because of this change.

4. EXPERIENCE PERIOD PREMIUM AND CLAIMS, BENEFIT CATEGORIES AND PROJECTION FACTORS

MDwise began selling individual policies with effective dates beginning January 2014. The effective rate increase for 2015 is 8.8% for all proposed individual policies.

Because they did not participate in the individual or small group markets prior to 2014 and 2014 experience is not yet credible, the rate development is based entirely on a manual rate.

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5. MANUAL RATE DEVELOPMENT

The basic manual rate development methodology is unchanged from the 2014 premium rate development. Updated market experience was not available at a sufficient level of detail to justify redeveloping the manual rate. Instead, we reflected emerging demographic and risk adjustment information in our morbidity assumptions and updated other assumptions that were different from 2014 including trend, the impact of reinsurance, benefit changes, leveraging of fixed cost sharing items and the addition of individuals expected to enroll in the Individual market starting in 2014 because of Indiana's transition from a 209(b) state to a 1634 state.

The approach to premium rate development is as follows:

1. Paid and/or allowed PMPM medical costs were developed using market information including competitor rate filings, premium rates, and financial filings. If historic experience net of member cost sharing was used, paid to allowed ratios were estimated using the Wakely pricing model. Table C-1 in Appendix C shows the various sources used for the small group source development.

2. Allowed PMPMs were adjusted for trend and ACA changes and requirements including EHB, pent up demand, morbidity changes between pre and post ACA enrollment and others described below.

3. The Wakely pricing model was calibrated to the adjusted allowed PMPMs and used to estimate paid to allowed ratios. Within a benefit plan offering, a consumer may choose to use providers in a preferred network of providers and receive reduced cost sharing, represented by Tier 1. If a consumer chooses instead to use non-preferred providers, the cost sharing is greater, represented by Tier 2. They have been blended with a 90% weighting on Tier 1 and 10% on Tier 2, reflective of MDwise's expectations on actual utilization. The pricing by tier and blended result is shown in Appendix A.

4. Administrative costs and regulatory fees and taxes, along with contribution to surplus were added.

Appendix C, Table C-2 shows the components of the starting allowed PMPM shown in Appendix A. A comparison to the 2014 development is also provided.

Source and Appropriateness of Experience Data Used

The allowed PMPM target for post reform experience was developed using pre-reform small group market information.

Even though the goal is to price individual products post reform, the post reform individual market may look more like the pre-reform small group market than the pre-reform individual market. Therefore, we reviewed rate filings and financial reports for Indiana small group products. We made adjustments for trend, benefit design, and others to adjust the allowed PMPM to the midpoint of the rating period.

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Population Changes

The manual rate incorporates results from the SOA study[1] (performed by Optum/Lewin) to estimate changes in morbidity from the Indiana pre-ACA market to that enrolled in Indiana post ACA. Results from other states and analyses, including those performed by Wakely were also reviewed, but the Lewin model framework was used. Wakely has performed detailed studies on behalf of individual states with broad health plan participation and detailed data collection. We have found some of the values provided by the health plans, high risk pool, and the state differ (sometimes significantly) from the values presented in the SOA study, which is reasonable given the different data sources used and differences in judgment likely between actuaries performing this type of modeling. We made adjustments and applied judgment with input from the health plan in developing the final estimates of how the post reform market would compare to the pre-reform market. The primary changes were to decrease the number of previously uninsured entering the market and to increase their assumed health status since the SOA values are targeted once the ACA has been fully implemented.

Wakely also reviewed emerging results from the Wakely National Risk Adjustment Reporting study. This study included participation from Indiana issuers, including MDwise. The issuers reported claims and demographic based risk adjustment information through February 2014. The project will include updated information throughout 2014 which we will be reviewing as it becomes available. Emerging Indiana information caused us to increase our morbidity assumption by 2%. This is primarily driven by a higher age distribution than originally anticipated. This adjustment captures expected morbidity over and above allowable rating variation.

An additional adjustment of 1.5% is made to account for the transition of individuals that had been covered under Indiana's Medicaid Spend-down program. In developing an assumption for the impact of this population on the market, Wakely considered information provided by the state regarding the population and emerging enrollment of this population into the exchange.

The components of the Morbidity Adjustment are shown in Appendix C, Table C-2.

Appendix F provides the detail behind the base SOA tables and our adjustments to the SOA tables to develop the final morbidity adjustment factor in Appendix C (1.0039).

Pent up demand and the 2014 strategic renewal impact adjustments are described in more detail below.

Cost Adjustments

We have made two adjustments to account for cost variances.

- Smoking Load – We adjusted the base period data by a factor of 0.9874 to create an index rate that is reflective of a non-smoking population.

[1] Web link (as of 4-4-2013): http://www.soa.org/NewlyInsured/

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- Bad Debt – To account for the likelihood that some policy holders will not pay premiums within the grace period, we have increased rates by a factor of 1.00275. This is calculated assuming a 15% rate of non-payment of one out of twelve months on about 22% of premium, after considering federal subsidies (.15 x .224 x 1/12 = .00275).

Trend Factors (cost / utilization)

We assumed PMPM medical costs would increase by 8% annually from 2012 to 2015 due to ongoing increases in utilization, unit costs and technology. This assumption is based on review of rate filings for Indiana and other states, national publicly available trend surveys, and judgment. These trends do not include the effect of demographics or benefits because those adjustments are included elsewhere.

Essential Health Benefits (EHB)

We adjusted the allowed claims sources in the manual rate development for expected changes in covered benefits due to EHB requirements, specific to individual and small group market starting cost sources. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

Adjustments for changing demographics, changes in benefits, and others were separately addressed and included in the premium rate development.

To incorporate these adjustments we increased the small group market source by 2%.

Provider Reimbursement Adjustment

MDwise provided Wakely with provider contracting targets by plan (based on service area) for inpatient facility, outpatient facility and professional categories of service. Wakely analyzed these targets and compared them to market information regarding current commercial reimbursement rates. We assumed provider volume by provider system would be consistent with current MDwise Medicaid volume by provider system. The total adjustments to allowed cost varied by plan and are reflected in the geographic factors.

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Strategic Renewal Impact

Many health plans were working to provide communication and incentive for individual policyholders to renew on 12/1/2013, 1/1/2014, or at their scheduled renewal. This type of strategic approach has been used in the past as states have implemented different state based reforms. This approach likely increased the average morbidity of individuals included in the risk adjustment pool in 2014. The healthy individuals will get a smaller rate increase under pre-ACA policies due to rating for health status while the sicker individuals would get a better rate on ACA policies since they do not rate for health status. For 2015, the impact of strategic renewal would have disappeared but the administration allowed states to continue renewing these policies on pre-ACA products and Indiana has allowed such policies (referred to as a transitional or "grandmothering").

We have been informed by the State of Indiana that approximately 20% or less of the market will renew transitional policies. We have included a 1% adjustment (1.01 factor) within our manual rate development for this (part of morbidity adjustment in Appendix C, Table C-2).

Pent Up Demand

In 2014, there were many new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services.

We expect very little remaining pent up demand in 2015. Therefore, we have removed the pent up demand effect and used a factor of 1.0 in Appendix C, Table C-2.

Inclusion of Capitation Payments

While MDwise will pay the Delivery Systems a global cap rate (percentage of premium), the State of Indiana has required MDwise to report the underlying provider payments as the true medical costs to provide coverage in MDwise's financial statements. This is because the Delivery Systems are delegated a portion of the administrative costs associated with their members. Therefore, the capitation paid to the delivery systems is meant to cover direct medical costs, and provider overhead. Based on discussions between MDwise, CCIIO and the state of Indiana, we understand that this treatment will continue in 2014 and beyond. This is important because of the risk corridor protection and minimum loss ratio treatment, which affect the relative level of risk inherent in the premium rate development and overall delivery system payment amounts.

6. CREDIBILITY OF EXPERIENCE

MDwise began operating in the individual market in 2014 and that experience is not yet credible. Per request from the State of Indiana Department of Insurance, we have entered projected 2014 information from last year's rate filing in the "Experience Period" section of Worksheet 1 of the URRT. However, the

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projection factors (cells J24:M29 on Worksheet 1) have been left blank. The service category PMPMs shown in the "Credibility Manual" section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

7. PAID TO ALLOWED RATIO

The Wakely pricing model uses a nationally-representative detailed medical and pharmacy claim and enrollment data (Truven MarketScan) for over 40 million lives to develop paid to allowed pricing estimates for final rate development (as opposed to metal tier categorization). The model uses actuarially sound pricing methods to value the impact of deductibles, copays, coinsurance and maximum out of pocket cost sharing parameters. We calibrated the utilization and unit cost assumptions by category of service in the model to the allowed cost estimates underlying the manual rate and/or experience rate, including adjustments for EHB, trend, provider reimbursement changes by service category, average expected demographics and other adjustments discussed elsewhere in this report.

8. RISK ADJUSTMENT AND REINSURANCE

Projected Risk Adjustments PMPM

We have developed manual rates for a 1.0 average statewide risk and assumed that MDwise would enroll average risk individuals. Therefore, no risk adjustment PMPM payment is assumed in 2015.

Reinsurance

The presence of the Federal reinsurance program will reduce costs for issuers in the individual market. This adjustment is intended to capture the portion of costs that will be reimbursed to health plans for reinsurance. The reinsurance payment parameters for 2015 were originally announced as an attachment point of $70,000, a reinsurance cap of $250,000, and a target coinsurance rate of 50%. In final regulations published in late May, CMS stated its intent to lower the 2015 attachment point to $45,000 and suggested the possibility of an adjustment to the 2015 target coinsurance rate. In rates developed for this filing, an attachment point of $45,000 has been assumed. We have assumed no change to the target coinsurance rate of 50%.

To estimate the impact of reinsurance, we reviewed several claims probability distributions (CPDs) from different sources, adjusted to our estimated allowed PMPMs. To estimate the impact of moving from allowed to paid continuance, we increased the attachment and maximum values from the federal parameters by the MOOP for various plans, since the vast majority of individuals would have already reached their MOOP when costs reach the reinsurance attachment point. Our estimates are very sensitive to the shape of the CPD, the overall allowed cost PMPM that the CPD is calibrated to, as well as the MOOP and underlying Actuarial Value of the plan. Based on sensitivity testing, we have assumed that the average reinsurance impact will be a 9.6% reduction to net allowed claims costs (11.1% to paid claims). This adjustment was applied uniformly across all benefit plan packages. We have assumed that the allocated

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federal reinsurance dollars will be sufficient to fund the federal reinsurance program in 2015, which is not guaranteed.

9. NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load

MDwise developed expected administrative costs based on current administrative costs for their Medicaid line of business, adjusted to reflect any differences in functions or level of effort for the commercial product. MDwise assumed a 50% of administrative expenses would increase by 3% from 2014 on a PMPM basis while 50% would increase with premium rates. For the small service areas, the PMPM component was increased to spread fixed costs across a small member cohort.

Contribution to Surplus & Risk Margin

Three percent (3%) of premiums has been allocated to contribution to surplus.

Taxes and Fees

Taxes and regulatory fees include the following:

1. PCORI Fee = $0.17 PMPM
2. Issuer Fee = It is not clear if MDwise will be exempt from the issuer fee in 2015. We have assumed they will be subject to the fee in this filing at 2.0%.
3. Health Insurance Exchange Fee = 3.5% of premium for products sold through the Exchange. MDwise expects the vast majority of their business to be sold through the exchange and we have included the full 3.5% load in premium rate development.

Please note that in the URRT taxes and fees section, the risk adjustment and reinsurance fees have been excluded.

Reinsurance and Risk Adjustment Fees

The following fees were netted out of the experience in the URRT.

1. Reinsurance Charge = $3.67 PMPM
2. Risk Adjustment User Fee = $1.00 PMPY ($0.08 PMPM)

10. PROJECTED LOSS RATIO

Wakely's estimates indicate projected MLRs for the individual line of business of 82.0% for 2015. Consistent with the MLR and Risk Corridor calculations, regulatory fees and taxes were excluded from premium in the calculation of this value.

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11. SINGLE RISK POOL

MDwise has established a single risk pool for all of its individual business. Since MDwise did not participate in the individual market prior to 2014, all of its individual business is non-grandfathered, non-transitional, and ACA-compliant.

12. INDEX RATE

Index Rate for Projection Period

The starting allowed claim index of $650.20 is developed from the historical claim index rate of the Indiana Small Group Market. Appendix C, Table C-2 illustrates this development. The bullet points below briefly describe specific line items in Table C-2. For comparative purposes, the adjustment for average percentage of smokers has been retained in the table. Per CCIIO instructions, the adjustment for the smoker load should not be included in the starting allowed claim cost, so to calculate the $650.20 the factor is excluded.

- Base Period Allowed PMPM – These historical claim index rates are developed from publicly available information.
- Cost Adjustment – This adjustment accounts for cost differences between the base period and projected period and include an adjustment for the expected bad debt that is introduced by the grace period.
- Benefit Adjustment – This adjustment accounts for differences between the base period benefits and those offered under the exchange as essential health benefits.
- Morbidity Adjustment – This adjustment accounts for differences in the morbidity of the population underlying the base period allowed PMPM and the population expected in the exchange market. Included in this adjustment are considerations for morbidity and demographic differences, pent-up demand, and the impact of transitional policies.
- Trend factor – We used an assumed trend of 8.0% over 30 months to trend the base period data to a midpoint of 7/1/2015.
- Allowed Claim Index Rate by Source – The allowed claim index rate is calculated as the product of the historical claim index rate and all the factors listed above in this section.

Market Adjusted Index Rate

We included the impact of reinsurance and risk adjustment and the exchange user fee to the index rate for the projection period to develop the market adjusted index rate.

The development of this index rate can be seen in Appendix A, item g.

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Plan Adjusted Index Rate

To bring the experience used in the manual rating to a "non-tobacco" basis, a downward adjustment is applied using a factor of 0.9874. Among the items contemplated when setting this assumption were the rates of tobacco use in Indiana as well as the proportion of people who will self-report as "Smokers."

We multiplied the market adjusted rate by provider contracting discounts, the actuarial value and the federal induced demand factors.

We then included the admin, commissions, ACA fees, tax, and profit margin.

The development of this index rate can be seen in Appendix A, item v.

Calibration

To bring the experience to age 21 rate, we divided the plan adjusted index rate by the weighted average age factor. The age factor was calculated as the weighted average of ACA age factors and the 2015 expected individual enrollment by age. The average age is approximately 50 years.

The development of this index rate can be seen in Appendix A, item w.

Consumer Adjusted Index Rate

The consumer adjusted index rates are calculated by multiplying the calibrated plan adjusted index rates by the consumer's specific age factor, area, and tobacco status. As last year's restrictions on the smoker load (limiting smoker loaded rates to the same 3:1 limit as non-smoker rates) have been removed, the loads have been change and are shown in Appendix D.

Using the age factors and smoking load Area Factors in Appendix D, one can take the index rate from Appendix A and develop the rates for each product and age combination. Two examples are provided in Appendix E.

13. AV METAL LEVELS

The Federal AVC was used without modification to generate the AV metal tier (column b on Appendix A). The Federal AVCs were as follows:

Bronze A	61.8%
Silver A (base)	71.9%
Silver A (73% CSR)	73.9%
Silver A (87% CSR)	87.7%
Silver A (94% CSR)	94.8%
Gold A	80.5%
Bronze B	58.3%
Silver B (base)	68.1%
Silver B (73% CSR)	73.8%

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Silver B (87% CSR)	86.1%
Silver B (94% CSR)	93.0%

14. AV PRICING VALUES

The reference plan underlying our pricing was a Silver plan. From this base PMPM, we applied benefit richness utilization adjustments to stratify this PMPM to levels suitable for each of the metal tiers. We used the following values which are equal to the Federal values published in the Federal Register payment notice, normalized to the silver benefit level:

Bronze = 1.00 / 1.03 = 0.9709

Silver = 1.03 / 1.03 = 1.0000

Gold = 1.08 / 1.03 = 1.0485

MDwise is not offering Platinum or Catastrophic plans.

The adjustment factors above are shown in Appendix A, column o.

The same underlying cost distribution and cost level was used. The only adjustment before determining AV pricing values was benefit richness utilization differences using Federal adjustment factors. **Therefore, differences in expected morbidity across metal tiers were not included in the pricing development for each metal tier plan.**

These adjustments do not incorporate a selection bias due to health status. Rather, they represent an adjustment due to any particular individual utilizing services differently when they have a richer or less rich benefit design.

The pricing AVs are higher than the Federal AVCs primarily because the estimated allowed PMPMs are higher than those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements like copays, deductibles and MOOPs. This effect is more pronounced in 2015 than it was in 2014 because of the morbidity increases assumed due to the addition of the high risk population (conversion from 209(b) to 1634) and the higher age distribution.

15. MEMBERSHIP PROJECTIONS

The membership projections for 2015 were developed by Wakely in consultation with MDwise based on emerging enrollment and expected new enrollment for 2015.

Appendix B shows estimates of the Cost Sharing Reduction by Silver base and Silver variant level. We used the Federal formula shown in the Advance Payment Notice, which is equal to the difference in AVC

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multiplied by the allowed cost PMPM for each base plan, increased by 1.12 for cost sharing utilization for the 87% and 94% variants.

16. TERMINATED PRODUCTS

MDwise began selling individual policies with effective dates beginning January 1, 2014. They have no prior products to terminate.

17. PLAN TYPE

MDwise is filing HMO products.

18. URRT WARNINGS

There were no warnings in the URRT.

19. RELIANCE

Wakely Consulting Group, Inc., 9777 Pyramid Ct, Suite 260, Englewood, CO 80112 relied on information provided by MDwise to develop the 2014 individual premium rates. This information includes, but is not limited to the following:

- Provider contracting levels, including descriptions of the relationship between the Delivery systems and MDwise
- Administrative cost projections
- Projected enrollment figures by QHP
- Product design information
- Provider network information including discount data
- CCIIO and the State of Indiana regulatory and compliance interpretations and rulings
- Commercial rate filings and financial reports of carriers participating in the pre-ACA market.

20. ACTUARIAL CERTIFICATION

I, Ross Winkelman, am a Fellow in the Society of Actuaries (FSA) and a member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

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The submission is in compliance with all applicable laws, regulations, and guidance of the Federal government and the state of Indiana as of July 25, 2014. The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

ASOP No. 5, Incurred Health and Disability Claims

ASOP No. 8, Regulatory Filings for Health Plan Entities

ASOP No. 12, Risk Classification

ASOP No. 23, Data Quality

ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

ASOP No. 41, Actuarial Communication

In my opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are not excessive nor deficient although actual experience may vary from the estimates inherent in the premium rate development.

The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs.

The Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

Electronic Signature

Ross Winkelman, FSA, MAAA
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Appendix A
Wakely Mdwise Premium Rate Development
Individual Market Premium Rates (Non-Smoker, 1.0 HHS Age Factor, by Metal Tier and Plan ID)

Plan ID (a)	Metal Tier (b)	Starting Allowed (c)	Impact of Reinsurance (% allowed) (d)	Impact of Risk Adjustment (e)	Exchange User Fee Adjustment (f)	Market Adjusted Index Rate (g)=(c)*(d)*(e)	Provider Contracting Adjustment (h)	Tobacco Adjustment (non-tobacco rates) (i)	Cost Sharing Utilization (j)	Tier 1 AV (k)	Tier 2 AV (l)	Tier 1 PMPM (m)=(g)*(h)*(i)*(j)*(k)	Tier 2 PMPM (n)=(g)*(h)*(i)*(j)*(l)	AV (o)	Composite PMPM* (p)=(g)*(h)*(i)*(j)*(o)
62033IN0010001	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010002	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010003	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010004	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010005	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
62033IN0010006	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010007	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010008	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010009	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010010	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
62033IN0010011	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010012	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010013	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010014	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010015	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
62033IN0010016	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	66.5%	63.4%	$319.31	$304.25	66.2%	$317.81
62033IN0010017	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	76.4%	72.5%	$377.49	$358.46	76.0%	$375.59
62033IN0010018	Gold	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0490	87.7%	96.5%	$454.71	$500.43	88.6%	$459.28
62033IN0010019	Bronze	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	0.9710	62.9%	62.9%	$302.04	$302.04	62.9%	$302.04
62033IN0010020	Silver	$650.20	0.8888	1.0000	$16.96	$577.90	0.8663	0.9874	1.0000	72.0%	72.0%	$356.03	$356.03	72.0%	$356.03
	Total/Average								1.0011	75.4%	73.5%	$373.20	$363.74	75.2%	$372.26

Plan ID (a)	Metal Tier (b)	Fixed Admin (q)	Variable Admin (r)	PMPM Regulatory Fees (s)	Other Regulatory Fees (t)	Contribution to Surplus (u)	Plan Adjusted Index Rates (v)=(p)+(q)+(r)+(s)+(t)+(u)	Average Age Factor (w)	Calibrated Plan Index Rate (1.0 HHS Factors) (x)=(v)/(w)	Target Loss Ratio (y)=(p)/[(v)-(s)-(t)]	Projected Member Months (z)	PMPM Impact of Reinsurance (aa)
62033IN0010001	Bronze	$32.94	$28.47	$3.36	$23.00	$12.54	$418.11	**1.75**	$238.92	81.1%	3,289	$36.09
62033IN0010002	Silver	$32.94	$33.04	$3.92	$26.78	$14.61	$486.86	1.75	$278.21	82.3%	235,181	$43.32
62033IN0010003	Gold	$32.94	$39.68	$4.48	$32.24	$17.59	$586.21	1.75	$334.98	83.6%	28,008	$53.79
62033IN0010004	Bronze	$32.94	$27.25	$3.36	$21.98	$11.99	$399.55	1.75	$228.31	80.7%	29,603	$34.12
62033IN0010005	Silver	$32.94	$31.53	$3.92	$25.51	$13.92	$463.84	1.75	$265.05	82.0%	53,995	$40.87
62033IN0010006	Bronze	$35.54	$28.47	$3.36	$23.15	$12.63	$420.96	1.75	$240.55	80.6%	1,328	$36.09
62033IN0010007	Silver	$35.54	$33.04	$3.92	$26.93	$14.69	$489.71	1.75	$279.84	81.9%	82,805	$43.32
62033IN0010008	Gold	$35.54	$39.68	$4.48	$32.40	$17.67	$589.06	1.75	$336.60	83.2%	9,456	$53.79
62033IN0010009	Bronze	$35.54	$27.25	$3.36	$22.13	$12.07	$402.39	1.75	$229.94	80.1%	11,956	$34.12
62033IN0010010	Silver	$35.54	$31.53	$3.92	$25.67	$14.00	$466.69	1.75	$266.68	81.5%	18,994	$40.87
62033IN0010011	Bronze	$35.54	$28.47	$3.36	$23.15	$12.63	$420.96	1.75	$240.55	80.6%	1,074	$36.09
62033IN0010012	Silver	$35.54	$33.04	$3.92	$26.93	$14.69	$489.71	1.75	$279.84	81.9%	85,906	$43.32
62033IN0010013	Gold	$35.54	$39.68	$4.48	$32.40	$17.67	$589.06	1.75	$336.60	83.2%	9,912	$53.79
62033IN0010014	Bronze	$35.54	$27.25	$3.36	$22.13	$12.07	$402.39	1.75	$229.94	80.1%	9,666	$34.12
62033IN0010015	Silver	$35.54	$31.53	$3.92	$25.67	$14.00	$466.69	1.75	$266.68	81.5%	19,745	$40.87
62033IN0010016	Bronze	$36.94	$28.47	$3.36	$23.24	$12.67	$422.49	1.75	$241.42	80.3%	797	$36.09
62033IN0010017	Silver	$36.94	$33.04	$3.92	$27.02	$14.74	$491.24	1.75	$280.71	81.6%	64,417	$43.32
62033IN0010018	Gold	$36.94	$39.68	$4.48	$32.48	$17.72	$590.59	1.75	$337.48	83.0%	5,928	$53.79
62033IN0010019	Bronze	$36.94	$27.25	$3.36	$22.22	$12.12	$403.93	1.75	$230.81	79.8%	7,171	$34.12
62033IN0010020	Silver	$36.94	$31.53	$3.92	$25.75	$14.05	$468.22	1.75	$267.56	81.2%	14,827	$40.87
	Total/Average	$34.41	$32.78	$3.91	$26.65	$14.54	$484.55	1.75	$276.89	82.0%	694,058	$42.90

* The exchange user fee was excluded in this column and re-included in column (t).
**[(c)*(h)*(i)*(j)*(o)] - [(c)*(h)*(i)*(j)*(o)-(d)] - 3.67

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Appendix B
Wakely Mdwise Cost Sharing Reduction Estimates and Justification
(based on a 1.0 Area Factor)

Base Silver Plan	No CSR Allowed PMPM	Federal AVCs for Base and CSR Silvers				87% and 94% Utilization	CSR Advance Payments by Level			Weighted Average PMPM*
		Base Silver	73% Silver	87% Silver	94% Silver		73% Silver	87% Silver	94% Silver	
62033IN0010002	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010005	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010007	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010010	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010012	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010015	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010017	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38
62033IN0010020	$556.15	68.15%	73.69%	87.56%	94.37%	1.12	$30.81	$120.90	$163.32	$72.38

* See Actuarial Memo, Assumes 23.3% No CSR, 34.9% at 73% Silver, 15.7% at 87% Silver, and 26.1% at 94% Silver.

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Appendix C

Table C-1

Small Group Source Starting Allowed PMPM Development

Source	Allowed PMPM	Weight
Anthem SG Financial	$352.41	25.0%
UHLC Rate Filing	$421.71	25.0%
AWLP SG Rate Filing	$405.76	25.0%
ADVA Rate Filing	$480.85	0.0%
Plan Finder 1) Anthem PPO	$412.45	4.2%
Plan Finder 2) Anthem Lumenos	$334.88	4.2%
Plan Finder 3) United ChoicePlus	$430.98	4.2%
Plan Finder 4) Humana IN Copay 10	$367.33	4.2%
Plan Finder 5) All Savers Group	$343.55	4.2%
Plan Finder 6) Aetna PPO	$422.90	4.2%
Total / Weighted Average	**$391.31**	**100.0%**

Table C-2

Average Allowed PMPM Development for Appendix A from Starting Allowed PMPM

Item	Description	Small Group
(a)	Base Period Allowed PMPM (Small Group)	$391.31
	Cost Adjustment	
(b)	Bad Debt	1.0028
(c)	Benefit Adjustment	1.0200
	Morbidity Adjustment	
(d)	Morbidity	1.0190
(e)	Demographic - Age Gender (Outside of allowable age rating)	1.0589
(f)	Pent Up Demand	1.0000
(g)	2014 Strategic Renewal Impact	1.0100
(h)	Trend Factor to 7/1/2015	1.2122
(i)	Market Demographic (Allowable age rating)	1.2298
(j)	Allowed Claim Index Rate (product of all figures above)	$650.20

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Appendix D
Age Factors, Smoker Loads, and Area Factors

Demographics	HHS Factor	Smoker Load	Non-Smoker Load
Children 00-20	**0.635**	**1.000**	**1.000**
Ages 21	1.000	1.050	1.000
22	1.000	1.061	1.000
23	1.000	1.071	1.000
24	1.000	1.082	1.000
25	1.004	1.093	1.000
26	1.024	1.104	1.000
27	1.048	1.114	1.000
28	1.087	1.125	1.000
29	1.119	1.136	1.000
30	1.135	1.146	1.000
31	1.159	1.157	1.000
32	1.183	1.168	1.000
33	1.198	1.179	1.000
34	1.214	1.189	1.000
35	1.222	1.200	1.000
36	1.230	1.211	1.000
37	1.238	1.221	1.000
38	1.246	1.232	1.000
39	1.262	1.243	1.000
40	1.278	1.254	1.000
41	1.302	1.264	1.000
42	1.325	1.275	1.000
43	1.357	1.286	1.000
44	1.397	1.296	1.000
45	1.444	1.307	1.000
46	1.500	1.318	1.000
47	1.563	1.329	1.000
48	1.635	1.339	1.000
49	1.706	1.350	1.000
50	1.786	1.361	1.000
51	1.865	1.371	1.000
52	1.952	1.382	1.000
53	2.040	1.393	1.000
54	2.135	1.403	1.000
55	2.230	1.414	1.000
56	2.333	1.425	1.000
57	2.437	1.436	1.000
58	2.548	1.446	1.000
59	2.603	1.457	1.000
60	2.714	1.468	1.000
61	2.810	1.478	1.000
62	2.873	1.489	1.000
63	2.952	1.500	1.000
64 and Older	3.000	1.500	1.000

Rating Area	Area Factor
1	1.0000
2	0.9713
3	1.0748
4	0.9814
5	1.0082
6	1.0243
7	1.0761
8	1.0748
9	1.0261
10	1.0785
11	1.0748
12	1.0691
13	1.0823
14	N/A
15	1.0823
16	0.8636
17	1.1179

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Appendix E
Sample Rate Calculations

Example 1

Sample Plan:	62033IN0010001		
Metal Level:	Bronze		
Effective Date:	1/1/2015		
Rating Area:	2		
Age:	42		
Smoker Status:	Non-Smoker		
Calculation of Monthly Premium:			
Base Rate:		$238.92	Appendix A
Area Factor:		0.971	Appendix D
Age Factor:		1.325	Appendix D
Smoker/Non-Smoker Load:		1.000	Appendix D
Monthly Premium:		$307.48	Product of numbers above

Example 2

Sample Plan:	62033IN0010002		
Metal Level:	Silver		
Effective Date:	1/1/2015		
Rating Area:	5		
Age:	35		
Smoker Status:	Smoker		
Calculation of Monthly Premium:			
Base Rate:		$278.21	Appendix A
Area Factor:		1.008	Appendix D
Age Factor:		1.222	Appendix D
Smoker/Non-Smoker Load:		1.200	Appendix D
Monthly Premium:		$411.31	Product of numbers above

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Appendix F - SOA Values, Including Adjustments to SOA Values and Final Morbidity Adjustment

	OPTUM VALUES								Adjusted Values							
Figure 1- Changes in Sources of Coverage under the ACA in Selected State in 2014																HOME
Baseline Coverage	Total	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	768,681	200,861	43,675	493,581	556	2	23,974	6,032	768,681	200,861	10,919	526,337	556	2	23,974	6,032
Employer 51-100	149,666	27,449	6,762	113,722	13	-	1,204	516	149,666	27,449	6,762	113,722	13	-	1,204	516
Employer 101+	2,358,762	-	55,065	2,253,680	1,217	157	39,491	9,152	2,358,762	-	13,766	2,294,979	1,217	157	39,491	9,152
High Risk Pool	10,969	185	8,662	526	-	-	1,595	-	10,969	185	8,662	526	-	-	1,595	-
Other Non-Group	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093
Retiree	81,477	-	-	68,081	-	-	13,395	-	81,477	-	-	68,081	-	-	13,395	-
TRICARE	84,044	-	-	-	-	84,044	-	-	84,044	-	-	-	-	84,044	-	-
Medicare	815,120	-	-	-	-	815,120	-	-	815,120	-	-	-	-	815,120	-	-
Dual Eligible	138,231	-	-	-	-	138,231	-	-	138,231	-	-	-	-	138,231	-	-
Medicaid/CHIP	945,008	5,410	6,128	16,018	38	62	917,352	-	945,008	5,410	6,128	16,018	38	62	917,352	-
Uninsured	922,141	32,591	202,697	93,143	1,816	-	291,966	299,929	922,141	32,591	50,674	93,143	1,816	-	291,966	451,952
% of Currently Uninsured	-	3.5%	22.0%	10.1%	0.2%	0.0%	31.7%	32.5%	-							
Total	**6,452,541**	**270,394**	**407,586**	**3,050,802**	**55,807**	**1,037,616**	**1,302,613**	**327,723**	**6,452,541**	**270,394**	**181,508**	**3,124,857**	**55,807**	**1,037,616**	**1,302,613**	**479,745**

Elasticity Model - Lewin Baseline ACA model

	OPTUM VALUES								Adjusted Values							
Figure 1A- Changes in Morbidity under the ACA in Selected State in 2014																
Baseline Coverage	Pre-ACA PMPM	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15
Employer 51-100	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08
Employer 101+	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92
High Risk Pool	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00
Other Non-Group	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32
Retiree	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00
TRICARE	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00
Medicare	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00
Dual Eligible	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00
Medicaid/CHIP	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00
Uninsured	$222.21	$369.76	$362.84	$627.13	$4,084.72	$0.00	$555.17	$125.31	$222.21	$369.76	$453.55	$627.13	$4,084.72	$0.00	$555.17	$125.31
Total	**$555.38**	**$481.18**	**$448.93**	**$518.34**	**$500.79**	**$1,097.05**	**$492.28**	**$133.45**	$557.04	$481.18	$456.37	$517.80	$500.79	$1,097.05	$492.28	$130.87

	Pre-ACA		Post ACA W/out Changes		Post ACA W/ Changes		Post ACA Modified / Original	
	Members	PMPM	Members	PMPM	Members	PMPM	Members	PMPM
Individual	178,442	$331.56	463,393	$455.18	237,315	$466.81	0.5121	1.0256
Small Group	768,681	$464.98	694,442	$454.86	727,198	$453.99	1.0472	0.9981

Post ACA PMPM / Pre-ACA PMPM (This is Morbidity Change Only)

1.4079 Individual to Individual
1.0039 Small Group to Individual
0.9764 Small Group to Small Group

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PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				☐ Yes ☐ No

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page		of	
Specialist Visit	See Page		of	
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page		of	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page		of	
Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

I, on behalf of _____hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by_____ for review and approval.

_____ _____ _____

Name: Title: Date:

STATEMENT OF VARIABILITY
INDIVIDUAL HMO – ON/OFF EXCHANGE
For Contract Form # 62033-2015-1

General Variable Information

Most numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Website URL addresses and Phone Numbers are bracketed throughout the Contract for the removal if necessary or to update if the web addresses or phone numbers change.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval.

Please note that the deductible, out of pocket and cost share value ranges bracketed in the schedule will only be arranged to match our company's individual benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

The following is an explanation of the variables used within this Contract form:

There are two reasons MDwise has chosen to use variability in this Policy and they are recurrent in nearly every section of every Article, including the Schedule of Benefits and Cover Page:

Distinction between Subscriber and Enrollee/Eligible Dependent is intended to reflect the difference between Individual and Child-Only Coverage. In Child-Only Coverage, the Subscriber is not the individual receiving coverage through the contract and this designation is made to ensure this is clear.

Distinction between MDwise (Us, We) and the Exchange is intended to provide variability in the contractual provisions for members who purchase their policy on or off the exchange.

COVER PAGE:

> **Contract Type** – Indicates whether the contract is for an on/off exchange policy and whether Policy is for individual or Child-Only Coverage.
>
> **Disclaimer** – Informs customers who are purchasing this policy off exchange that they will not be eligible for the APTC and CSR available to through the Marketplace.

ARTICLE 1 - DEFININTIONS:

> **Open Enrollment** allows variability between and Policies purchased On/Off Exchange

Special Enrollment allows variability between Policies purchased On/Off Exchange

QHP - allows variability between Policies purchased On/Off Exchange.

ARTICLE 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligibility of Subscriber & Dependents – allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange

Annual Open Enrollment and Effective Date for Coverage – allows for the variability in the periods in which the consumer's policy will become active based on whether they purchase their policy On or Off exchange.

Special Enrollment and Effective Date for Coverage – allows variability between Individual/Child-Only and On/Off Exchange in the language outlining Special Enrollment Periods.

Notification of Eligibility Changes allows variability between Policies purchased On/Off Exchange.

Service Area Requirements – allows variability between Individual/Child-Only Policies.

ARTICLE 5 - PREMIUM PAYMENT:

Premium Payment - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Three-Month Grace Period - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Payment upon Termination - allows variability between Individual/Child-Only Policies.

ARTICLE 6 – PROCEDURES FOR OBTAINING HEALTH SERVICES:

Selection of a Primary Medical Provider - allows variability between Individual/Child-Only.

Preauthorization - allows variability between Individual/Child-Only Policies.

Health Services by Participating Providers - allows variability between Individual/Child-Only Policies.

Inpatient Emergency Health Services by Non-Participating Providers - allows variability between Individual/Child-Only Policies.

ARTICLE 7 – PROCEDURES FOR REIMBURSEMENTS OF ALLOWED AMOUNTS

Identification Card - allows variability between Individual/Child-Only Policies.

Participating Provider Services - allows variability between Individual/Child-Only Policies.

Procedures for Health Services Received from Non-Participating Providers - allows variability between Individual/Child-Only Policies.

Filing a Claim for Non-Participating Provider Services - allows variability between Individual/Child-Only Policies.

Coverage through Non-custodial Parent- allows variability between Individual/Child-Only Policies.

ARTICLE 8 – GRIEVANCE PROCEDURES:

Internal Grievance Procedure - allows variability between Individual/Child-Only Policies.

ARTICLE 9 – RENEWABILTY AND TERMINATION:

Renewability and Termination of Contract - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Discontinuance of a Particular Type of Contract - allows variability between Individual/Child-Only Policies.

Notice and Effective Date of Termination - allows variability between Individual/Child-Only Policies.

Process for Termination of Coverage by Written Request of Subscriber - allows variability between Policies purchased On/Off Exchange.

Process for Termination of Coverage Due to Loss of Eligibility - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Process for Termination of Coverage Due to Non-Payment of Premiums - allows variability between Individual/Child-Only Policies.

Process for Termination of Coverage When the Subscriber Changes to Another Qualified Health Plan During Open Enrollment or Special Enrollment - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Continued Inpatient Hospital Benefit - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Extended Coverage for Disabled Children - allows variability between Individual/Child-Only Policies.

Reinstatement - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

ARTICLE 12 – GENERAL PROVISIONS:

Limitations of Action - allows variability between Individual/Child-Only Policies.

Right of Recovery - allows variability between Individual/Child-Only Policies.

Medicare - allows variability between Policies purchased On/Off Exchange.

SCHEDULE OF BENEFITS:

Benefit Plan - will be the metal level for the product the consumer has selected.

Deductible - amount option ranges are as shown in schedule, for the different metal option offerings.

Out of Pocket Limit - (The most you will pay per calendar year) ranges (individual and family) are as shown in the schedule for the different metal option offerings.

Copayment - amount ranges are as shown in the schedule for the different metal option offerings.

Coinsurance/Cost Share - options ranges are as shown in schedule for the different metal option offerings.

Visit limits and Day limit - ranges are as shown in the schedule for the different metal option offerings.

Ambulance – Cost share options ranges are as shown in the schedule.

Behavioral Health Services – Copay ranges shown, for the various covered service locations, for the different metal option offerings.

Accidental Dental Service – Copay range for the different metal option offerings are as shown in the schedule.

Diagnostic Services – Cost share options ranges are as shown in the schedule.

Emergency room - Cost share options ranges are as shown in the schedule.

Home Care Services - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Hospice Care – Cost share options ranges are as shown in the schedule.

Inpatient and Outpatient Professional Services – Cost share options ranges are as shown in the schedule.

Inpatient Facility Services – Cost share options ranges are as shown in the schedule.

Medical Supplies, Durable Medical Equipment and Appliances – Cost share options ranges are as shown in the schedule.

Outpatient Services – Cost share options ranges are as shown in the schedule.

Physician Home Visits and Office Visits – Cost share options ranges are as shown in the schedule.

Surgical Services – Cost share options ranges are as shown in the schedule.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder– Cost share options ranges are as shown in the schedule.

Therapy Services – Cost share options ranges are as shown in the schedule.

Urgent Care Center Services – Cost share options ranges are as shown in the schedule.

Pediatric Vision – Cost share options ranges are as shown in the schedule.

Transport - Transportation and Lodging – Cost share options ranges are as shown in the schedule.

Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure – Cost share options ranges are as shown in the schedule.

Participating Retail Pharmacy Prescription Drug Copay/Coinsurance – Cost share options ranges are as shown in the schedule.

Orally Administered Cancer Chemotherapy – Cost share options ranges are as shown in the schedule.

June 6, 2014

Karl Knable
Indiana Department of Insurance
Indianapolis, Indiana

Dear Karl,

We appreciate the quick and thorough review of the filing. The questions raised below have highlighted areas that we'd like to address through revision of our rates. As you know, MDwise has received more information from the state regarding the spend-down population that may support a decrease in the adjustment included in our initial submission. Additionally, MDwise is participating in the Wakely National Risk Adjustment Reporting (WNRAR) project. We expect results from that project in the coming weeks. We anticipate that the results will help us refine the general morbidity assumption and the impact of the transition plans. In each case, we expect the changes to result in lower premiums. Please let us know if you'd like to discuss this general approach.

Below you will find the objections you sent with our responses. Also, we have attached a revised Appendix A.

1. **We will need to see your current enrollment data including count, premium and demographics.**

   Please see the spreadsheet attached to the objection response.

2. **You indicate that the trend is 8%, please provide some documentation for this value.**

   The actuarial memorandum indicates we used two reference points and judgment for setting the trend assumption. The first reference point is rate filings. The rate filings in Indiana we reviewed showed annual PMPM medical cost trend assumptions ranging from 6.8% to 12% with a subscriber-weighted average of 9.6%. The second reference point is national trend surveys. The 2014 Segal Health Plan Cost Trend Survey states "Health plan cost trend rates show the slowest growth in 14 years of trend forecasts". Segal estimates trends for HMOs to be 7.2% without Rx and 7.0% with Rx. We considered the information gathered from these reference points to set the trend at 8%.

3. **Please provide a demonstration of how the .8962 factor was determined for the impact of reinsurance.**

   Wakely developed a reinsurance model to calculate the percentage impact of reinsurance based on the reinsurance parameters and an expected allowed cost. The model relies on a continuance table of medical and pharmacy costs from the Truven MarketScan data, calibrated to pricing allowed costs. The percentage from that model is then applied to the allowed costs across the various QHPs and metal levels. The .8962 is a projected member month-weighted average of the various impact factors. As explained in our response to question #6, we are sending a revised Appendix A, and this number will now be 0.9111. This change does not impact the premiums.

4. **From Section 5, please provide numerical justification for benefit adjustment (1.02), morbidity (1.1545), demographic (1.0692) and strategic renewal impact (1.1). The 10% impact due to renewal strategies seems high.**

The benefit adjustment infuses into the base period allowed PMPM the cost of covering essential health benefits that may not have been previously covered under small group plans. The 1.02 factor is consistent with Wakely's best estimate from work in other states and includes estimates for each of the following benefit changes:

	Additional PMPM	
Benefit	Low	High
Maternity and prescription drug coverage	$0.40	$0.65
Mental health and substance abuse parity	$0.10	$0.30
Habilitative Services	$3.00	$5.00
Pediatric vision and dental	$2.75	$4.25
Total	$6.25	$10.20

The morbidity factor of 1.1545 is made up of two parts. The first is a factor of 1.0039 and its development is shown in Appendix F. The second part is a 15% adjustment to account for the increased costs from the Medicaid Spend down population. This is based on an analysis performed by Wakely which relied heavily on a report by Milliman. The Milliman report indicated a potential impact as 5%-10%. A primary driver in our higher estimate is a different assumption for converting Medicaid costs to commercial equivalent costs. The morbidity factor in table C-2 line (d) is 1.0039 * 1.15, or 1.1545. As more information has been released regarding this population since this rate filing, Wakely would like to make changes to this assumption in a revised submission.

The demographic factor is derived from two factors. The first is a factor of 1.0381 which was used as part of the 2014 filing that was calculated to show the difference between the current market and the expected market. Now that we have information regarding the actual demographics of those enrolling in the exchange and that they are older than originally expected, we are increasing that factor by 1.03. The product of the two is the 1.0692 factor. This demographic factor represents additional expected morbidity due to older individuals enrolling than were in base period data, outside of allowable rate variation (3:1 age factors).

The strategic renewal impact of 1.1 is our current best estimate, based on theoretical modeling but very little data because such data is not available yet. The Wakely National Risk Adjustment Reporting project results with data through April will become available in the coming weeks and should provide detailed, quantitative information so that we can develop a more credible estimate. Wakely would like to make changes to this factor in a revised submission if this new information supports a different assumption.

5. **With regard to the market demographic factor of 1.2298, how is this different from the morbidity adjustment?**

This demographic factor is based on the difference between the base period market demographics and the actual market demographics as can be rated for using the HHS age factors. The demographics under the morbidity section reflect that there may be increased/decreases risk that cannot be captured with allowable rating factors because the age factors are limited to 3 to 1.

6. **From Section 5, please provide an example of how you get from the $810.19 to $407.40 for the first listed plan.**

We are including a revised Appendix A that will outline how to get from the Starting Allowed PMPM to the Composite PMPM. The previous version used weighted averages that didn't allow for the calculations to be done using the provided numbers. The revised Appendix A will allow you to follow the calculation. The correction meets the requirement in the actuarial memorandum instructions that the impact of reinsurance and exchange user fee be shown as the same amount for all plans. Plan differences are now reflected in the benefit plan differences. This change does not impact the final premiums.

7. **In Appendix A, the exchange user fee impact is $12.27, how is this allocated between on and off exchange and how the 12.27 is determined.**

   The exchange user fee is 3.5% of total premiums. The $12.27 represents 3.5% of the expected total premium under the filed assumptions at a 1.0 age factor. As mentioned in response to question #6, we are sending a revised Appendix A and the new amount will be $21.24. This change does not impact the final premiums.

   MDwise is not going to be actively marketing it's off exchange program and therefore expects no material enrollment off the exchange. As a result, the 3.5% is not reduced for any off-exchange enrollment.

8. **You mention a factor of 1.0339 on page 4 to be used in Appendix C, can you help me track this?**

   The 1.0339 is a typo in the documentation (no impact to rates). The factor should be 1.0039. This factor's development is shown in Appendix F. Then, in Appendix C, this factor is combined with a 15% adjustment to morbidity to account for the increased costs from the transitioning Medicaid Spend down population. The morbidity factor in table C-2 line (d) is 1.0039 * 1.15, or 1.1545.

9. **With regard to risk adjustment, can you discuss why you think there will not be a risk adjustment impact on the rates while considering the Medicaid spend down and the additional HIV population.**

   We have developed manual rates for a 1.0 average statewide risk and assumed that MDwise would enroll average risk individuals. We have assumed there will not be a bias among the Medicaid Spend down and additional HIV populations when they select a product; therefore, MDwise's risk will remain similar to that of the market as a whole. While it is unlikely MDwise will enroll an average population, it is very uncertain if the population will be healthier or sicker than average and we assume risk adjustment will adjust for differences from average risk. Therefore, any assumptions regarding MDwise's population being different than average would include an equal adjustment to medical expenses and revenue and have no effect on premium rates.

10. **I don't see any documentation for the provider contracting adjustment.**

    The rate development included an adjustment for provider contracting as compared to existing, statewide average assumed contracting levels. Factors are developed by comparing the relativities of assumed market contracting rates underlying market experience from rate filings and financial statements to MDwise's contracting levels. For example, we've assumed that facilities are reimbursed at x% of Medicare and that professionals are reimbursed at y% of Medicare in the commercial market underlying the 2012 base period PMPMs from rate filings and financial statements (i.e. our starting PMPM). The provider discounts are then determined by taking MDwise's contracts, let's say a% for facility and b% for professional, as a ratio to those assumptions, so a%/x% and b%/y%. Those ratios are then blended by the expected mix of services between facility and professional and for other categories such as prescription drug.

11. **I don't see any documentation for the tobacco adjustment of .9874.**

    Wakely assumed an average smoker load of 1.20 and a non-smoker load of 1.0 for the various plans used in developing the base period allowed PMPM. A report from Indiana (http://www.in.gov/isdh/tpc/files/IN_Adult_Smoking_NOV2012.pdf) indicates that there is a smoking prevalence of 25.6% in Indiana. We reduced that amount by 75% to reflect that not all smokers will be self-reporting when purchasing insurance. A blend of the two loads, assuming 6.4% for smokers (25.6% * .25) results in a factor of 1.0128. We then backed this out of the base period allowed PMPM by using the factor 0.9874 (1/1.0128).

12. **Where is the cost sharing utilization explained or derived?**

    The adjustments are equal to the factors provided in Table 11 on page number 15433 of the "Federal Register Vol. 78, No. 47 Monday, March 11, 2013 Rules and Regulations" but relative to the silver metal tier factor. For example, in the table the factor for the Gold metal tier is 1.08 and the Silver metal tier is 1.03. The adjustment for the Gold plans is then 1.08 divided by 1.03 (1.0485). Per ACA requirements, these adjustments do not include a selection bias due to health status.

13. **Please provide more detail around the development of each of the fees in the bottom half of Appendix A, such as Fixed Admin, Variable Admin, PMPM regulatory fees, and Other Fees.**

    Fixed Admin – This amount was calculated by trending the prior year fixed admin amount forward by 3%. On a 1.0 age basis, that is $18.27 * 1.03 = 18.82 (with our assumed 1.75 age factor this number is $32.94). This is the number used for Service Area 1. That fixed admin amount is adjusted for the other service areas with lower membership as the cost is spread out over fewer members.

    Variable Admin – This amount is set so that the variable admin amount will be a percentage of premium consistent with the 2014 filing, or 6.8%.

    PMPM Regulatory Fees – This is calculated as the sum of the Reinsurance of $3.67, the Risk Adjustment User Fee of $0.08, and the PCORI fee of $0.25. These amounts are shown in section 9 of the actuarial memorandum.

    Other Fees – This includes 3.5% for the Exchange User Fee and 2.0% for the Issuer Fee. The $33.37 is 5.5% of the Plan Adjusted Index Rate of $606.74.

14. **You performed an age calibration to get the 1.75 factor, please provide the detail.**

    MDwise is participating in the Wakely National Risk Adjustment Reporting (WNRAR) project. The Indiana issuers are submitting risk adjustment and demographic only information to Wakely periodically during 2014. The 1.75 age factor is based on demographic only submissions with data through March and an estimate of additional enrollment subsequent to those submissions. The state wide individual market demographic factor for post ACA business is higher, but we anticipate additional enrollment at the younger ages. The 1.75 is based on this adjusted expected distribution of enrollment and HHS age factors.

15. **In the EHB explanation, you state that there was an impact for State mandated benefits that only applied to group coverage. Since you started with group rates, have you backed this out somewhere else?**

    We will revise the wording in this section to remove this bullet point as it is a carryover from the initial 2014 Actuarial Memorandum. The statement applied to any Individual market sources, indicating that they would need to be adjusted, while the Small Group market sources did not.

16. **You discuss the inclusion of capitation payments, please discuss this including the values shown in the URRT for each of the benefit categories.**

    Under the MDwise financial structure, the participating delivery systems are the risk bearing entities. They are paid a percentage of revenue, with MDwise retaining a portion for its administrative costs. We have developed the rates using the expected true medical costs as opposed to expected capitation payouts to the delivery systems since this is how MDwise is required to report their financial statements and reflects the true costs of providing the coverage. The statement regarding capitation in the actuarial memorandum refers to this. The capitation amount shown on the URRT refers to the standard capitation concept of medical services that are capitated.

17. **In the URRT, you use a Paid to Allowed factor of .765. Can you provide some documentation on how this was developed?**

    This ratio is the same as shown in column O of Appendix A. It is developed by running the benefit plan designs through the Wakely Benefit Pricer to determine the plan AVs.

18. **Can you show how you get to the $51.14 reinsurance factor in the URRT from the 7.9% reduction in claim costs mentioned in Section 8?**

    As mentioned in our response to question 6, because of the way we displayed Appendix A with weighted averages, other amounts we have used cannot be directly calculated. We are sending a revised Appendix A that will allow you to follow the calculation. The correction meets the requirement in the actuarial memorandum instructions that the impact of reinsurance and exchange user fee be shown as the same amount for all plans. Plan differences are now reflected in the benefit plan differences. The new number is $42.71 and is included in column (aa) of the revised version of Appendix A which is included with this letter. It can be calculated in the following manner.

    From Appendix A, calculate the product of the values in columns (c), (h), (i), (j), and (o).

    From Appendix A, calculate the product of the values in columns (c), (h), (i), (j), (o), and (d).

Subtract the value found in step 2 from step 1 and then subtract out the reinsurance fee of 3.67.

Weight the results of those steps for each row of Appendix A by the projected member months (column z) to get the result.

19. **Last year MDwise was exempt from the issuer fee. Show projections of how you think they will be impacted for this year and what that impact is.**

    MDwise believes that the 2014 Marketplace premiums will exceed 20% of total MDwise premiums, thereby eliminating the existing non-profit exemption that MDwise benefitted from in the 2014 filing. Because of this, we have estimated an impact of 2% on premiums, based upon national estimates of the issuer fee.

    As you know, MDwise has applied for licensure of a separate, wholly owned, HMO. If this license is granted, MDwise anticipates transferring the existing Marketplace membership into that HMO, which may reduce the amount of issuer tax owed and potentially allow a reduction in the 2015 premiums.

20. **The PCORI fee looks high.**

    For plan years ending in any fiscal year beginning on or after Oct. 1, 2014, the fee is indexed for medical inflation. We will revise our estimate to reflect an increase of just 3%, so the new amount will be $0.17. This change will lower the premiums slightly. We will make this change when we make the other pricing changes for spend down and overall morbidity.

21. **Please break out the calculation of the MLR showing the pieces in the numerator and denominator.**

    This can be done using the Total/Average row of Appendix A. The numerator is column (p) ($475.61) and the denominator is the sum of column (v) less the sums of columns (s) and (t) ($606.74 - $4.00 - $33.37).

22. **For this year in worksheet I of the URRT, please provide PMPM for the premium based on 2014 current rates and show the index rate from last year's filing.**

    The image below contains the section in the URRT with the amounts you requested. If this is what you are expecting to see, let us know and we will revise when we resend the URRT.

Section I: Experience period data				
Experience Period:	1/1/2014	to	12/31/2014	
		Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:		$172,678,357	$381.84	100.00%
Incurred Claims in Experience Period		$1	0.00	0.00%
Allowed Claims:		$1	0.00	0.00%
Index Rate of Experience Period			$534.00	
Experience Period Member Months		452,227		

23. **In the URRT, the drug and hospital PMPM seem high compared to what most carriers are using. Can you discuss why you are comfortable with these factors?**

    Since our overall manual rate didn't change from the 2014 development except for trend from 2014 to 2015, we did not change the allocation by service category. Our updated pricing model using Truven MarketScan data shows a lower hospital PMPM and pharmacy cost PMPM. We will submit a revised URRT with manual rate updated as part of the updated pricing model. This change will impact each of the service categories. This change will have no effect on pricing as we used the Truven Marketscan based pricing model to develop the pricing AVs.

Please let us know if there are any further questions or concerns.

Sincerely,

MDwise, Inc.

62033IN0010001

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,000.00			$4,500.00
Coinsurance (%, Insurer's Cost Share)			65.00%			50.00%
OOP Maximum ($)			$6,600.00			$6,600.00
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$750.00	☑	☐		$750.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$150.00
Specialist Visit	☑	☐		$75.00	☑	☐		$150.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$75.00	☑	☐		$150.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$250.00	☑	☐		$400.00
Rehabilitative Speech Therapy	☑	☐		$75.00	☑	☐		$150.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$75.00	☑	☐		$150.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$75.00	☑	☐		$150.00
X-rays and Diagnostic Imaging	☑	☐		$75.00	☑	☐		$150.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$30.00	☐	☐		$30.00
Preferred Brand Drugs	☐	☐		$75.00	☐	☐		$75.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	65%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	65%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.8%
Metal Tier:	Bronze

62033IN0010002 standard

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			$3,200.00
Coinsurance (%, Insurer's Cost Share)			85.00%			70.00%
OOP Maximum ($)			$4,500.00			$5,200.00
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$350.00	☑	☑		$350.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		$60.00
Specialist Visit	☑	☐		$40.00	☑	☑		$60.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$40.00	☑	☑		$60.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$125.00	☑	☑		$250.00
Rehabilitative Speech Therapy	☑	☐		$40.00	☑	☑		$60.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$40.00	☑	☑		$60.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		$60.00
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		$60.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		$15.00
Preferred Brand Drugs	☐	☐		$45.00	☐	☐		$45.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	85%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	85%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.9%
Metal Tier:	Silver

62033IN0010002 73% AV

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,150.00			$3,200.00
Coinsurance (%, Insurer's Cost Share)			90.00%			70.00%
OOP Maximum ($)			$4,250.00			$5,200.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$350.00	☑	☑		$350.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☑		$60.00
Specialist Visit	☑	☐		$40.00	☑	☑		$60.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$40.00	☑	☑		$60.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$125.00	☑	☑		$250.00
Rehabilitative Speech Therapy	☑	☐		$40.00	☑	☑		$60.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$40.00	☑	☑		$60.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☑		$60.00
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☑		$60.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		$15.00
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		$40.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	90%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	90%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.9%
Metal Tier:	Silver

62033IN0010002 87% AV

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			$1,500.00
Coinsurance (%, Insurer's Cost Share)			95.00%			80.00%
OOP Maximum ($)			$2,250.00			$2,250.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$100.00	☑	☐		$100.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$40.00
Specialist Visit	☑	☐		$20.00	☑	☐		$40.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$20.00	☑	☐		$40.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$75.00	☑	☐		$150.00
Rehabilitative Speech Therapy	☑	☐		$20.00	☑	☐		$40.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$20.00	☑	☐		$40.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$20.00	☑	☐		$50.00
X-rays and Diagnostic Imaging	☑	☐		$20.00	☑	☐		$50.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		$10.00
Preferred Brand Drugs	☐	☐		$20.00	☐	☐		$20.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	95%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	95%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.7%
Metal Tier:	Gold

62033IN0010002 94% AV

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			$750.00
Coinsurance (%, Insurer's Cost Share)			95.00%			80.00%
OOP Maximum ($)			$550.00			$1,500.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$100.00	☑	☐		$100.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$20.00
Specialist Visit	☑	☐		$10.00	☑	☐		$20.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$10.00	☑	☐		$20.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$25.00	☑	☐		$50.00
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☐		$20.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☐		$20.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$10.00	☑	☐		$30.00
X-rays and Diagnostic Imaging	☑	☐		$10.00	☑	☐		$30.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$10.00	☐	☐		$10.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	95%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	95%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.8%
Metal Tier:	Platinum

62033IN0010003

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			$1,000.00
Coinsurance (%, Insurer's Cost Share)			90.00%			75.00%
OOP Maximum ($)			$3,250.00			$6,600.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$50.00
Specialist Visit	☑	☐		$35.00	☑	☐		$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$35.00	☑	☐		$50.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☑	☐		$150.00
Rehabilitative Speech Therapy	☑	☐		$35.00	☑	☐		$50.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$35.00	☑	☐		$50.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$25.00	☑	☐		$50.00
X-rays and Diagnostic Imaging	☑	☐		$25.00	☑	☐		$50.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		$10.00
Preferred Brand Drugs	☐	☐		$35.00	☐	☐		$35.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	90%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	90%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.5%
Metal Tier:	Gold

62033IN0010004

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,500.00			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%			60.00%
OOP Maximum ($)			$6,600.00			$6,600.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$750.00	☑	☐		$750.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$150.00
Specialist Visit	☑	☐		$90.00	☑	☐		$150.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$90.00	☑	☐		$150.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$300.00	☑	☐		$400.00
Rehabilitative Speech Therapy	☑	☐		$90.00	☑	☐		$150.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$90.00	☑	☐		$150.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$75.00	☑	☐		$150.00
X-rays and Diagnostic Imaging	☑	☐		$75.00	☑	☐		$150.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$30.00	☐	☐		$30.00
Preferred Brand Drugs	☐	☐		$85.00	☐	☐		$85.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	70%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	70%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.3%
Metal Tier:	Bronze

62033IN0010005 standard

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			$3,250.00
Coinsurance (%, Insurer's Cost Share)			85.00%			70.00%
OOP Maximum ($)			$6,600.00			$6,600.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$350.00	☑	☐		$350.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$80.00
Specialist Visit	☑	☐		$45.00	☑	☐		$80.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$45.00	☑	☐		$80.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$150.00	☑	☐		$350.00
Rehabilitative Speech Therapy	☑	☐		$45.00	☑	☐		$80.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$45.00	☑	☐		$80.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$40.00	☑	☐		$80.00
X-rays and Diagnostic Imaging	☑	☐		$40.00	☑	☐		$80.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		$15.00
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		$40.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	85%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	85%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.1%
Metal Tier:	Silver

62033IN001005 73% AV

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$5,200.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,250.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☐	☐		$250.00	☑	☐		$250.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$70.00
Specialist Visit	☑	☐		$35.00	☑	☐		$70.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$35.00	☑	☐		$70.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$100.00	☑	☐		$250.00
Rehabilitative Speech Therapy	☑	☐		$35.00	☑	☐		$70.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$35.00	☑	☐		$70.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$30.00	☑	☐		$60.00
X-rays and Diagnostic Imaging	☑	☐		$30.00	☑	☐		$60.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☐ All		
Generics	☐	☐		$15.00	☐	☐		$15.00
Preferred Brand Drugs	☐	☐		$25.00	☐	☐		$25.00
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.7%
Metal Tier:	Silver

62033IN0010005 87% AV

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$700.00			$1,500.00
Coinsurance (%, Insurer's Cost Share)			95.00%			80.00%
OOP Maximum ($)			$1,500.00			$2,250.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$100.00	☑	☐		$100.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$30.00
Specialist Visit	☑	☐		$15.00	☑	☐		$30.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☐		$30.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$65.00	☑	☐		$130.00
Rehabilitative Speech Therapy	☑	☐		$15.00	☑	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$15.00	☑	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$15.00	☑	☐		$30.00
X-rays and Diagnostic Imaging	☑	☐		$15.00	☑	☐		$30.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		$10.00
Preferred Brand Drugs	☐	☐		$15.00	☐	☐		$15.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	95%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	95%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold

62033IN0010005 94% AV

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	90%
2nd Tier Utilization:	10%

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			$750.00
Coinsurance (%, Insurer's Cost Share)			95.00%			80.00%
OOP Maximum ($)			$750.00			$1,000.00
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☐ All		
Emergency Room Services	☑	☐		$100.00	☑	☐		$100.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$0.00	☑	☐		$20.00
Specialist Visit	☑	☐		$10.00	☑	☐		$20.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$10.00	☑	☐		$20.00
Imaging (CT/PET Scans, MRIs)	☑	☐		$25.00	☑	☐		$50.00
Rehabilitative Speech Therapy	☑	☐		$10.00	☑	☐		$20.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$10.00	☑	☐		$20.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$10.00	☑	☐		$20.00
X-rays and Diagnostic Imaging	☑	☐		$10.00	☑	☐		$20.00
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$4.00	☐	☐		$4.00
Preferred Brand Drugs	☐	☐		$10.00	☐	☐		$10.00
Non-Preferred Brand Drugs	☑	☑			☑	☑	95%	
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑	95%	

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.0%
Metal Tier:	Platinum

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/06/2014		Rate	Actuarial Memorandum	07/25/2014	Actuarial Memorandum MDwise Issuer 62033 (Wakely 5-11-2014).pdf (Superceded) Revised Appendix A 62033.pdf (Superceded)
05/10/2014		Supporting Document	Statement of Variability	06/03/2014	Statement of Variability MDwise Marketplace, Inc 62033-2015-1.pdf (Superceded)
05/07/2014		Form	MDwise Marketplace	06/03/2014	Final MDwise Marketplace 62033-2015-1 Policy Adult Child On Off Exchange 5 10 14 Clean.pdf (Superceded) Final MDwise Marketplace 62033-2015-1 Policy Adult Child On Off Exchange 5 10 14 redline.pdf (Superceded)
05/07/2014		Rate	Actuarial Memorandum	06/06/2014	Actuarial Memorandum MDwise Issuer 62033 (Wakely 5-11-2014).pdf
05/07/2014		Supporting Document	04 Major Medical Experience Workbook (Accident & Health)	07/25/2014	Major Medical Experience Workbook 62033-2015-1.xlsx (Superceded)
05/07/2014		Supporting Document	Actuarial Memorandum and Certifications	07/25/2014	Actuarial Memorandum MDwise Issuer 62033 (Wakely 5-11-2014).pdf (Superceded)
05/07/2014		Supporting Document	Unified Rate Review Template	07/25/2014	MDwise 2015 URRT 62033 - Links Removed.xlsm (Superceded)

State: Indiana **Filing Company:** MDwise Marketplace, Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005D Individual - HMO
Product Name: MDwise Marketplace
Project Name/Number: MDwise Marketplace/62033IN001

Attachment Major Medical Experience Workbook 62033-2015-1.xlsx is not a PDF document and cannot be reproduced here.

Attachment MDwise 2015 URRT 62033 - Links Removed.xlsm is not a PDF document and cannot be reproduced here.

Actuarial Memorandum

MDwise Issuer #62033

Individual Health Insurance Exchange Premium Rate Filing

May 11, 2014

Developed By:

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1. EXECUTIVE SUMMARY

This memorandum documents the development of individual rates for MDwise. These rates will be offered inside of the State of Indiana's health insurance exchange, which is being operated by the federal government.

MDwise is a not-for-profit corporation that purchased 100% of the stock in IU Health Plan, Inc., a fully licensed HMO, (IUHP) on December 29, 2006. IUHP was merged into MDwise, Inc. as of January 1, 2007. MDwise remains a fully licensed Indiana domestic HMO. MDwise is jointly controlled by Indiana University Health, Inc. and Health & Hospital Corporation of Marion County Indiana. The two parent companies are not-for-profit, are incorporated in the State of Indiana, and are provider delivery system companies.

Beginning January 1, 2011, MDwise was granted a four-year contract with the State of Indiana (the "State"), through the Family and Social Service Administration ("FSSA") and Office of Medicaid Policy and Planning ("OMPP"), to arrange for and administer two risk-based managed care programs ("Hoosier Healthwise" and "Healthy Indiana Plan") for certain Indiana Medicaid enrollees. MDwise contracts with various delivery networks. The delivery networks accept the medical service risk for enrollees who choose a primary care provider after selecting the MDwise network. There were approximately 280,000 members enrolled in the Hoosier Healthwise and Healthy Indiana Plan products at December 31, 2013.

Under an Accountable Care Organization model, MDwise contracts with several integrated delivery systems to provide medical services and claims administration under risk contracts for their current business. MDwise has operated under this model since its inception.

MDwise is offering two individual health insurance products in the Bronze and Silver metal tiers and one individual health insurance product in the Gold metal tier. Being a non-profit health plan focused on low income individuals, MDwise expects most enrollment to be in the Silver plan, for individuals eligible for premium tax credits and cost sharing reductions. MDwise's mission is to provide health care services to the lower income population. One of the primary reasons that MDwise is entering the individual market within the health insurance exchange is to provide its Medicaid members with an MDwise product offering if they lose Medicaid eligibility.

MDwise has applied for a new HMO license in the State of Indiana (MDwise Marketplace). Our filing is in the review process. MDwise anticipates it to be active in time for 2015 Open Enrollment season. MDwise has applied and received a new HIOS ID number of 62033.

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2. GENERAL INFORMATION

Company Legal Name: MDwise Marketplace, Inc.

State: Indiana

HIOS Issuer ID: 62033

Market: Individual Market

Effective Date: January 1, 2015

Company Contact Information

Primary Contact Name: Elizabeth Eichhorn

Primary Contact Telephone Number: 317-822-7232

Primary Contact Email Address: Eeichhorn@mdwise.org

3. PROPOSED RATE INCREASES

MDwise began selling individual policies with effective dates beginning January 2014. They did not previously participate in the individual market. The effective rate increase is 35% for 2015 for all proposed individual policies. This large increase is driven primarily by Indiana's transition from a 209(b) state to a 1634 state and the associated population expected to enroll in the individual market because of this change.

4. EXPERIENCE PERIOD PREMIUM AND CLAIMS, BENEFIT CATEGORIES AND PROJECTION FACTORS

MDwise began selling individual policies with effective dates beginning January 2014. The effective rate increase for 2015 is 35% for all proposed individual policies.

Because they did not participate in the individual or small group markets prior to 2014 and 2014 experience is not yet credible, the rate development is based entirely on a manual rate.

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5. MANUAL RATE DEVELOPMENT

The basic manual rate development methodology is unchanged from the 2014 premium rate development. Updated market experience was not available at a sufficient level of detail to justify redeveloping the manual rate. Instead, we reflected emerging demographic and risk adjustment information in our morbidity assumptions and updated other assumptions that were different from 2014 including trend, the impact of reinsurance, benefit changes, leveraging of fixed cost sharing items and the addition of individuals expected to enroll in the Individual market starting in 2014 because of Indiana's transition from a 209(b) state to a 1634 state.

The approach to premium rate development is as follows:

1. Paid and/or allowed PMPM medical costs were developed using market information including competitor rate filings, premium rates, and financial filings. If historic experience net of member cost sharing was used, paid to allowed ratios were estimated using the Wakely pricing model. Table C-1 in Appendix C shows the various sources used for the small group source development.

2. Allowed PMPMs were adjusted for trend and ACA changes and requirements including EHB, pent up demand, morbidity changes between pre and post ACA enrollment and others described below.

3. The Wakely pricing model was calibrated to the adjusted allowed PMPMs and used to estimate paid to allowed ratios. Within a benefit plan offering, a consumer may choose to use providers in a preferred network of providers and receive reduced cost sharing, represented by Tier 1. If a consumer chooses instead to use non-preferred providers, the cost sharing is greater, represented by Tier 2. They have been blended with a 90% weighting on Tier 1 and 10% on Tier 2, reflective of MDwise's expectations on actual utilization. The pricing by tier and blended result is shown in Appendix A.

4. Administrative costs and regulatory fees and taxes, along with contribution to surplus were added.

Appendix C, Table C-2 shows the components of the starting allowed PMPM shown in Appendix A. A comparison to the 2014 development is also provided.

Source and Appropriateness of Experience Data Used

The allowed PMPM target for post reform experience was developed using pre-reform small group market information.

Even though the goal is to price individual products post reform, the post reform individual market may look more like the pre-reform small group market than the pre-reform individual market. Therefore, we reviewed rate filings and financial reports for Indiana small group products. We made adjustments for trend, benefit design, and others to adjust the allowed PMPM to the midpoint of the rating period.

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Population Changes

The manual rate incorporates results from the SOA study[1] (performed by Optum/Lewin) to estimate changes in morbidity from the Indiana pre-ACA market to that enrolled in Indiana post ACA. Results from other states and analyses, including those performed by Wakely were also reviewed, but the Lewin model framework was used. Wakely has performed detailed studies on behalf of individual states with broad health plan participation and detailed data collection. We have found some of the values provided by the health plans, high risk pool, and the state differ (sometimes significantly) from the values presented in the SOA study, which is reasonable given the different data sources used and differences in judgment likely between actuaries performing this type of modeling. We made adjustments and applied judgment with input from the health plan in developing the final estimates of how the post reform market would compare to the pre-reform market. The primary changes were to decrease the number of previously uninsured entering the market and to increase their assumed health status since the SOA values are targeted once the ACA has been fully implemented.

Wakely also reviewed emerging results from the Wakely National Risk Adjustment Reporting study. This study included participation from Indiana issuers, including MDwise. The issuers reported claims and demographic based risk adjustment information through February 2014. The project will include updated information throughout 2014 which we will be reviewing as it becomes available. Emerging Indiana information caused us to increase our morbidity assumption by 3%. This is primarily driven by a higher age distribution than originally anticipated. This adjustment captures expected morbidity over and above allowable rating variation.

The components of the Morbidity Adjustment are shown in Appendix C, Table C-2.

Appendix F provides the detail behind the base SOA tables and our adjustments to the SOA tables to develop the final morbidity adjustment factor in Appendix C (1.0339).

Pent up demand and the 2014 strategic renewal impact adjustments are described in more detail below.

Cost Adjustments

We have made two adjustments to account for cost variances.

- Smoking Load – We adjusted the base period data by a factor of 0.9874 to create an index rate that is reflective of a non-smoking population.
- Bad Debt – To account for the likelihood that some policy holders will not pay premiums within the grace period, we have increased rates by a factor of 1.00275. This is calculated assuming a 15% rate of non-payment of one out of twelve months on about 22% of premium, after considering federal subsidies (.15 x .224 x 1/12 = .00275).

[1] Web link (as of 4-4-2013): http://www.soa.org/NewlyInsured/

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Trend Factors (cost / utilization)

We assumed PMPM medical costs would increase by 8% annually from 2012 to 2015 due to ongoing increases in utilization, unit costs and technology. This assumption is based on review of rate filings for Indiana and other states, national publicly available trend surveys, and judgment. These trends do not include the effect of demographics or benefits because those adjustments are included elsewhere.

Essential Health Benefits (EHB)

We adjusted the allowed claims sources in the manual rate development for expected changes in covered benefits due to EHB requirements, specific to individual and small group market starting cost sources. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

Adjustments for changing demographics, changes in benefits, and others were separately addressed and included in the premium rate development.

To incorporate these adjustments we increased the small group market source by 2%.

Provider Reimbursement Adjustment

MDwise provided Wakely with provider contracting targets by plan (based on service area) for inpatient facility, outpatient facility and professional categories of service. Wakely analyzed these targets and compared them to market information regarding current commercial reimbursement rates. We assumed provider volume by provider system would be consistent with current MDwise Medicaid volume by provider system. The total adjustments to allowed cost varied by plan and are reflected in the geographic factors.

Strategic Renewal Impact

Many health plans were working to provide communication and incentive for individual policyholders to renew on 12/1/2013, 1/1/2014, or at their scheduled renewal. This type of strategic approach has been used in the past as states have implemented different state based reforms. This approach likely increased the average morbidity of individuals included in the risk adjustment pool in 2014. The healthy individuals

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will get a smaller rate increase under pre-ACA policies due to rating for health status while the sicker individuals would get a better rate on ACA policies since they do not rate for health status. For 2015, the impact of strategic renewal would have disappeared but the administration allowed states to continue renewing these policies on pre-ACA products and Indiana has allowed such policies (referred to as a transitional or "grandmothering").

We have included a 10% adjustment (1.10 factor) within our manual rate development for this (part of morbidity adjustment in Appendix C, Table C-2).

Pent Up Demand

In 2014, there were many new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services.

We expect very little remaining pent up demand in 2015. Therefore, we have removed the pent up demand effect and used a factor of 1.0 in Appendix C, Table C-2.

Inclusion of Capitation Payments

While MDwise will pay the Delivery Systems a global cap rate (percentage of premium), the State of Indiana has required MDwise to report the underlying provider payments as the true medical costs to provide coverage in MDwise's financial statements. This is because the Delivery Systems are delegated a portion of the administrative costs associated with their members. Therefore, the capitation paid to the delivery systems is meant to cover direct medical costs, and provider overhead. Based on discussions between MDwise, CCIIO and the state of Indiana, we understand that this treatment will continue in 2014 and beyond. This is important because of the risk corridor protection and minimum loss ratio treatment, which affect the relative level of risk inherent in the premium rate development and overall delivery system payment amounts.

6. CREDIBILITY OF EXPERIENCE

MDwise began operating in the individual market in 2014 and that experience is not yet credible. As a result, the "Experience Period" section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the "Credibility Manual" section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

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7. PAID TO ALLOWED RATIO

The Wakely pricing model uses a nationally-representative detailed medical and pharmacy claim and enrollment data (Truven MarketScan) for over 40 million lives to develop paid to allowed pricing estimates for final rate development (as opposed to metal tier categorization). The model uses actuarially sound pricing methods to value the impact of deductibles, copays, coinsurance and maximum out of pocket cost sharing parameters. We calibrated the utilization and unit cost assumptions by category of service in the model to the allowed cost estimates underlying the manual rate and/or experience rate, including adjustments for EHB, trend, provider reimbursement changes by service category, average expected demographics and other adjustments discussed elsewhere in this report.

8. RISK ADJUSTMENT AND REINSURANCE

Projected Risk Adjustments PMPM

We have developed manual rates for a 1.0 average statewide risk and assumed that MDwise would enroll average risk individuals. Therefore, no risk adjustment PMPM payment is assumed in 2015.

Reinsurance

The presence of the Federal reinsurance program will reduce costs for issuers in the individual market. This adjustment is intended to capture the portion of costs that will be reimbursed to health plans for reinsurance. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. HHS will reimburse health plans 50% of paid costs between the attachment point and maximum coverage limit.

To estimate the impact of reinsurance, we reviewed several claims probability distributions (CPDs) from different sources, adjusted to our estimated allowed PMPMs. To estimate the impact of moving from allowed to paid continuance, we increased the attachment and maximum values from the federal parameters by the MOOP for various plans, since the vast majority of individuals would have already reached their MOOP when costs reach the reinsurance attachment point. Our estimates are very sensitive to the shape of the CPD, the overall allowed cost PMPM that the CPD is calibrated to, as well as the MOOP and underlying Actuarial Value of the plan. Based on sensitivity testing, we have assumed that the average reinsurance impact will be a 7.9% reduction to net allowed claims costs. This adjustment was applied uniformly across all benefit plan packages. We have assumed that the allocated federal reinsurance dollars will be sufficient to fund the federal reinsurance program in 2015, which is not guaranteed.

9. NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load

MDwise developed expected administrative costs based on current administrative costs for their Medicaid line of business, adjusted to reflect any differences in functions or level of effort for the

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commercial product. MDwise assumed a 50% of administrative expenses would increase by 3% from 2014 on a PMPM basis while 50% would increase with premium rates. For the small service areas, the PMPM component was increased to spread fixed costs across a small member cohort.

Contribution to Surplus & Risk Margin

Three percent (3%) of premiums has been allocated to contribution to surplus.

Taxes and Fees

Taxes and regulatory fees include the following:

1. PCORI Fee = $0.25 PMPM
2. Issuer Fee = It is not clear if MDwise will be exempt from the issuer fee in 2015. We have assumed they will be subject to the fee in this filing.
3. Health Insurance Exchange Fee = 3.5% of premium for products sold through the Exchange. MDwise expects the vast majority of their business to be sold through the exchange and we have included the full 3.5% load in premium rate development.

Please note that in the URRT taxes and fees section, the risk adjustment and reinsurance fees have been excluded.

Reinsurance and Risk Adjustment Fees

The following fees were netted out of the experience in the URRT.

1. Reinsurance Charge = $3.67 PMPM
2. Risk Adjustment User Fee = $1.00 PMPY ($0.08 PMPM)

10. PROJECTED LOSS RATIO

Wakely's estimates indicate projected MLRs for the individual line of business of 83.8% for 2015. Consistent with the MLR and Risk Corridor calculations, regulatory fees and taxes were excluded from premium in the calculation of this value.

11. SINGLE RISK POOL

MDwise has established a single risk pool for all of its individual business. Since MDwise did not participate in the individual market prior to 2014, all of its individual business is non-grandfathered, non-transitional, and ACA-compliant.

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12. INDEX RATE

Index Rate for Projection Period

The starting allowed claim index of $810.19 is developed from the historical claim index rate of the Indiana Small Group Market. Appendix C, Table C-2 illustrates this development. The bullet points below briefly describe specific line items in Table C-2. For comparative purposes, the adjustment for average percentage of smokers has been retained in the table. Per CCIIO instructions, the adjustment for the smoker load should not be included in the starting allowed claim cost, so to calculate the $810.19 the factor is excluded.

- Base Period Allowed PMPM – These historical claim index rates are developed from publicly available information.
- Cost Adjustment – This adjustment accounts for cost differences between the base period and projected period and include an adjustment for the embedded smoking load in the base period and expected bad debt that is introduced by the grace period.
- Benefit Adjustment – This adjustment accounts for differences between the base period benefits and those offered under the exchange as essential health benefits.
- Morbidity Adjustment – This adjustment accounts for differences in the morbidity of the population underlying the base period allowed PMPM and the population expected in the exchange market. Included in this adjustment are considerations for morbidity and demographic differences, pent-up demand, and the impact of transitional policies.
- Trend factor – We used an assumed trend of 8.0% over 30 months to trend the base period data to a midpoint of 7/1/2015.
- Allowed Claim Index Rate by Source – The allowed claim index rate is calculated as the product of the historical claim index rate and all the factors listed above in this section.

Market Adjusted Index Rate

We included the impact of reinsurance and risk adjustment and the exchange user fee to the index rate for the projection period to develop the market adjusted index rate.

The development of this index rate can be seen in Appendix A, item g.

Plan Adjusted Index Rate

To bring the experience used in the manual rating to a “non-tobacco” basis, a downward adjustment is applied using a factor of 0.9875. Among the items contemplated when setting this assumption were the rates of tobacco use in Indiana as well as the proportion of people who will self-report as “Smokers.”

We multiplied the market adjusted rate by provider contracting discounts, the actuarial value and the federal induced demand factors.

We then included the admin, commissions, ACA fees, tax, and profit margin.

The development of this index rate can be seen in Appendix A, item v.

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Calibration

To bring the experience to age 21 rate, we divided the plan adjusted index rate by the weighted average age factor. The age factor was calculated as the weighted average of ACA age factors and the 2015 expected individual enrollment by age. The average age is approximately 50 years.

The development of this index rate can be seen in Appendix A, item w.

Consumer Adjusted Index Rate

The consumer adjusted index rates are calculated by multiplying the calibrated plan adjusted index rates by the consumer's specific age factor, area, and tobacco status. As last year's restrictions on the smoker load (limiting smoker loaded rates to the same 3:1 limit as non-smoker rates) have been removed, the loads have been change and are shown in Appendix D.

Using the age factors and smoking load Area Factors in Appendix D, one can take the index rate from Appendix A and develop the rates for each product and age combination. Two examples are provided in Appendix E.

13. AV METAL LEVELS

The Federal AVC was used without modification to generate the AV metal tier (column b on Appendix A). The Federal AVCs were as follows:

Bronze A	61.8%
Silver A (base)	71.9%
Silver A (73% CSR)	73.9%
Silver A (87% CSR)	87.7%
Silver A (94% CSR)	94.8%
Gold A	80.5%
Bronze B	58.3%
Silver B (base)	68.1%
Silver B (73% CSR)	73.8%
Silver B (87% CSR)	86.1%
Silver B (94% CSR)	93.0%

14. AV PRICING VALUES

The reference plan underlying our pricing was a Silver plan. From this base PMPM, we applied benefit richness utilization adjustments to stratify this PMPM to levels suitable for each of the metal tiers. We used the following values which are equal to the Federal values published in the Federal Register payment notice, normalized to the silver benefit level:

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Bronze = 1.00 / 1.03 = 0.9709

Silver = 1.03 / 1.03 = 1.0000

Gold = 1.08 / 1.03 = 1.0485

MDwise is not offering Platinum or Catastrophic plans.

The adjustment factors above are shown in Appendix A, column o.

The same underlying cost distribution and cost level was used. The only adjustment before determining AV pricing values was benefit richness utilization differences using Federal adjustment factors. **Therefore, differences in expected morbidity across metal tiers were not included in the pricing development for each metal tier plan.**

These adjustments do not incorporate a selection bias due to health status. Rather, they represent an adjustment due to any particular individual utilizing services differently when they have a richer or less rich benefit design.

The pricing AVs are higher than the Federal AVCs primarily because the estimated allowed PMPMs are higher than those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements like copays, deductibles and MOOPs. This effect is more pronounced in 2015 than it was in 2014 because of the morbidity increases assumed due to the addition of the high risk population (conversion from 209(b) to 1634) and the higher age distribution.

15. MEMBERSHIP PROJECTIONS

The membership projections for 2015 were developed by Wakely in consultation with MDwise based on emerging enrollment and expected new enrollment for 2015.

Appendix B shows estimates of the Cost Sharing Reduction by Silver base and Silver variant level. We used the Federal formula shown in the Advance Payment Notice, which is equal to the difference in AVC multiplied by the allowed cost PMPM for each base plan, increased by 1.12 for cost sharing utilization for the 87% and 94% variants.

16. TERMINATED PRODUCTS

MDwise began selling individual policies with effective dates beginning January 1, 2014. They have no prior products to terminate.

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17. PLAN TYPE

MDwise is filing HMO products.

18. URRT WARNINGS

There were no warnings in the URRT.

19. RELIANCE

Wakely Consulting Group, Inc., 9777 Pyramid Ct, Suite 260, Englewood, CO 80112 relied on information provided by MDwise to develop the 2014 individual premium rates. This information includes, but is not limited to the following:

- Provider contracting levels, including descriptions of the relationship between the Delivery systems and MDwise
- Administrative cost projections
- Projected enrollment figures by QHP
- Product design information
- Provider network information including discount data
- CCIIO and the State of Indiana regulatory and compliance interpretations and rulings
- Commercial rate filings and financial reports of carriers participating in the pre-ACA market.

20. ACTUARIAL CERTIFICATION

I, Ross Winkelman, am a Fellow in the Society of Actuaries (FSA) and a member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

The submission is in compliance with all applicable laws, regulations, and guidance of the Federal government and the state of Indiana as of May 10, 2014. The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

ASOP No. 5, Incurred Health and Disability Claims

ASOP No. 8, Regulatory Filings for Health Plan Entities

ASOP No. 12, Risk Classification

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ASOP No. 23, Data Quality

ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

ASOP No. 41, Actuarial Communication

In my opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are not excessive nor deficient although actual experience may vary from the estimates inherent in the premium rate development.

The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs.

The Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

Electronic Signature

Ross Winkelman, FSA, MAAA
Managing Director
(720) 226-9801
RossW@Wakely.com

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Appendix A

Wakely Mdwise Premium Rate Development

Individual Market Premium Rates (Non-Smoker, 1.0 HHS Age Factor, by Metal Tier and Plan ID)

Plan ID (a)	Metal Tier (b)	Starting Allowed (c)	Impact of Reinsurance (% allowed) (d)	Impact of Risk Adjustment (e)	Exchange User Fee Adjustment (f)	Market Adjusted Index Rate (g)	Provider Contracting Adjustment (h)	Tobacco Adjustment (non-tobacco rates) (i)	Cost Sharing Utilization (j)	Tier 1 AV (k)	Tier 2 AV (l)	Tier 1 PMPM (m)	Tier 2 PMPM (n)	AV (o)	Composite PMPM (p)*
62033IN0010001	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010002	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010003	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010004	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010005	Silver								1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
62033IN0010006	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010007	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010008	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010009	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010010	Silver	$810.19	0.8962	1.0000	$12.27	$738.33	0.8663	0.9874	1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
62033IN0010011	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010012	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010013	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010014	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010015	Silver								1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
62033IN0010016	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010017	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010018	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010019	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010020	Silver								1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
	Total/Average								1.0012	76.7%	74.7%	$476.82	$464.71	76.5%	$475.61

Plan ID (a)	Metal Tier (b)	Fixed Admin (q)	Variable Admin (r)	PMPM Regulatory Fees (s)	Other Regulatory Fees (t)	Contribution to Surplus (u)	Plan Adjusted Index Rates (v)	Average Age Factor (w)	Calibrated Plan Index Rate (1.0 HHS Factors) (x)	Target Loss Ratio (y)	Projected Member Months (z)
62033IN0010001	Bronze	$32.94	$35.73	$3.44	$28.82	$15.72	$524.05	**1.75**	$299.46	79.9%	3,289
62033IN0010002	Silver	$32.94	$41.47	$4.01	$33.55	$18.30	$610.01	1.75	$348.57	80.9%	235,181
62033IN0010003	Gold	$32.94	$49.81	$4.58	$40.39	$22.03	$734.35	1.75	$419.63	81.8%	28,008
62033IN0010004	Bronze	$32.94	$34.21	$3.44	$27.55	$15.03	$500.91	1.75	$286.23	79.6%	29,603
62033IN0010005	Silver	$32.94	$39.58	$4.01	$31.97	$17.44	$581.31	1.75	$332.17	80.6%	53,995
62033IN0010006	Bronze	$35.54	$35.73	$3.44	$28.98	$15.81	$526.90	1.75	$301.08	79.5%	1,328
62033IN0010007	Silver	$35.54	$41.47	$4.01	$33.71	$18.39	$612.85	1.75	$350.20	80.5%	82,805
62033IN0010008	Gold	$35.54	$49.81	$4.58	$40.55	$22.12	$737.20	1.75	$421.26	81.5%	9,456
62033IN0010009	Bronze	$35.54	$34.21	$3.44	$27.71	$15.11	$503.76	1.75	$287.86	79.2%	11,956
62033IN0010010	Silver	$35.54	$39.58	$4.01	$32.13	$17.52	$584.15	1.75	$333.80	80.2%	18,994
62033IN0010011	Bronze	$35.54	$35.73	$3.44	$28.98	$15.81	$526.90	1.75	$301.08	79.5%	1,074
62033IN0010012	Silver	$35.54	$41.47	$4.01	$33.71	$18.39	$612.85	1.75	$350.20	80.5%	85,906
62033IN0010013	Gold	$35.54	$49.81	$4.58	$40.55	$22.12	$737.20	1.75	$421.26	81.5%	9,912
62033IN0010014	Bronze	$35.54	$34.21	$3.44	$27.71	$15.11	$503.76	1.75	$287.86	79.2%	9,666
62033IN0010015	Silver	$35.54	$39.58	$4.01	$32.13	$17.52	$584.15	1.75	$333.80	80.2%	19,745
62033IN0010016	Bronze	$36.94	$35.73	$3.44	$29.06	$15.85	$528.43	1.75	$301.96	79.3%	797
62033IN0010017	Silver	$36.94	$41.47	$4.01	$33.79	$18.43	$614.38	1.75	$351.08	80.3%	64,417
62033IN0010018	Gold	$36.94	$49.81	$4.58	$40.63	$22.16	$738.73	1.75	$422.13	81.3%	5,928
62033IN0010019	Bronze	$36.94	$34.21	$3.44	$27.79	$15.16	$505.29	1.75	$288.74	78.9%	7,171
62033IN0010020	Silver	$36.94	$39.58	$4.01	$32.21	$17.57	$585.68	1.75	$334.68	80.0%	14,827
	Total/Average	$34.41	$41.15	$4.00	$33.37	$18.20	$606.74	1.75	$346.71	80.6%	694,058

* The exchange user fee was excluded in this column and re-included in column (t).

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Appendix B

Wakely Mdwise Cost Sharing Reduction Estimates and Justification

(based on a 1.0 Area Factor)

Base Silver Plan	No CSR Allowed PMPM	Federal AVCs for Base and CSR Silvers				87% and 94% Utilization	CSR Advance Payments by Level			Weighted Average PMPM*
		Base Silver	73% Silver	87% Silver	94% Silver		73% Silver	87% Silver	94% Silver	
62033IN0010002	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010005	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010007	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010010	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010012	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010015	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010017	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010020	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19

* See Actuarial Memo, Assumes 23.3% No CSR, 34.9% at 73% Silver, 15.7% at 87% Silver, and 26.1% at 94% Silver.

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Appendix C

Table C-1

Small Group Source Starting Allowed PMPM Development

Source	Allowed PMPM	Weight
Anthem SG Financial	$352.41	25.0%
UHLC Rate Filing	$421.71	25.0%
AWLP SG Rate Filing	$405.76	25.0%
ADVA Rate Filing	$480.85	0.0%
Plan Finder 1) Anthem PPO	$412.45	4.2%
Plan Finder 2) Anthem Lumenos	$334.88	4.2%
Plan Finder 3) United ChoicePlus	$430.98	4.2%
Plan Finder 4) Humana IN Copay 10	$367.33	4.2%
Plan Finder 5) All Savers Group	$343.55	4.2%
Plan Finder 6) Aetna PPO	$422.90	4.2%
Total / Weighted Average	**$391.31**	**100.0%**

Table C-2

Average Allowed PMPM Development for Appendix A from Starting Allowed PMPM

Item	Description	2015 Rate Development
(a)	Base Period Allowed PMPM (Small Group)	$391.31
	Cost Adjustment	
(b)	Bad Debt	1.0028
(c)	Benefit Adjustment	1.0200
	Morbidity Adjustment	
(d)	Morbidity	1.1545
(e)	Demographic - Age Gender (Outside of allowable age rating)	1.0692
(f)	Pent Up Demand	1.0000
(g)	2014 Strategic Renewal Impact	1.1000
(h)	Trend Factor to 7/1/2015	1.2122
(i)	Market Demographic (Allowable age rating)	1.2298
(j)	Allowed Claim Index Rate (product of all figures above)	$810.19

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Appendix D
Age Factors, Smoker Loads, and Area Factors

Demographics		HHS Factor	Smoker Load	Non-Smoker Load
	Children 00-20	0.635	1.000	1.000
Ages	21	1.000	1.050	1.000
	22	1.000	1.061	1.000
	23	1.000	1.071	1.000
	24	1.000	1.082	1.000
	25	1.004	1.093	1.000
	26	1.024	1.104	1.000
	27	1.048	1.114	1.000
	28	1.087	1.125	1.000
	29	1.119	1.136	1.000
	30	1.135	1.146	1.000
	31	1.159	1.157	1.000
	32	1.183	1.168	1.000
	33	1.198	1.179	1.000
	34	1.214	1.189	1.000
	35	1.222	1.200	1.000
	36	1.230	1.211	1.000
	37	1.238	1.221	1.000
	38	1.246	1.232	1.000
	39	1.262	1.243	1.000
	40	1.278	1.254	1.000
	41	1.302	1.264	1.000
	42	1.325	1.275	1.000
	43	1.357	1.286	1.000
	44	1.397	1.296	1.000
	45	1.444	1.307	1.000
	46	1.500	1.318	1.000
	47	1.563	1.329	1.000
	48	1.635	1.339	1.000
	49	1.706	1.350	1.000
	50	1.786	1.361	1.000
	51	1.865	1.371	1.000
	52	1.952	1.382	1.000
	53	2.040	1.393	1.000
	54	2.135	1.404	1.000
	55	2.230	1.414	1.000
	56	2.333	1.425	1.000
	57	2.437	1.436	1.000
	58	2.548	1.446	1.000
	59	2.603	1.457	1.000
	60	2.714	1.468	1.000
	61	2.810	1.479	1.000
	62	2.873	1.489	1.000
	63	2.952	1.500	1.000
	64 and Older	3.000	1.500	1.000

Rating Area	Area Factor
1	1.0000
2	0.9713
3	1.0748
4	0.9814
5	1.0082
6	1.0243
7	1.0761
8	1.0748
9	1.0261
10	1.0785
11	1.0748
12	1.0691
13	1.0823
14	N/A
15	1.0823
16	0.8636
17	1.1179

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Appendix E
Sample Rate Calculations

Example 1

Sample Plan:	62033IN0010001	
Metal Level:	Bronze	
Effective Date:	1/1/2015	
Rating Area:	2	
Age:	42	
Smoker Status:	Non-Smoker	
Calculation of Monthly Premium:		
Base Rate:	$299.46	Appendix A
Area Factor:	0.971	Appendix D
Age Factor:	1.325	Appendix D
Smoker/Non-Smoker Load:	1.000	Appendix D
Monthly Premium:	$385.39	Product of numbers above

Example 2

Sample Plan:	62033IN0010002	
Metal Level:	Silver	
Effective Date:	1/1/2015	
Rating Area:	5	
Age:	35	
Smoker Status:	Smoker	
Calculation of Monthly Premium:		
Base Rate:	$348.57	Appendix A
Area Factor:	1.008	Appendix D
Age Factor:	1.222	Appendix D
Smoker/Non-Smoker Load:	1.200	Appendix D
Monthly Premium:	$515.36	Product of numbers above

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Appendix F - SOA Values, Including Adjustments to SOA Values and Final Morbidity Adjustment

	OPTUM VALUES								Adjusted Values							
Figure 1- Changes in Sources of Coverage under the ACA in Selected State in 2014																HOME
Baseline Coverage	Total	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	768,681	200,861	43,675	493,581	556	2	23,974	6,032	768,681	200,861	10,919	526,337	556	2	23,974	6,032
Employer 51-100	149,666	27,449	6,762	113,722	13	-	1,204	516	149,666	27,449	6,762	113,722	13	-	1,204	516
Employer 101+	2,358,762	-	55,065	2,253,680	1,217	157	39,491	9,152	2,358,762	-	13,766	2,294,979	1,217	157	39,491	9,152
High Risk Pool	10,969	185	8,662	526	-	-	1,595	-	10,969	185	8,662	526	-	-	1,595	-
Other Non-Group	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093
Retiree	81,477	-	-	68,081	-	-	13,395	-	81,477	-	-	68,081	-	-	13,395	-
TRICARE	84,044	-	-	-	-	84,044	-	-	84,044	-	-	-	-	84,044	-	-
Medicare	815,120	-	-	-	-	815,120	-	-	815,120	-	-	-	-	815,120	-	-
Dual Eligible	138,231	-	-	-	-	138,231	-	-	138,231	-	-	-	-	138,231	-	-
Medicaid/CHIP	945,008	5,410	6,128	16,018	38	62	917,352	-	945,008	5,410	6,128	16,018	38	62	917,352	-
Uninsured	922,141	32,591	202,697	93,143	1,816	-	291,966	299,929	922,141	32,591	50,674	93,143	1,816	-	291,966	451,952
% of Currently Uninsured	-	3.5%	22.0%	10.1%	0.2%	0.0%	31.7%	32.5%	-							
Total	**6,452,541**	**270,394**	**407,586**	**3,050,802**	**55,807**	**1,037,616**	**1,302,613**	**327,723**	**6,452,541**	**270,394**	**181,508**	**3,124,857**	**55,807**	**1,037,616**	**1,302,613**	**479,745**

Elasticity Model - Lewin Baseline ACA model

	OPTUM VALUES								Adjusted Values							
Figure 1A- Changes in Morbidity under the ACA in Selected State in 2014																
Baseline Coverage	Pre-ACA PMPM	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15
Employer 51-100	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08
Employer 101+	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92
High Risk Pool	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00
Other Non-Group	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32
Retiree	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00
TRICARE	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00
Medicare	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00
Dual Eligible	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00
Medicaid/CHIP	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00
Uninsured	$222.21	$369.76	$362.84	$627.13	$4,084.72	$0.00	$555.17	$125.31	$222.21	$369.76	$453.55	$627.13	$4,084.72	$0.00	$555.17	$125.31
Total	**$555.38**	**$481.18**	**$448.93**	**$518.34**	**$500.79**	**$1,097.05**	**$492.28**	**$133.45**	$557.04	$481.18	$456.37	$517.80	$500.79	$1,097.05	$492.28	$130.87

	Pre-ACA		Post ACA W/out Changes		Post ACA W/ Changes		Post ACA Modified / Original	
	Members	PMPM	Members	PMPM	Members	PMPM	Members	PMPM
Individual	178,442	$331.56	463,393	$455.18	237,315	$466.81	0.5121	1.0256
Small Group	768,681	$464.98	694,442	$454.86	727,198	$453.99	1.0472	0.9981

Post ACA PMPM / Pre-ACA PMPM (This is Morbidity Change Only)

1.4079 Individual to Individual
1.0039 Small Group to Individual
0.9764 Small Group to Small Group

WAKELY CONSULTING GROUP
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Appendix A

Wakely Mdwise Premium Rate Development

Individual Market Premium Rates (Non-Smoker, 1.0 HHS Age Factor, by Metal Tier and Plan ID)

Plan ID (a)	Metal Tier (b)	Starting Allowed (c)	Impact of Reinsurance (% allowed) (d)	Impact of Risk Adjustment (e)	Exchange User Fee Adjustment (f)	Market Adjusted Index Rate (g)	Provider Contracting Adjustment (h)	Tobacco Adjustment (non-tobacco rates) (i)	Cost Sharing Utilization (j)	Tier 1 AV (k)	Tier 2 AV (l)	Tier 1 PMPM (m)	Tier 2 PMPM (n)	AV (o)	Composite PMPM (p)*
62033IN0010001	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	66.8%	63.6%	$409.34	$390.02	66.4%	$407.40
62033IN0010002	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	76.4%	72.5%	$482.18	$457.87	76.0%	$479.75
62033IN0010003	Gold	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010004	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	63.2%	63.2%	$387.76	$387.76	63.2%	$387.76
62033IN0010005	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	72.1%	72.1%	$455.38	$455.38	72.1%	$455.38
62033IN0010006	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	66.8%	63.6%	$409.34	$390.02	66.4%	$407.40
62033IN0010007	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	76.4%	72.5%	$482.18	$457.87	76.0%	$479.75
62033IN0010008	Gold	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010009	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	63.2%	63.2%	$387.76	$387.76	63.2%	$387.76
62033IN0010010	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	72.1%	72.1%	$455.38	$455.38	72.1%	$455.38
62033IN0010011	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	66.8%	63.6%	$409.34	$390.02	66.4%	$407.40
62033IN0010012	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	76.4%	72.5%	$482.18	$457.87	76.0%	$479.75
62033IN0010013	Gold	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010014	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	63.2%	63.2%	$387.76	$387.76	63.2%	$387.76
62033IN0010015	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	72.1%	72.1%	$455.38	$455.38	72.1%	$455.38
62033IN0010016	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	66.8%	63.6%	$409.34	$390.02	66.4%	$407.40
62033IN0010017	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	76.4%	72.5%	$482.18	$457.87	76.0%	$479.75
62033IN0010018	Gold	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010019	Bronze	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	0.9710	63.2%	63.2%	$387.76	$387.76	63.2%	$387.76
62033IN0010020	Silver	$810.19	0.9111	1.0000	$21.24	$738.19	0.8663	0.9874	1.0000	72.1%	72.1%	$455.38	$455.38	72.1%	$455.38
	Total/Average								1.0011	75.4%	73.5%	$476.82	$464.71	73.1%	$475.61

Plan ID (a)	Metal Tier (b)	Fixed Admin (q)	Variable Admin (r)	PMPM Regulatory Fees (s)	Other Regulatory Fees (t)	Contribution to Surplus (u)	Plan Adjusted Index Rates (v)	Average Age Factor (w)	Calibrated Plan Index Rate (1.0 HHS Factors) (x)	Target Loss Ratio (y)	Projected Member Months (z)	PMPM Impact of Reinsurance (aa)
62033IN0010001	Bronze	$32.94	$35.73	$3.44	$28.82	$15.72	$524.05	**1.75**	$299.46	82.8%	3,289	$36.06
62033IN0010002	Silver	$32.94	$41.47	$4.01	$33.55	$18.30	$610.01	1.75	$348.57	83.8%	235,181	$43.12
62033IN0010003	Gold	$32.94	$49.81	$4.58	$40.39	$22.03	$734.35	1.75	$419.63	84.8%	28,008	$53.35
62033IN0010004	Bronze	$32.94	$34.21	$3.44	$27.55	$15.03	$500.91	1.75	$286.23	82.5%	29,603	$34.15
62033IN0010005	Silver	$32.94	$39.58	$4.01	$31.97	$17.44	$581.31	1.75	$332.17	83.5%	53,995	$40.74
62033IN0010006	Bronze	$35.54	$35.73	$3.44	$28.98	$15.81	$526.90	1.75	$301.08	82.4%	1,328	$36.06
62033IN0010007	Silver	$35.54	$41.47	$4.01	$33.71	$18.39	$612.85	1.75	$350.20	83.4%	82,805	$43.12
62033IN0010008	Gold	$35.54	$49.81	$4.58	$40.55	$22.12	$737.20	1.75	$421.26	84.5%	9,456	$53.35
62033IN0010009	Bronze	$35.54	$34.21	$3.44	$27.71	$15.11	$503.76	1.75	$287.86	82.0%	11,956	$34.15
62033IN0010010	Silver	$35.54	$39.58	$4.01	$32.13	$17.52	$584.15	1.75	$333.80	83.1%	18,994	$40.74
62033IN0010011	Bronze	$35.54	$35.73	$3.44	$28.98	$15.81	$526.90	1.75	$301.08	82.4%	1,074	$36.06
62033IN0010012	Silver	$35.54	$41.47	$4.01	$33.71	$18.39	$612.85	1.75	$350.20	83.4%	85,906	$43.12
62033IN0010013	Gold	$35.54	$49.81	$4.58	$40.55	$22.12	$737.20	1.75	$421.26	84.5%	9,912	$53.35
62033IN0010014	Bronze	$35.54	$34.21	$3.44	$27.71	$15.11	$503.76	1.75	$287.86	82.0%	9,666	$34.15
62033IN0010015	Silver	$35.54	$39.58	$4.01	$32.13	$17.52	$584.15	1.75	$333.80	83.1%	19,745	$40.74
62033IN0010016	Bronze	$36.94	$35.73	$3.44	$29.06	$15.85	$528.43	1.75	$301.96	82.1%	797	$36.06
62033IN0010017	Silver	$36.94	$41.47	$4.01	$33.79	$18.43	$614.38	1.75	$351.08	83.2%	64,417	$43.12
62033IN0010018	Gold	$36.94	$49.81	$4.58	$40.63	$22.16	$738.73	1.75	$422.13	84.3%	5,928	$53.35
62033IN0010019	Bronze	$36.94	$34.21	$3.44	$27.79	$15.16	$505.29	1.75	$288.74	81.8%	7,171	$34.15
62033IN0010020	Silver	$36.94	$39.58	$4.01	$32.21	$17.57	$585.68	1.75	$334.68	82.9%	14,827	$40.74
	Total/Average	$34.41	$41.15	$4.00	$33.37	$18.20	$606.74	1.75	$346.71	83.5%	694,058	$42.71

* The exchange user fee was excluded in this column and re-included in column (t).

STATEMENT OF VARIABILITY
INDIVIDUAL HMO – ON/OFF EXCHANGE
For Contract Form # 62033-2015-1

General Variable Information

Most numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Website URL addresses and Phone Numbers are bracketed throughout the Contract for the removal if necessary or to update if the web addresses or phone numbers change.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval.

Please note that the deductible, out of pocket and cost share value ranges bracketed in the schedule will only be arranged to match our company's individual benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

The following is an explanation of the variables used within this Contract form:

There are two reasons MDwise has chosen to use variability in this Policy and they are recurrent in nearly every section of every Article, including the Schedule of Benefits and Cover Page:

Distinction between Subscriber and Enrollee/Eligible Dependent is intended to reflect the difference between Individual and Child-Only Coverage. In Child-Only Coverage, the Subscriber is not the individual receiving coverage through the contract and this designation is made to ensure this is clear.

Distinction between MDwise (Us, We) and the Exchange is intended to provide variability in the contractual provisions for members who purchase their policy on or off the exchange.

COVER PAGE:

> **Contract Type** – Indicates whether the contract is for an on/off exchange policy and whether Policy is for individual or Child-Only Coverage.
>
> **Issuer Legal Name** - Indicates the legal name of the Issuer of the policy.
>
> **Disclaimer** – Informs customers who are purchasing this policy off exchange that they will not be eligible for the APTC and CSR available to through the Marketplace.

ARTICLE 1 - DEFININTIONS:

Open Enrollment allows variability between and Policies purchased On/Off Exchange

Special Enrollment allows variability between Policies purchased On/Off Exchange

QHP - allows variability between Policies purchased On/Off Exchange.

ARTICLE 2 – ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligibility of Subscriber & Dependents – allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange

Annual Open Enrollment and Effective Date for Coverage – allows for the variability in the periods in which the consumer's policy will become active based on whether they purchase their policy On or Off exchange.

Special Enrollment and Effective Date for Coverage – allows variability between Individual/Child-Only and On/Off Exchange in the language outlining Special Enrollment Periods.

Notification of Eligibility Changes allows variability between Policies purchased On/Off Exchange.

Service Area Requirements – allows variability between Individual/Child-Only Policies.

ARTICLE 5 - PREMIUM PAYMENT:

Premium Payment - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Three-Month Grace Period - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Payment upon Termination - allows variability between Individual/Child-Only Policies.

ARTICLE 6 – PROCEDURES FOR OBTAINING HEALTH SERVICES:

Selection of a Primary Medical Provider - allows variability between Individual/Child-Only.

Preauthorization - allows variability between Individual/Child-Only Policies.

Health Services by Participating Providers - allows variability between Individual/Child-Only Policies.

Inpatient Emergency Health Services by Non-Participating Providers - allows variability between Individual/Child-Only Policies.

ARTICLE 7 – PROCEDURES FOR REIMBURSEMENTS OF ALLOWED AMOUNTS

Identification Card - allows variability between Individual/Child-Only Policies.

Participating Provider Services - allows variability between Individual/Child-Only Policies.

Procedures for Health Services Received from Non-Participating Providers - allows variability between Individual/Child-Only Policies.

Filing a Claim for Non-Participating Provider Services - allows variability between Individual/Child-Only Policies.

Coverage through Non-custodial Parent- allows variability between Individual/Child-Only Policies.

ARTICLE 8 – GRIEVANCE PROCEDURES:

Internal Grievance Procedure - allows variability between Individual/Child-Only Policies.

ARTICLE 9 – RENEWABILTY AND TERMINATION:

Renewability and Termination of Contract - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Discontinuance of a Particular Type of Contract - allows variability between Individual/Child-Only Policies.

Notice and Effective Date of Termination - allows variability between Individual/Child-Only Policies.

Process for Termination of Coverage by Written Request of Subscriber - allows variability between Policies purchased On/Off Exchange.

Process for Termination of Coverage Due to Loss of Eligibility - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Process for Termination of Coverage Due to Non-Payment of Premiums - allows variability between Individual/Child-Only Policies.

Process for Termination of Coverage When the Subscriber Changes to Another Qualified Health Plan During Open Enrollment or Special Enrollment - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Continued Inpatient Hospital Benefit - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

Extended Coverage for Disabled Children - allows variability between Individual/Child-Only Policies.

Reinstatement - allows variability between Individual/Child-Only Policies and Policies purchased On/Off Exchange.

ARTICLE 12 – GENERAL PROVISIONS:

Limitations of Action - allows variability between Individual/Child-Only Policies.

Right of Recovery - allows variability between Individual/Child-Only Policies.

Medicare - allows variability between Policies purchased On/Off Exchange.

SCHEDULE OF BENEFITS:

Benefit Plan - will be the metal level for the product the consumer has selected.

Deductible - amount option ranges are as shown in schedule, for the different metal option offerings.

Out of Pocket Limit - (The most you will pay per calendar year) ranges (individual and family) are as shown in the schedule for the different metal option offerings.

Copayment - amount ranges are as shown in the schedule for the different metal option offerings.

Coinsurance/Cost Share - options ranges are as shown in schedule for the different metal option offerings.

Visit limits and Day limit - ranges are as shown in the schedule for the different metal option offerings.

Ambulance – Cost share options ranges are as shown in the schedule.

Behavioral Health Services – Copay ranges shown, for the various covered service locations, for the different metal option offerings.

Accidental Dental Service – Copay range for the different metal option offerings are as shown in the schedule.

Diagnostic Services – Cost share options ranges are as shown in the schedule.

Emergency room - Cost share options ranges are as shown in the schedule.

Home Care Services - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Hospice Care – Cost share options ranges are as shown in the schedule.

Inpatient and Outpatient Professional Services – Cost share options ranges are as shown in the schedule.

Inpatient Facility Services – Cost share options ranges are as shown in the schedule.

Medical Supplies, Durable Medical Equipment and Appliances – Cost share options ranges are as shown in the schedule.

Outpatient Services – Cost share options ranges are as shown in the schedule.

Physician Home Visits and Office Visits – Cost share options ranges are as shown in the schedule.

Surgical Services – Cost share options ranges are as shown in the schedule.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder– Cost share options ranges are as shown in the schedule.

Therapy Services – Cost share options ranges are as shown in the schedule.

Urgent Care Center Services – Cost share options ranges are as shown in the schedule.

Pediatric Vision – Cost share options ranges are as shown in the schedule.

Transport - Transportation and Lodging – Cost share options ranges are as shown in the schedule.

Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure – Cost share options ranges are as shown in the schedule.

Participating Retail Pharmacy Prescription Drug Copay/Coinsurance – Cost share options ranges are as shown in the schedule.

Orally Administered Cancer Chemotherapy – Cost share options ranges are as shown in the schedule.

[Individual/Child-Only/On/Off Exchange] Contract

(Herein called this Contract)

issued by

[MDwise, Inc.][MDwise Marketplace, Inc.]
P.O. Box 441423
Indianapolis, Indiana 46244-1423

An Indiana Not-for-Profit Health Maintenance Organization

AGREEMENT AND CONSIDERATION

[MDwise Marketplace Plan]

[MDwise, Inc.][MDwise Marketplace, Inc.] (herein referred to as MDwise, We, Us, and Our) has issued a Contract to You [to provide coverage for a Dependent]. Persons Covered under this Contract are considered to be Enrollees of MDwise. [This Contract provides Coverage only for Enrolled Dependents. The Subscriber is never Covered under this Contract.]

This Contract sets forth in detail [Your][the] rights and obligations [of the Subscriber and Dependent] as [an][the] Enrollee. It is important that You **READ THIS CONTRACT CAREFULLY.** You should familiarize Yourself with its terms and conditions before receiving Health Services.

This Contract is made in consideration of the [Subscriber's][Enrollee's] Application [submitted through the Exchange] and payment of the required Premium. The [Subscriber's][Enrollee's] Application is made a part of this Contract by this reference.

This Contract shall take effect on the date specified below. This Contract will be continued in force by the payment of the required Premium when due, subject to the termination provisions of this Contract. We shall fund all benefits payable under this Contract.

This Contract is delivered in and governed by the laws of the State of Indiana. All Coverage under this Contract shall begin at 12:00 midnight and end at 11:59:59 p.m. Eastern Standard Time.

Information regarding this Contract may be obtained by contacting Us at: [1-855-417-5615 or www.MDwisemarketplace.org]. If the Enrollee has material modifications or questions related to their health insurance coverage, contact the [Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596].

Authorized Representative

TEN-DAY FREE LOOK

The Subscriber has the right to examine this Contract for 10 days from the date You received the Contract. If, for any reason, the Subscriber does not want this Contract, he or she may return it to Us within 10 days from the date You received the Contract. The Contract will be deemed delivered when deposited in the United States mail with first class postage prepaid, or when it is personally delivered, to the address shown above. Upon return, this Contract will be deemed void and any Premium will be refunded. Any Health Services received during this 10-day period are solely the responsibility of the Subscriber if the Contract is deemed void. In making this decision, You should review the enrollment date restrictions of the Open Enrollment to identify any conditions for enrolling in a different Qualified Health Plan.

[DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payment Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for health insurance coverage issued through the Indiana Marketplace. Please be advised that this Contract does not qualify for these affordability programs because it is not issued through the Indiana Marketplace.]

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SCHEDULE OF BENEFITS

FOREWORD

Introduction

The [Subscriber and] Enrolled Dependents, [if any], are Enrollees of MDwise. [You][Enrollees] will be Covered as provided by this [Individual][Child-Only] Contract. (Referred to herein as this Contract.)

This Contract replaces and supersedes any Contract that We may have previously issued to the Subscriber [or Enrollee]. This Contract is an individual product and is not subject to the Employee Retirement Income Security Act of 1974, as amended.

How To Use This Contract

This Contract must be read in its entirety for a clear meaning. Many of its provisions are interrelated. You may get a false impression if You read just one or two provisions.

Certain terms used in this Contract are defined. Defined terms will be capitalized in this Contract. The meaning of defined terms should be taken into account in interpreting this Contract.

This Contract may be amended from time to time. When that happens, We will send You a new Contract or Amendment pages for this Contract. Keep this Contract in a safe place for Your future reference.

Obtaining Health Services

As an Enrollee You must obtain Health Services directly from Participating Providers. The only exceptions are those listed below.

(A) Emergency Health Services, and
(B) Health Services that meet all 3 requirements below:
  (1) are not available through Participating Providers
  (2) have been recommended by a Participating Provider, and
  (3) We have approved in advance through written Prior Authorization.

You are responsible for verifying the participation status of a Provider before receiving Health Services.

If You fail to check a Provider's participation status as required and as a result use a Non-Participating Provider (1) the Health Services, other than Emergency Services, will not be Covered, and (2) You will be responsible for paying for such services.

The participation status of a Provider may change from time to time. So it is important that You check the status each time before receiving Health Services.

We can give You the information You need in order to locate a Participating Provider. You can verify a Provider's participation status by contacting Us or by referencing Our provider directory at www.mdwisemarketplace.org.

Except for Emergency Health Services, Your Provider is responsible for obtaining a Prior Authorization before receiving any Health Services from a Non-Participating Provider. A Prior Authorization to a Non-Participating Provider must be initiated in writing by that Provider and approved in writing by Us prior to the time of the service. ***Your providers failure to obtain the required Prior Authorization will result in the Health Services not being Covered. You will be responsible for paying for such services. It is your responsibility to confirm that the appropriate authorization was obtained prior to services.***

Coverage for some Health Services is subject to Our prior written approval. Non participating and Participating Providers are responsible for obtaining Our Prior Authorization for such services on Your behalf.

Contact Us

Your satisfaction as an Enrollee is very important to Us. Please contact Us if You have a question or concern about Your Coverage or procedures You must follow. You can reach Our Customer Service Department during normal business hours at [1-855-417-5615, or www.MDwisemarketplace.org.]

Article 1

DEFINITIONS

This Article defines the terms used throughout this Contract. It is not intended to set forth Covered or Non-Covered Health Services.

"Adverse Benefit Determination" – a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Enrollee's eligibility to participate in the Contract, as well as any rescission of Coverage under this Contract or any decision to deny Coverage in an initial eligibility determination.

"Allowed Amount" – Reasonable and Customary Charges for Health Services incurred while Coverage is in effect.

"Affordable Care Act" or "ACA" - the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.

"Alternate Facility" - a Non-Hospital health care facility that, pursuant to the law of the jurisdiction in which treatment is received provides one of the following.

A. One (1) or more of the following on an outpatient basis surgical services, Emergency Health Services, rehab services, lab services, diagnostic services, or
B. Provides on an inpatient or outpatient basis Behavioral Health and Mental Health Services or Chemical Dependency Services, if Covered under the Contract.

An Alternate Facility may include an attachment to a Hospital but does not include a Provider's office.

"Appeal"- an oral or written request for Us to change Our decision regarding a Grievance or a claims dispute.

"Autism Spectrum Disorder" - a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Health and Mental Health" - a physical or behavioral condition having an emotional or psychological origin or effect. Behavioral Health and Mental Health includes behavioral or emotional disorders as well as chemical dependency.

"Brand Name Drug" - a prescription drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

"CMS" - the Centers for Medicare and Medicaid Services.

"Calendar Year" - January 1 through December 31 of any given year.

"Chemical Dependency" - alcoholism and chemical or drug dependency.

"Child" – child of the Subscriber or Subscriber's spouse, including the following listed below.

1) Natural child,
2) Stepchild,
3) Legally adopted child,
4) Child placed for the purpose of adoption, or
5) Child placed under legal guardianship or legal custody.

"CHIP" – the Children's Health Insurance Program, as implemented by the Federal Balanced Budget Act of 1997.

"Claim Documentation" – information required by Us to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, Explanation Of Benefit (EOB)/Explanation Of Payment (EOP) medical bills or records, other Contract information, and network repricing information.

"Coinsurance" - a percentage of the Allowed Amount that You must pay for certain covered Health Services. (See also Copay.)

"Confinement" and **"Confined"** - an uninterrupted stay following formal admission to a Hospital, Inpatient Transitional Care Unit, or Alternate Facility. Confinement and Confined refer to inpatient care.

"Contract" – this Contract that includes the Application [of the Subscriber][for Coverage] and any amendments to this Contract signed by Our executive officer. Such items constitute the entire agreement regarding the benefits, exclusions and other conditions between MDwise and the Subscriber.

"Contract Month" - calendar month.

"Copays" or **"Copay"** - a dollar amount that You must pay directly to a Provider for certain Covered Health Services. Such dollar amount is in addition to the Premium. (See also Coinsurance.)

"Cosmetic Procedures" - procedures that improve physical appearance but do not correct or materially improve a physical function. Cosmetic Procedures include, but are not limited to, drug treatment, plastic surgery, and nutritional procedures and treatments.

"Cover" - pay for Health Services to the extent they are Covered under this Contract.

"Coverage" or **"Covered"** - Your right to payment for Health Services, subject to the terms, conditions, limitations and exclusions of this Contract.

"Covered Person" or **"Enrollee"** - the Subscriber or an Enrolled Dependent, but only while the person is Covered under this Contract. References to You and Your throughout this Contract are references to a Covered Person or Enrollee.

"Custodial Care"- Non-health-related services such as assistance in activities of daily living or health-related services that do not seek to cure, are provided when the medical condition of the Enrollee is not changing, and do not require administration by skilled, licensed medical personnel.

"Deductible" - the amount an Enrollee must pay in a Calendar Year for Covered Health Services before We will pay. Copays do not apply toward the Deductible. Coinsurance does apply toward the Deductible.

"Delivery System" - a defined group of Participating Providers, linked through a contract to each Delivery System, which supply a full range of Health Services. The Delivery System contracts with Us to provide Health Services to Enrollees who have selected the Delivery System for providing and coordinating all Covered Health Services.

Your PMP's Delivery System will be Your Delivery System. Your Delivery System may be referred to throughout this Contract as "Tier 1" and the Delivery System that is not Your Delivery System, may be referred to as "Tier 2."

"Dental Care" - all services provided by or under the direction of a Dentist. Such services include preventive care and all other care of the teeth and the surrounding tissues, correction of a faulty meeting of the teeth, and surgical procedures that involve the hard or soft tissues of the mouth.

"Dentist" - any Provider, D.D.S., or medical dentistry, D.M.D., who is duly licensed and qualified to provide Dental Care under the laws of the jurisdiction in which treatment is received.

"Dependent" - a person who is [either the Subscriber's legal spouse or] a Child until he or she attains age [26][21].

"Designated Representative"- an individual You have appointed to assist or represent You with a Grievance, Appeal or External Appeal. This person may include, but not be limited to Providers, attorneys, friends or family members. You must identify Your Designated Representative to Us in writing in order to prevent the disclosure of Your medical information to unauthorized persons.

"Designated Transplant Facility" - a Hospital or Alternate Facility that has entered into an agreement with or on Our behalf to render Health Services for Covered transplants. The facility may or may not be located within Our Service Area.

"Durable Medical Equipment" or "DME" - medical equipment that meets the following requirements.

(A) Can withstand repeated use and is not disposable,
(B) Is used to serve a medical purpose,
(C) Is generally not useful to a person in the absence of a Sickness or Injury,
(D) Is appropriate for use in the home, and
(E) Is the most cost-effective type of medical apparatus appropriate for the condition.

"Effective Date"- the date when Your Coverage begins under this Contract.

"Effective Date of Termination" - the date when Your Coverage ends under this Contract.

"Eligible [Subscriber][Dependent]" – an individual who satisfies the eligibility requirements to enroll as a [Subscriber][Dependent], as set forth in Article 2 of this Contract.

"Emergency" - a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to do any of the following.

(A) Place an Enrollee's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(B) Result in serious impairment to the Enrollee's bodily functions, or
(C) Result in serious dysfunction of a bodily organ or part of the Enrollee.

"Enrolled Dependent"[or "Enrollee"] – a Dependent who is enrolled for Coverage under this Contract.

"Enrollee" – a person who is enrolled for coverage under this Contract.

"Essential Health Benefits" – those benefits identified by CMS as Essential Health Benefits and included in the benchmark plan identified by the state of Indiana.

"Experimental, Investigational or Unproven" - services, treatments, supplies, drugs, devices or procedures We have determined to be any one or more of the following at the time a Coverage determination for any particular case is made.

(A) Considered by any government agency or subdivision or the CMS Medicare Coverage Issues Manual to be experimental, investigational, not reasonable and necessary, or any similar finding. Government agencies and subdivisions include, but are not limited to the U.S. Food and Drug Administration and the Agency for Healthcare Research and Quality.
(B) Not covered under Medicare reimbursement laws, regulations, or interpretations, on the basis that such are experimental, investigational, unproven, not reasonable and necessary, or any similar finding.
(C) Not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use.
(D) Not identified as appropriate for the proposed use in the American Hospital Formulary Service, the U.S. Pharmacopoeia Dispensing Information, or the American Medical Drug Evaluations.
(E) Subject to review and approval by any institutional review board for the proposed use.
(F) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the U.S. Food and Drug Administration regulations (regardless of whether the trial is actually subject to U.S. Food and Drug Administration oversight).
(G) Not demonstrated through prevailing peer reviewed medical literature to be safe and effective for treating

or diagnosing the condition for which it is proposed.

Determinations regarding whether a particular service, treatment, supply, drug, device or procedure is considered to be Experimental, Investigational or Unproven are made by Our Medical Director under Our procedural guidelines.

"External Appeal" - a voluntary Appeal process in which an Internal Review Organization reviews certain Appeal decisions We made and determines whether to uphold or reverse them.

"FDA" - the United States Food and Drug Administration.

["Federally Facilitated Exchange" or "Exchange" - the health benefit exchange established by the Affordable Care Act for the state of Indiana. You can reach the Exchange at the following toll free number, email, website or mailing address.

Health Insurance Marketplace
200 Independence Ave. SW
Washington, DC 20201
www.healthcare.gov
1-800-318-2596]

"Formulary" - a list of Prescription Drugs that We prefer for dispensing to Enrollees. We will review and change the list from time to time.

"Genetic Screening or Testing" - a laboratory test that is a direct test of a person's genes or chromosomes to detect abnormalities or defects.

"Grace Period" - applicable period of time identified in Sections 5.4 and 5.5

"Grievance" - an oral or written complaint submitted in accordance with Our formal Grievance procedure by the Enrollee or on behalf of the Enrollee regarding any aspect of Our organization relating to the Enrollee.

"Health Services" - medical or health care services, whether or not Covered under this Contract, which include but are not limited to medical evaluation, diagnosis, treatments, procedures, drugs, therapies, devices, and supplies.

"Home Health Care Services" - Health Services provided by a Home Health Agency authorized to provide such services under the law of the jurisdiction in which treatment is received.

"Hospice Care Agency" - an agency or organization that meets all of the requirements listed below.

(A) Is certified to render Hospice Care,
(B) provides twenty-four hour care, seven days a week,
(C) is under the direct supervision of a Participating Provider, and
(D) maintains written records of the services provided.

"Hospice Care or Services" - a program of care that meets all of the requirements listed below.

(A) Is provided by a licensed Hospice Care Agency,
(B) focuses on palliative rather than curative treatment, and
(C) provides supportive measures to an Enrollee with a prognosis of less than six months to live.

"Hospice Facility"– a facility that is licensed and operated in accordance with the law of jurisdiction in which treatment is received, and provides twenty-four (24) hour nursing services.

"Hospital" - an institution that meets all of the requirements listed below.

(A) Is operated under the law,
(B) is primarily engaged in providing Health Services on an inpatient basis,
(C) provides for the care and treatment of injured or sick people,
(D) has medical, diagnostic and surgical facilities,
(E) is operated by or under the supervision of a staff of Providers,

(F) has 24-hour nursing services, and
(G) is licensed as a Hospital in the jurisdiction in which it operates.

A Hospital is not primarily a place for rest, Custodial Care, or care of the aged. A Hospital is not an Inpatient Transitional Care Unit, nursing home, convalescent home or similar institution.

"Independent Review Organization or IRO" - an organization certified by the Indiana Department of Insurance to conduct External Appeals.

"Maternity Services" – all Health Services related to Pregnancy including all of the following listed below.
(A) Prenatal and postnatal care, including newborn hearing test,
(B) childbirth, and
(C) early termination of Pregnancy.

"MDwise" - MDwise, Inc. references to We, Us, and Our throughout this Contract are references to MDwise.

"Medicaid" - Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs, as amended from time to time.

"Medical Director" - a licensed Provider of medicine or osteopathy appointed by Us to provide medical review of Health Services proposed or rendered for Enrollees.

"Medically Necessary" - Health Services that We have determined to be ***all*** of the following listed below.
(A) Medically appropriate and necessary to meet the Enrollee's basic health needs,
(B) the most cost-effective method of treatment and rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Health Service,
(C) consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and healthcare coverage organizations and governmental agencies,
(D) accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered at a frequency and duration considered by the medical community as medically appropriate,
(E) required for reasons other than the comfort or convenience of the Enrollee or his or her Provider,
(F) of a demonstrated medical value in treating the condition of the Enrollee, and
(G) consistent with patterns of care found in established managed care environments for treatment of the particular health condition.

The definition of Medically Necessary used in this Contract relates only to Coverage, and may differ from the way in which a Provider engaged in the practice of medicine may define Medically Necessary.

The fact that a Provider has performed or prescribed a Health Service does not mean that it is Medically Necessary. Nor does the fact that a particular Health Service may be the only option available for a particular condition mean that it is Medically Necessary. We retain the right to make all final decisions as to which Health Services are or were Medically Necessary, subject to the procedures specified in this Contract.

"Medicare" – the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended from time to time.

"Non-Covered" – those Health Services not Covered under the terms of this Contract.

"Non-Restorative Condition" - a condition where You will not (1) return to the state You were in prior to an Injury or an illness, or (2) achieve a state or perform a function(s) that never existed.

"Non-Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has not entered into an agreement with Your Delivery System or one of Our Delivery Systems.

"Open Enrollment" - an annual period [set by the Exchange] during which individuals eligible to enroll [in Qualified Health Plans] may enroll [in a Qualified Health Plan or may change Qualified Health Plans][in this Contract].

"Orthotic" - an appliance or apparatus used to support, align, or correct deformities or to improve the function of movable parts of the body, such as but not limited to braces or splints.

"Out-of-Pocket Limit" - the maximum amounts of Coinsurance and Copays an Enrollee must pay each Calendar Year for Covered Health Services. Once this limit is met, Coinsurance or Copays for such Services are not required for the rest of that Calendar Year. Amounts paid for Coinsurance, Copays and the Deductibles apply toward the Out-of Pocket Limit.

"Participating Pharmacy" - a pharmacy that has entered into an agreement with Us, or our Pharmacy Benefits Manager, to provide Prescription Drug services to Enrollees, and includes any subcontractors of such Participating Pharmacy

"Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has entered into an agreement with Your Delivery System or one of Our Delivery Systems, and includes any subcontractors of such Participating Providers.

Participating Providers within Your Delivery System are considered Tier 1 Participating Providers. Participating Providers that are not in Your Delivery System, but that are in one of Our Delivery Systems are considered Tier 2 Participating Providers.

"Physician" - a license medical provider, holding an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) degree.

"Post-service Grievance" - any Grievance that involves Health Services that have already been provided.

"Premium" - the fee We charge for each [Subscriber and] Enrolled Dependent Covered under this Contract. The Premium is paid in consideration for the benefits and services provided by Us under this Contract.

"Prescription Drug" - a drug that has been approved by the FDA, and under federal or state law can only be dispensed with a prescription. These are known as legend drugs. Prescription Drugs also include insulin, diabetic supplies, and inhaler aid devices.

"Pre-service Grievance" - a Grievance that must be decided before an Enrollee can obtain Health Services Covered under the Contract.

"Primary Medical Provider" or **"PMP"** – a Participating Provider in Your Delivery System practicing and duly licensed as a Physician in family practice, internal medicine, gynecology, obstetrics, or pediatrics, and who has agreed to assume primary responsibility for Your medical care under this Contract.

"Preauthorization" - the process of obtaining approval from Us that a Health Service, treatment plan, Prescription Drug, or DME is medically necessary prior to those services being rendered. "Preauthorization" may also be referred to as "Prior Authorization."

"Provider" - a Doctor, Hospital, Inpatient Transitional Care Unit, Home Health Care Agency, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

["Qualified Health Plan" - a health plan offered on the Exchange that satisfies the requirements set forth under the ACA (42 U.S.C. 18021(a)(1)).]

"Reasonable and Customary Charge" - the amount paid for a Health Service in a geographic area based on what Providers in the area usually charge for the same or similar Health Service.

"Reconstructive Surgery" - any surgery incidental to any of the following listed below.

(A) An injury,
(B) A Sickness, or
(C) Congenital defects and birth abnormalities.

Reconstructive Surgery for congenital defects and birth abnormalities includes but is not limited to orthodontic and oral surgery involved in the management of cleft lip and cleft palate for an Enrollee.

Reconstructive Surgery includes the following reconstruction for a Covered mastectomy (1) all stages of reconstruction of the breast on which the mastectomy has been performed, and (2) surgery and reconstruction of the other breast to produce symmetry, in the manner determined by the attending Provider and the Enrollee to be appropriate, subject to the provisions of this Contract.

"Routine Care Costs" - the cost of Medically Necessary services related to the care method that is under evaluation in a clinical trial. The term does not include any of the following listed below.

(A) The health care service, item, or investigational drug that is the subject of the clinical trial.
(B) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
(C) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
(D) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
(E) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where a clinical trial is conducted.
(F) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
(G) A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.

"Routine Immunization" - an immunization administered to the age-appropriate general population and recommended by the (A) Centers for Disease Control and Prevention (CDC), (B) American Academy of Pediatrics, and (C) American Academy of Family Physicians.

"Semi-private Room" - a room with two or more beds in a Hospital, an Approved Inpatient Transitional Care Unit, or an Alternate Facility.

"Service Area" - the geographic area We serve, as defined in the Schedule of Benefits. For this product the "Service Area" may not include Our licensed Service Area in its entirety, as approved by the Indiana Department of Insurance.

"Skilled Nursing Care" - services from licensed nurses in Your own home or in a nursing home.

"Special Enrollment" - periods during which individuals eligible to enroll [under this Contract][in Qualified Health Plans] may enroll in [a Qualified Health Plan, or may change Qualified Health Plans][in this Contract], as a result of triggering events provided in Section 2.5 [and as determined by the Exchange].

"Stabilize" - to provide Health Services to an Enrollee in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the Enrollee's condition is not likely to occur.

This includes Emergency Health Services provided to an Enrollee in a Hospital's care setting throughout or during the following discharge, transfer to another health care facility, or transfer to the Hospital's inpatient setting.

"Subscriber" - an individual whose name is on the Contract and [is][has] enrolled [an Eligible Dependent] for Coverage under this Contract. [The term Subscriber does not include Enrolled Dependents][A Subscriber is the legal parent or legal guardian of the Enrolled Dependent. A Subscriber does not have Coverage under this Contract].

"Urgent Care" - the treatment of an unexpected Sickness or Injury that is not life or limb threatening but requires prompt medical attention.

"Urgent Care Center" - a licensed medical service center that provides Urgent Care.

"Urgent Grievance" - a request for a Health Service that, if subject to the time limits applicable to Post-service Grievances or Pre-Service Grievances would do either of the following.

(A) Would seriously jeopardize Your life, health or ability to reach and maintain maximum function, or
(B) In the opinion of physicians familiar with Your condition, would subject You to severe pain that cannot be adequately managed unless We approve the Claim.

Once identified as such, an Urgent Grievance will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

Article 2

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Section 2.1 Eligibility of [the Subscriber] and Dependents. To be eligible to enroll as a [Subscriber\[Dependent], You must be all of the following listed below.

(A) Under age [65][21].
(B) Residing in Our Service Area.
(C) A legal resident of Indiana.
(D) Not eligible for or enrolled in Medicare, Medicaid or CHIP.
(E) Not covered by any other group or individual health benefit plan.
(F) [Eligible for Coverage on the Exchange]
(G) [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective].
(H)

[To be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the Exchange application completed by the Subscriber, and meet the definition of Dependent as well as all Dependent eligibility criteria established under this Contract and by the Exchange.]

We shall not require any person to submit to Genetic Screening or Testing, or use the results of such in determining eligibility for enrollment, inquire as to the results of Genetic Screening or Testing, or make an adverse decision against any person based on such results.

Section 2.2 Pre-Existing Conditions and Nondiscrimination. No Eligible Subscriber or Dependent will be refused enrollment based on health status, health care needs, expected length of life, quality of life, genetic information, previous medical information, disability or age.

Section 2.3 Enrollment and Effective Date for Coverage. Sections 2.4 through 2.5 provide information on how [an Eligible] Subscriber may enroll [an Eligible Dependent] in this Contract during the applicable enrollment periods [set by the Exchange] and the Effective Dates for Coverage for such enrollments. Regardless of how [an Eligible] Subscriber enrolls [an Eligible Dependent] in this Contract, enrollment is subject to Our receiving initial payment of Premium. No Coverage shall be Effective before this Contract takes effect. No Dependent shall be Covered until [You are Covered][enrolled for Coverage].

The Effective Date of this Contract is stated on Page 1.

Section 2.4 Annual Open Enrollment and Effective Date for Coverage. This Section 2.4 explains how an

Eligible Subscriber enrolls[an Eligible Dependent] for Coverage during the Open Enrollment periods [set by the Exchange] and sets forth the Effective Date for Coverage for such enrollment.

(A) Enrollment during Open Enrollment. During an Open Enrollment period, an Eligible Subscriber can enroll for Coverage by submitting a completed application to [Us}[the Exchange] during Open Enrollment. [The Exchange will notify Us of Your selection and transmit to Us all of the information necessary to enroll You for Coverage.] If We do not receive the selection during Open Enrollment, the eligible person can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.

[If a person qualifies as a Dependent but does not enroll when the Eligible Subscriber first applies for enrollment, the Dependents can only enroll for Coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.]

[As stated in Section 2.1, to be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the application completed by the Subscriber and submitted to [Us][the Exchange], and meet all Dependent eligibility criteria established by Us.]

(B) Effective Dates for Coverage during Annual Open Enrollment. For applications received during any annual Open Enrollment period, Coverage will be effective [according to the dates listed below][on the date identified by the Exchange].

(1) If the selection is received by [Us][the Exchange] between the first and the fifteenth day of the Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or the first day of the following month.

(2) If the selection is received by [Us][the Exchange] between the sixteenth and the last day of the Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or the first day of the second following month.

Section 2.5 Special Enrollment and Effective Date for Coverage. This Section 2.5 explains how an Eligible Subscriber may enroll for Coverage during a Special Enrollment period [set by the Exchange] and sets forth the Effective Date for Coverage for such enrollment.

Special Enrollment period Effective Dates for Coverage depend on the type of event, the date of request for a special enrollment period, and the date of plan selection. [CMS][We] will determine enrollee eligibility for all special enrollment periods.

[For additional information on Special Enrollment period set by the Exchange and how to enroll in or change Qualified Health Plans during a Special Enrollment period, You may contact the Exchange at [1-800-318-2596] or visit the Exchange website at [www.healthcare.gov.]

(A) [Special Enrollment Triggering Events.

(1) Loss of Minimum Essential Coverage.

(2) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.

(3) Obtaining status as a United States citizen, national, or lawfully present individual.

(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.

(5) Violation of a Qualified Health Plan of a material provision of its contract.

(6) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(7) Relocation to a new service area of the Exchange.

(8) An Indian, as defined in Section 4 of the Indian Health Care Improvement Act, may

enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(9) Demonstration to the Exchange, in accordance with the guidelines established by the United States Department of Health and Human Services, that You or Your Dependent satisfy other exceptional circumstances provided by the Exchange.

(10) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

(A) [Special Enrollment Triggering Events.

(1) Involuntary loss of Minimum Essential Coverage for any reason other than fraud, failure to pay Premium, or misrepresentation of material fact.

(2) Loss of Minimum Essential Coverage due to dissolution of marriage.

(3) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.

(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.

(5) Violation of a Qualified Health Plan of a material provision of its contract.

(6) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(7) Relocation to a new service area of the Exchange.

(8) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

(B) New Dependents as a Result of Marriage or Loss of Essential Minimum Coverage. If [You have][the Subscriber has] a new Dependent as a result of marriage, or due to [Your][the] Dependent's loss of essential minimum coverage, [You][the Subscriber] may elect to enroll [Your][the new] Dependent in this Contract, provided [You request][the Subscriber requests] enrollment within 60 days of the date of marriage or loss of essential minimum coverage. The Effective Date for Coverage will be on the first day of the month following the date of marriage or loss of essential minimum coverage. If We receive [an application form][notification from the Exchange] to add [Your][the new] Dependent more than 60 days after this qualifying event, We will not be able to enroll that person until the next Open Enrollment period.

(C) New Dependents as a Result of Birth, Adoption, or Placement for Adoption. If You have a new Dependent as a result of birth, adoption, or placement for adoption, Your new Dependent will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption or placement for adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for Your Dependent beyond 31 days, provided You submit [an application form to Us][a form through the Exchange] to add Your Dependent to the Contract and pay the required premium. The form must be submitted to [Us][the Exchange] within 60 days after the date of birth or adoption. If the form is not submitted to [us][the Exchange] within 60 days after the date of birth or adoption, Coverage will cease on the expiration of the 31 day period provided above.

[If an Enrolled Dependent has a child as a result of birth, adoption, or placement for adoption, the Enrolled Dependent's child will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption, or placement for adoption or date of entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for the Enrolled Dependent's child beyond 31 days, provided: (1) the child is placed under legal guardianship or legal custody of the Subscriber or the Subscriber's spouse and the child otherwise satisfies the eligibility requirements to enroll as a Dependent as set forth in this Article 2; (2) the Subscriber submits a form [to Us][through the Exchange] to add the child to the Contract within 60 days after the date of birth or adoptions; and (3) the Subscriber pays the required premium.]

(D) [CHIP. Eligible Dependents may also enroll under either of the two additional circumstances identified in (1) and (2).

(1) The Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility.

(2) The Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

You must request Special Enrollment for Your Dependent within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive notification to add Your Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, We will not be able to enroll that person until the next Open Enrollment period.]

(E) Other Qualifying Events. For all other Special Enrollment qualifying events[identified by the Exchange], the Effective Date for Coverage for [You and Your] Enrolled Dependents, [if any], is determined based on the date [We receive][the Exchange] receives Your selection according to the applicable timeframes listed below.

(1) If the selection is received [by Us] [by the Exchange] between the first and the fifteenth day of the month, the Effective Date for Coverage will be of the first day of the following month.

(2) If the selection is received by [Us}][the Exchange] between the sixteenth and the last day of the month, the Effective Date for Coverage will be of the first day of the second following month.

Section 2.6 Notify Us [or the Exchange] of Eligibility Changes. The Subscriber is responsible for notifying Us [or the Exchange] in writing of any change in eligibility that affects [the Subscriber or the][any] Enrolled Dependents. We [or the Exchange] must be notified no later than 30 days from the date of the event. We have the right to bill the Subscriber for the cost of any Health Services We have paid during the period of time the person was not enrolled under the Contract.

A change in the eligibility [of the Enrolled Dependent] may be any of the following listed below.

(A) [A determination of ineligibility made by the Exchange.]
(B) [Any change with respect to the eligibility standards specified by the Exchange for which You are required to notify the Exchange.]
(C) Address change.
(D) [Marriage.
(E) Divorce.]
(F) Death.
(G) [Birth of a Dependent].
(H) [Change in disability status of a Dependent.]
(I) Dependent Child] is no longer eligible because they have reached the limiting age.

Section 2.7 Service Area Requirements. [Subscribers][Dependents] must live in Our Service Area.

Article 3

BENEFITS AND COVERED HEALTH SERVICES

Subject to the Exclusions sets forth in this Contract and the terms and conditions of this Contract, We will Cover the following Medically Necessary Health Services [for an Enrolled Dependent].

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copay, and Benefit Limitation information.

You are responsible for any fees incurred for Non-Covered Health Services.

Section 3. 1 Ambulance Services. Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians, paramedics, or other certified medical professionals from or between any of the following listed below.

- From Your home, scene of accident or medical Emergency to a Hospital,
- Between Hospitals,
- Between a Hospital and Skilled Nursing Facility, or
- From a Hospital or Skilled Nursing Facility to Your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when You are not transported will be Covered if Medically Necessary.

Ambulance services are a Covered Health Service only when Medically Necessary, except when ordered by an employer, school, fire or public safety official and the Enrollee is not in a position to refuse, or when an Enrollee is required by Us to move from a Non-Participating Provider to a Participating Provider.

Ambulance trips must be made to the closest local facility that can give Covered Health Services appropriate for Your condition. If none of these facilities are in Your local area, You are Covered for trips to the closest facility outside Your local area.

Non-Covered Services for Ambulance include any of the following.

- Trips to a Physician's office or clinic, or a morgue or funeral home.
- Ambulance usage when another type of transportation can be used without endangering the Enrollee's health.
- Ambulance usage for the convenience of the Enrollee, family or Provider.

Section 3.2 Behavioral Health and Mental Health Services.

- Inpatient services. Medical management, individual or group psychotherapy, psychological testing, family counseling with family members to assist in Your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
- Observation stays. Overnight stays in behavioral health hospital facilities that do not meet inpatient levels of Medical Necessity, but do meet observation level based on nationally accepted criteria.
- Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
- Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.

- Outpatient Treatment or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

To assist You in obtaining appropriate and quality care, We will ask Your Provider to submit a treatment plan to Us within 48 hours of an inpatient or observation level of care, or after You have had an initial outpatient evaluation and nine (9) subsequent visits in an outpatient setting. We may discuss the goals of treatment and changes in the treatment plan, including alternative courses of treatment, with Your Provider in order to manage Your benefits effectively and efficiently.

Non-Covered Behavioral Health Services include all of the following.

- Supervised living or halfway houses.
- Health Services or care provided by a residential treatment center, school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, outward bound programs, even if psychotherapy is included.
- Health Services related to non-compliance of care if the Enrollee ends treatment for Substance Abuse against the medical advice of a Provider.

Section 3.3 Dental Health Services Related to Accidental Injury. Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are Covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Treatment for pain is only Covered if it is the result of an accidental injury. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Health Services for Accidental Dental include, but are not limited to all of the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia.

Section 3.4 Other Dental Health Services. Anesthesia and Hospital charges for dental care, for an Enrollee less than 19 years of age or an Enrollee who is physically or mentally disabled, are Covered if the Enrollee requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Enrollee's condition under general anesthesia. This Coverage does not apply to treatment for temporal mandibular joint disorders (TMJ). Extraction of teeth to prepare the jaw for radiation treatment or neoplastic disease is Covered.

Routine dental care is not a Covered Health Service under this Contract.

Section 3.5 Diabetic Equipment, Education and Supplies. Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when all of the following requirements listed below are met.

- Ordered in writing by a Physician or a podiatrist.
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Health Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes pursuant to Sections 3.13, 3.16, and 3.17.

Section 3.6 Diagnostic Health Services. Diagnostic Health Services are tests or procedures performed when You have specific symptoms, to detect or monitor Your condition. Coverage for Diagnostic Health Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to those listed below.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- Computer Tomography and Computer Axial Tomography Scans (CAT).
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Health Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy necessary (e.g. intravenous dye) to perform tests are Covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Diagnostic Breast Cancer Screening Mammography. The following breast cancer screening mammography Health Services are Covered Diagnostic Health Services.

- If the female Enrollee is at least 35 years of age, she may have one (1) Covered baseline breast cancer screening mammography performed before she becomes 40 years of age.
- If the Enrollee is less than 40 years of age and is high risk, she may have one (1) breast cancer screening mammography performed every year.
- Any additional mammography views that are required for proper evaluation..
- Ultrasound services, if determined Medically Necessary by the physician treating the Enrollee.

A woman is considered "high risk" if she meets at least one (1) of the following.

(1) Has a personal history of breast cancer.
(2) Has a personal history of breast disease proven benign by biopsy.
(3) Has a mother, sister, or daughter who has had breast cancer.
(4) Is at least 30 years of age and has not given birth.

Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Diagnostic Health Service for an Enrollee under the age of fifty (50) if the Enrollee is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and

laboratory tests for cancer for any nonsympomatic Enrollee, in accordance with the current American Cancer Society guidelines.

Diagnostic Prostate Cancer Screening. If an Enrollee is at least 50 years of age, one (1) prostate specific antigen test is Covered annually. If an Enrollee is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test is Covered annually.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Section 3.7 Emergency Health Care Services. Benefits for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever You are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copay/Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, Your Physician or the Inpatient facility must seek authorization for your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, Your Provider will be notified whether the Inpatient setting is appropriate and considered Medically Necessary.If Prior Authorization is not obtained within 48 hours of your admission You may be financially responsible for Your Inpatient care.

Care and treatment provided once You are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or Stabilize Your condition in an Emergency may be Covered if We authorize the continuation of care and it is Medically Necessary. Transfer to a Participating Provider will be made available to persons receiving post-stabilization care in a Non-Participating Provider facility.

Section 3.8 Urgent Care Center Services. An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital.

Section 3.9 Home Care Services. Health Services performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Enrollee must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Health Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Services.
- Nutritional Guidance.
- Home Health Aide Services. The Enrollee must be receiving skilled nursing or therapy. Health Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Massage, Music, and Manipulation Therapy which will not be Covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

Non-Covered Home Health Care Services include the following.

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services as such services are Covered under Therapy Services.

- Helpful environmental materials such as hand rails, bath stools ramps, telephones, air conditioners, and similar services, appliances and devices.
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if Your Provider obtains prior approval from Our Home Infusion Therapy Administrator. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Section 3.10 Hospice Services. Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician and hospice medical director. Covered Health Services will continue if the Enrollee lives longer than six months, provided the hospice medical director or other hospice doctor recertifies that You are terminally ill.

Covered Hospice Services include the following list.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

Non-Covered Hospice Services include services provided by volunteers and housekeeping services.

Section 3.11 Inpatient Services. Inpatient Services include all of the following.

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for Room, Board and General Nursing Services,
- Ancillary (related) services, and
- Professional Health Services from a Physician while an Inpatient.

<u>Room, Board, and General Nursing Services</u>

- A room with two or more beds.
- A private room if it is Medically Necessary that You use a private room. You will be required to supplement the difference in cost if a private room is desired, but not Medically Necessary.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive Health Services for intensive care of critically ill patients.

<u>Ancillary (Related) Services</u>

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and Health Services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Health Services.
- Therapy Services.

Professional Health Services

Medical care visits limited to one visit per day by any one Physician.

- Intensive medical care for constant attendance and treatment when Your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a Physician who is not Your surgeon while You are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of Your condition requires the skills of separate Physicians.
- Consultation which is a personal bedside examination by another Physician when ordered by Your Physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

When an Enrollee is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copay per admission in the Schedule of Benefits is waived for the second admission.

Section 3.12 Maternity Services. Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. Maternity Services are used for normal or complicated pregnancy and ordinary routine nursery care for a healthy newborn. In order to aid in facilitating a pregnant Enrollee's prenatal care, she is required to notify Us of her pregnancy within 7 days of the date that she becomes aware that she is pregnant.

If the Enrollee is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider to have Covered Maternity Services paid at the Delivery System level. If the Enrollee is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Delivery System level if the Enrollee is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date.

Covered Maternity Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period.

If a newborn child is required to stay as an Inpatient past the mother's discharge date, the Health Services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copay.

Coverage for the Inpatient postpartum stay for You and Your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care and Postnatal Care.

Covered Maternity Services include post-delivery care visits at Your residence by a Physician or Nurse performed no later than 48 hours following You and Your newborn child's discharge from the Hospital. Coverage for this visit includes all of the following listed below.

1. Parent education,
2. Assistance and training in breast or bottle feeding, and
3. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

We will Cover an examination given at the earliest feasible time to Your newborn child for the detection of the following disorders.

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia.
- Galactosemia.
- Maple Syrup urine disease.

- Homocystinuria.
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
- Physiologic hearing screening examination for the detection of hearing impairments.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.
- HIV testing in infants exposed to HIV/AIDS.
- Pulse oximetry screening examination for the detection of low oxygen levels.

Section 3.13 Medical Supplies, Durable Medical Equipment and Appliances.

- Medical and surgical supplies –Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera and Remicade. Covered Health Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.
    - Covered Health Services include the following.
        1. Allergy serum extracts
        2. Chem strips, Glucometer, Lancets
        3. Clinitest
        4. Needles/syringes
        5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Health Services
        6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.
    - Non-Covered Health Services include the following.
        1. Adhesive tape, band aids, cotton tipped applicators
        2. Arch supports
        3. Doughnut cushions
        4. Hot packs, ice bags
        5. vitamins
        6. medijectors

- Durable Medical Equipment - The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Contract will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Health Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Enrollee, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is Covered.

    - Covered Health Services include the following.
        1. Hemodialysis equipment
        2. Crutches and replacement of pads and tips
        3. Pressure machines
        4. Infusion pump for IV fluids and medicine
        5. Glucometer
        6. Tracheotomy tube
        7. Cardiac, neonatal and sleep apnea monitors

8. Augmentive communication devices are Covered when We approve based on the Enrollee's condition.
9. CPAP machines when indicated for sleep apnea.

- Non-Covered items include the following.
  1. Air conditioners
  2. Ice bags/coldpack pump
  3. Raised toilet seats
  4. Rental of equipment if the Enrollee is in a Facility that is expected to provide such equipment
  5. Translift chairs
  6. Treadmill exerciser
  7. Tub chair used in shower.

- Prosthetics – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Health Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are Covered.

  - Covered Health Services include, the following.
    1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
    2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
    3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
    4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
    5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Enrollee selects eyeglasses and frames, then reimbursement for both lenses and frames will be Covered.
    6. Cochlear implant.
    7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
    8. Restoration prosthesis (composite facial prosthesis).
    9. Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Benefit Period).

  - Non-Covered Prosthetic appliances include the following.
    1. Dentures, replacing teeth or structures directly supporting teeth.

2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

- Orthotic Devices – The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered. The casting is Covered when an orthotic appliance is billed with it, but not if billed separately.

  - Covered Health Services for Orthotic Devices include the following.
    1. Cervical collars.
    2. Ankle foot orthosis.
    3. Corsets (back and special surgical).
    4. Splints (extremity).
    5. Trusses and supports.
    6. Slings.
    7. Wristlets.
    8. Built-up shoe.
    9. Custom made shoe inserts.
  - Orthotic appliances may be replaced once per year per Enrollee when Medically Necessary in the Enrollee's situation. However, additional replacements will be allowed for Enrollees under age 18 due to rapid growth, or for any Enrollee when an appliance is damaged and cannot be repaired.
  - Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.
  - Non-Covered Health Services for Orthotic Devices include the following.
    1. Orthopedic shoes (except therapeutic shoes for diabetics).
    2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
    3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
    4. Garter belts or similar devices.

- Prosthetic limbs & Orthotic custom fabricated brace or support –
  - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be Covered if they satisfy both requirements listed below.
    1. Determined by Your Physician to be Medically Necessary to restore or maintain Your ability to perform activities of daily living or essential job related activities, and
    2. Not solely for comfort or convenience.
  - Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the Coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.
  - Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are Covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract.

Replacements and Repairs. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be Covered, as approved by Us.

The repair, adjustment or replacement of the purchased equipment, supply or appliance is Covered if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be Covered if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

Section 3.14 Outpatient Services. Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Contract. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us.

When Diagnostic Health Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copay is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these Health Services.

Section 3.15 Autism Spectrum Disorder Services.
Coverage is provided for the treatment of Autism Spectrum Disorders. Treatment is limited to Health Services prescribed by Your Physician in accordance with a treatment plan.

- Autism Spectrum Disorder, as defined in the definition section of the Policy, means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Coverage for Health Services will be provided as prescribed by Your treating Physician in accordance with the treatment plan.
- Any exclusion or limitation in this Contract in conflict with the Coverage described in this provision will not apply.
- Coverage for Autism Spectrum Disorders will not be subject to dollar limits, Deductibles, Copay or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copays or Coinsurance provisions that apply to physical illness under this Contract.

Section 3.16 Physician Home Visits and Office Services. Covered Health Services include care provided by a Physician in their office or Your home. Refer to the Sections 3.2, 3.9, 3.12, and 3.17 for Health Services Covered by the Contract. For Emergency Care refer to Sections 3.7 and 3.8.

- Office Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copay is required.

- Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in Your home.

- Diagnostic Health Services when required to diagnose or monitor a symptom, disease or condition.

- Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

- Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Section 3.17 Preventive Care Services. Preventive Care Services include, Outpatient services and Office Services. Screenings and other Health Services are Covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

- Enrollees who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Health Services benefit.

- Preventive Care Services in this section shall meet requirements as determined by federal and state law.

- Health Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF.

Section 3.18 Routine Care Costs as Part of a Cancer or Other Life-Threatening Disease or Condition Clinical Trial. Routine Care Costs as part of an Approved Clinical Trial if the Health Services are otherwise Covered Health Services under this Contract.

An Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

1. The trial is approved or funded by one, or a combination, of the following:
    - A National Institutes Health institute.
    - A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center.
    - The United States Food and Drug Administration.
    - The United States Department of Veterans Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
    - The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
    - The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).
    - The Centers of Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare and Medicaid Services.
    - The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 C.F.R. 146.103.
    - A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.
    - A qualified non-governmental research entity in guidelines issued by the National Institutes of health for center support grants.
2. A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.
3. A study or investigation done for drug trials which are exempt from the investigational new drug application.

Your PMP must provide Us with written authorization for Your participation in a Cancer Clinical Trial.

Routine Costs as part of an Approved Clinical Trial does not include any of the following.

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial,
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.
- Transportation, lodging, food, or other expense for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the cancer clinical trial.
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient.
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

The term "life threatening condition" means any disease or condition from which death is likely unless the disease or condition is treated.

Section 3.19 Surgical Services. Coverage for Surgical Services when provided as part of Physician Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to the list below.

- Performance of accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary.
- Usual and related pre-operative and post-operative care.
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

- Covered Surgical Services include the following.
    - Operative and cutting procedures.
    - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
    - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

<u>Reconstructive Services</u>. Certain Reconstructive Services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are Covered. Reconstructive Services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract. Covered Reconstructive Services are limited to the following list.

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further Coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or Younger.
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia.
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect.
- Tongue release for diagnosis of tongue-tied.
- Congenital disorders that cause skull deformity such as Crouzon's disease.
- Cleft lip.
- Cleft palate.

<u>Mastectomy Notice.</u> An Enrollee who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive Coverage for all of the following listed below.

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Section 3.20 Sterilization. Sterilization is a Covered Service.

Section 3.21 Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder. Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders if provided within Our guidelines.

Section 3.22 Therapy Services. When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, Coverage for these Therapy Services is limited to the following list.

- Physical Medicine Therapy Services. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.
    - Physical Therapy Services including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Physical Therapy Services include but are not limited to maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness, repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients), range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities, general exercise programs, diathermy, ultrasound and heat treatments for pulmonary conditions, diapulse, work hardening.
    - Speech Therapy Services for the correction of a speech impairment.
    - Occupational Therapy Services for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Occupational Therapy Services include but are not limited to supplies (looms, ceramic tiles, leather, utensils), therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again, general exercises to promote overall fitness and flexibility, therapy to improve motivation, suction therapy for newborns (feeding machines), soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial, adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
    - Manipulation Therapy Services includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy Services as specified in the Schedule of Benefits. Manipulation Therapy Services rendered in the home as part of Home Care Services are not Covered.
- Other Therapy Services
    - Cardiac Rehabilitation Services to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not Covered.
    - Pulmonary Rehabilitation Services to restore an individual's functional status after a pulmonary or cardiac event, or to improve respiratory capacity in persons with chronic lung conditions.
    - Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
    - Dialysis Treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of Coverage the Contract will not require You to

receive dialysis treatment at a Participating Provider dialysis facility if that facility is further than 30 miles from Your home. If You require dialysis treatment and the nearest Participating Provider dialysis facility is more than 30 miles from Your home, the Contract will allow You to receive treatment at a Participating Provider dialysis facility nearest to Your home as Covered Health Service.

- Radiation Therapy Services for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, treatment planning.
- Inhalation Therapy Services for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Inhalation Therapy Services include but are not limited to, introduction of dry or moist gases into the lungs, nonpressurized inhalation treatment, intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive airway pressure ventilation (CPAP), continuous negative pressure ventilation (CNP), chest percussion, therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers, broncho-pulmonary drainage and breathing exercises.
- Pulmonary Rehabilitation Services to restore an individual's functional status after an illness or injury. Covered Pulmonary Rehabilitation Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also Covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary Rehabilitation Services in the acute Inpatient rehabilitation setting is not a Covered Health Service.
- Nutritional Counseling Services that are Medically Necessary or that are ordered by a Participating Provider. Limit of twelve (12) sessions annually.

Section 3.23 Physical Medicine and Rehabilitation Services. A structured therapeutic program under the supervision of a physical medicine and rehabilitation specialist and developed treatment plan of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical Medicine and Rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Long term rehabilitation for longer than 60 days in an inpatient setting is not a Covered Service.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Health Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Health Service.

Section 3.24 Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services. The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Enrollee cost shares.

Covered Transplant Procedure. Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period**.** Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Transplant Provider agreement. Contact the Case Manager for specific Participating Transplant Provider information for Health Services received at or coordinated by a Participating Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Transplant Provider Facility.

Prior Approval and Precertification. In order to maximize Your benefits, We strongly encourage You to call Our transplant department to discuss benefit Coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We may require additional work-ups and/or treatments before determining eligibility for the transplant benefit (e.g. psychotherapy). We will assist You in maximizing Your benefits by providing Coverage information, including details regarding what is Covered and whether any clinical Coverage guidelines, medical policies, Participating Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of Your I.D. Card. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are Covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging. The Contract will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Enrollee receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Enrollee must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed.

Non-Covered Services for transportations and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by Us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Section 3.25 Prescription Drug Benefits.

Pharmacy Benefits Manager**.** The pharmacy benefits available to You under this Contract are managed by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which We contract to manage Your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, and provides clinical management services. The management and other services the PBM provides include, among others, making recommendations to, and updating, the Covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and, operating a Mail Service pharmacy. The PBM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, Drug interactions or Drug/pregnancy concerns.

You may request a copy of the Covered Prescription Drug list by calling the Customer Service telephone number on the back of Your I.D. Card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage. You may request a list of Pharmacies in the PBM network by calling the customer service number listed on the back of Your I.D. Card.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Health Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Contract can determine Medical Necessity. The Contract may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Health Services will be limited based on Medical Necessity, quantity and/or age limits established by the Contract, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit Coverage. At the time You fill a prescription, the Participating Pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee which is reviewed and adopted by Us. We, or the PBM may contact Your Provider if additional information is required to determine whether Prior Authorization should be granted. We communicate the results of the decision to both You and Your Provider.

If Prior Authorization is denied, You have the right to appeal through the appeals process outlined in Article 8.

For a list of the current Drugs requiring Prior Authorization, please contact the Pharmacy Customer Service telephone number on the back of Your I.D. card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage under Your Contract. Refer to the Prescription Drug benefit sections in this Contract for information on Coverage, limitations and exclusions. Your Participating Provider or Participating Pharmacist may check with Us to verify Covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Contract.

- Therapeutic Substitution of Drugs is a program approved by Us and managed by the PBM. This is a voluntary program designed to inform Enrollees and Physicians about possible alternatives to certain prescribed Drugs. We, or the PBM, may contact You and Your prescribing Physician to make You aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only You and Your Physician can determine whether the therapeutic substitute is appropriate for You. For questions or issues involving therapeutic Drug substitutes, call the Customer Service telephone number on the back of Your I.D. card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

- Step Therapy. Step therapy protocol means that an Enrollee may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Enrollees access high quality yet cost effective Prescription

Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Participating Pharmacies**.** The PBM's Participating Pharmacies are available to Enrollees who use medically necessary drugs

Participating mail service pharmacies have toll free access to registered pharmacists to answer your questions. Participating specialty pharmacies have dedicated patient care coordinators to help You manage Your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists.

You may obtain a list of the Participating Pharmacies, and Covered Drugs, by calling the Customer Service telephone number on the back of Your ID card, or review the lists on Our website at *www.mdwisemarketplace.org*.

Covered Prescription Drug Benefits include the following.

- Prescription Legend Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are Covered when obtained through an eligible Pharmacy.
- If certain supplies, equipment or appliances are not obtained by Mail Service or from a Participating Pharmacy then they are Covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits and may be subject to applicable DME Copays or Coinsurance.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Non-Covered Prescription Drug Benefits

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by Us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for Coverage under the Medical Supplies benefit, they are Covered Health Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.

- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Health Services.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Refills of lost or stolen medications.
- Refills earlier than 72 hours before Your next refill is due.
- Refills on expired Prescription Drugs.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, are not Covered, unless otherwise required by law or approved by Us. "Clinically equivalent" means Drugs that, for the majority of Enrollees, can be expected to produce similar therapeutic outcomes for a disease or condition.

Deductible/Coinsurance/Copay. Each Prescription Order may be subject to a Deductible and Coinsurance/Copay. If the Prescription Order includes more than one Covered Drug, a separate Coinsurance/Copay will apply to each Covered Drug.

Days Supply. The number of days supply of a Drug which You may receive is limited. The days supply limit applicable to Prescription Drug Coverage is shown in the Schedule of Benefits. If You are going on vacation and You need more than the days supply allowed for under this Contract, You should ask Your Pharmacist to call the PBM and request an override for one additional refill. This will allow You to fill Your next prescription early. If You require more than one extra refill, please call the Pharmacy Customer Service telephone number on the back of Your I.D. Card.

Prescription Drug Classifications. Your Copay/Coinsurance amount may vary based on whether the Prescription Drug has been classified by Us as a Tier 1, Tier 2, Tier 3, or Tier 4 Prescription Drug. The determination of Prescription Drug class is made by Us based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, and where appropriate certain clinical economic factors.

- Tier 1Drugs have the lowest Copay. This class will contain low cost and preferred medications that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs will have a higher Copay than Tier 1 Prescription Drugs. This class will contain preferred medications that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3Prescription Drugs will have a required Coinsurance payment after You have hit your Deductible. This class will contain non-preferred and high cost medications. This will include medications considered Generic, single source brands, and multi-source brands.
- Tier 4 Prescriptions are subject to a day supply limit for Retail and Mail Service, and are subject to the applicable Coinsurance shown in the Schedule of Benefits. Coinsurance payment will occur after You have hit your Deductible. Tier 4 Drugs are Prescription Legend Drugs which are any of the following listed below.
    - Are only approved to treat limited patient populations, indications or conditions, or
    - Are normally injected, infused or require close monitoring by a physician or clinically trained individual, or
    - Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Class and Formulary Assignment Process. We have established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of Prescription Drug class assignments and formulary inclusion are made by Us based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, generic availability, the degree of utilization of one Drug over another in Our patient population, and where appropriate, certain clinical economic factors.

We retain the right at Our discretion to determine Coverage for dosage formulations in terms of Covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may Cover one form of administration and exclusion or place other forms of administration in another tier.

Special Programs. From time to time We may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Tier 1 Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copays or Coinsurance for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program. The Half-Tablet Program will allow Enrollees to pay a reduced Copay on selected "once daily dosage" medications. The Half-Tablet Program allows an Enrollee to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Enrollee's decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of Your I.D. Card.

Section 3.26 Payment of Prescription Drug Benefits. The amount of benefits paid is based upon whether You receive the Covered Health Services from a Participating Pharmacy, a Non-Participating Pharmacy, or the PBM's Mail Service Program. It is also based upon how We have classified the Prescription Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The amounts for which You are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copay/Coinsurance for which You are responsible.

Your Copay(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Contract from Drug manufacturers or similar vendors. For Covered Health Services provided by a Participating Pharmacy or through the PBM's Mail Service, You are responsible for all Deductibles and/or Copay/Coinsurance amounts.

For Covered Health Services provided by a Non-Participating Pharmacy, You will be responsible for the amount(s) shown in the Schedule of Benefits.

How to Obtain Prescription Drug Benefits. How You obtain Your benefits depends upon whether You go to a Participating or a Non-Participating Pharmacy.

- Participating Pharmacy – Present Your written Prescription Order from Your Physician, and Your I.D. Card to the pharmacist at a Participating Pharmacy. The Pharmacy will file Your claim for You. You will be charged at the point of purchase for applicable Deductible and/or Copay/Coinsurance amounts. If You do not present Your I.D. Card, You will have to pay the full retail price of the prescription. If You do pay the full charge, ask Your pharmacist for an itemized receipt and submit it to Us with a written request for refund.
- Tier 4 Drugs - You or Your Physician can order Your Tier 4 Drugs directly from a Participating Pharmacy, simply call the Pharmacy Customer Service telephone number on the back of Your ID card.
- Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy. You must submit a Prescription Drug claim form for reimbursement consideration. These forms are available from Us, the PBM, or from the Group. You must complete the top section of the form and ask the Non-Participating Pharmacy to complete the bottom section. If for any reason the bottom

section of this form cannot be completed by the pharmacist, You must attach an itemized receipt to the claim form and submit to Us or the PBM. The itemized receipt must show all of those items listed below.
  - Name and address of the Non-Participating Pharmacy.
  - Patient's name.
  - Prescription number.
  - Date the prescription was filled.
  - Name of the Drug.
  - Cost of the prescription.
  - Quantity of each Covered Drug or refill dispensed.
- You are responsible for the amount shown in the Schedule of Benefits.
- The Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from Your Physician, or have Your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copay amounts to the Mail Service when You request a prescription or refill.

Drug Exception Program. This is a program designed to allow Enrollees to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. The Drug Exception Program is separate from and in addition to the Grievance Procedures set forth in Article 8. Please call the Customer Service number on the back of your I.D. Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary.

Section 3.27 Pediatric Vision Benefits. Pediatric vision services are Covered under this Contract for Enrollees under the age of 19. Adult eyewear is not Covered under this Contract.

- A complete pediatric eye exam, including dilation if professional indicated
- One pair of eyeglass lenses. Lenses include single vision, bifocal, trifocal or lenticular. You may choose plastic or polycarbonate lenses and scratch resistant coating.
- One pair of eyeglass frames.
- Contact lenses in lieu of eyeglasses.
- Low vision services including a comprehensive low vision exam, optical/non-optical aids, and supplemental testing.

Please refer to the Schedule of Benefits for detailed information.

Article 4

EXCLUSIONS

Section 4.1 We do not provide Coverage for any of the following.

1. Health Services that are not Medically Necessary.
2. Health Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available for a condition will not make it eligible for Coverage if We deem it to be Experimental/Investigative.
3. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
4. Health Services that are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

5. Any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
6. A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
7. Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
8. Court ordered testing or care unless Medically Necessary.
9. Health Services for which You have no legal obligation to pay in the absence of this or like Coverage.
10. Physician or Other Practitioners' charges for consulting with Enrollees by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Enrollee except as otherwise described in this Contract.
11. Surcharges for furnishing and/or receiving medical records and reports.
12. Charges for doing research with Providers not directly responsible for Your care.
13. Charges that are not documented in Provider records.
14. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
15. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
16. Health Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
17. Health Services prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
18. Completion of claim forms or charges for medical records or reports unless otherwise required by law.
19. Mileage, lodging and meals costs, and other Enrollee travel related expenses, except as authorized by Us or specifically stated as a Covered Health Service.
20. Health Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Enrollee had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.
21. Charges in excess of Our Allowed Amounts.
22. Health Services incurred prior to Your Effective Date.
23. Health Services incurred after the termination date of this Coverage except as specified elsewhere in this Contract.
24. Any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts) or for the removal of tattoos. Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not Covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Enrollee was Covered by another carrier/self funded plan prior to Coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.
25. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
26. Custodial Care, convalescent care or rest cures.
27. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Enrollee's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

28. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
29. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a
30. Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
31. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
32. Wilderness camps.
33. Routine foot care (including the cutting and removal of corns and calluses), Nail trimming, cutting and debriding, Hygienic and preventive maintenance foot care, including, but not limited to the following list.
    1. Cleaning and soaking the feet.
    2. Applying skin creams in order to maintain skin tone.
    3. Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
34. Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses.
35. Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including, but not limited to the list below.
    1. Extraction, restoration and replacement of teeth.
    2. Medical or surgical treatments of dental conditions.
    3. Services to improve dental clinical outcomes.
36. Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Health Service.
37. Dental implants.
38. Dental braces.
39. Dental x-rays, supplies and appliances and all associated expense, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following listed below.
    1. Transplant preparation.
    2. Initiation of immunosuppresives.
    3. Direct treatment of acute traumatic injury, cancer or cleft palate.
40. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
41. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as Covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
42. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not Covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Contract or any previous [MDwise Contract], and it applies if the surgery was performed while the Enrollee was Covered by a previous carrier/self funded plan prior to Coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to myocardial infarction, excessive nausea/vomiting, pneumonia, and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.
43. Marital counseling.
44. Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

45. Vision orthoptic training.
46. Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.
47. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
48. Services to reverse voluntarily induced sterility.
49. Diagnostic testing or treatment related to infertility.
50. Personal hygiene, environmental control, or convenience items including but not limited to the following list.
    1. Air conditioners, humidifiers, air purifiers,
    2. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals,
    3. Charges for non-medical self-care except as otherwise stated,
    4. Purchase or rental of supplies for common household use, such as water purifiers,
    5. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds,
    6. Infant helmets to treat positional plagiocephaly,
    7. Safety helmets for Enrollees with neuromuscular diseases, or
    8. Sports helmets.
51. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
52. Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Contract.
53. Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.
54. Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
55. Self-help training and other forms of non-medical self care, except as otherwise provided in this Contract.
56. Examinations relating to research screenings.
57. Stand-by charges of a Physician.
58. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
59. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
60. Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility, Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
61. Manipulation Therapy services rendered in the home as part of Home Care Services.
62. For any new FDA Approved Drug Product or Technology **(including but not limited to medications, medical supplies, or devices)** available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
63. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
64. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

65. Abortion, except in the following cases.
    1. The pregnant woman became pregnant through an act of rape or incest.
    2. An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.
66. Any services or supplies provided to a person not Covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
67. Surgical treatment of gynecomastia.
68. Treatment of hyperhidrosis (excessive sweating).
69. Any service for which You are responsible under the terms of this Contract to pay a Copay, Coinsurance or Deductible, and the Copay, Coinsurance or Deductible is waived by any Participating Provider.
70. Human Growth Hormone for children born small for gestational age. It is only a Covered Health Service in other situations when allowed by Us through Prior Authorization.
71. Complications directly related to a service or treatment that is a Non-Covered Health Service under this Contract because it was determined by Us to be Experimental/Investigational or non Medically Necessary. Directly related means that the Health Service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
72. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
73. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
74. Treatment of telangiectatic dermal veins (spider veins) by any method.
75. Reconstructive Health Services except as specifically stated in Section 3.19 of this Contract, or as required by law.
76. Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
77. Non-preventive medical nutritional therapy from a Non-Participating Provider.
78. Health Services from a Non-Participating Provider, except as specified elsewhere in this Contract.

Section 4.2 Experimental/Investigative Health Services Exclusion. We do not provide Coverage for any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the Health Service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply satisfies any or all of the following listed below.

- Cannot be legally marketed in the United States without the final approval of the FDA, or other licensing or regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any Health Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Health Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

- The scientific evidence is conclusory concerning the effect of the Health Service on health outcomes,
- The evidence demonstrates the Health Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects,
- The evidence demonstrates the Health Service has been shown to be as beneficial for the total population for whom the Health Service might be proposed as any established alternatives, and
- The evidence demonstrates the Health Service has been shown to improve the net health outcomes of the total population for whom the Health Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

Off-Label Drug Treatment. Coverage for a Drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

(1) The Drug is recognized for treatment of the indication in at least one standard reference compendium.
(2) The Drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the Drugs' use to be contraindicated or the Drug has not been approved by the FDA for any indication.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof, or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Documents of an IRB or other similar body performing substantially the same function, or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Medical records, or
- The opinions of consulting Providers and other experts in the field.

Article 5

PREMIUM PAYMENT

Section 5.1 Premium Rate. Your Premium rate is determined using the following acceptable rating factors: age, tobacco use, family size, and geography.

[Your][An Enrollee's] tobacco use impacts the determination of [Your][the] Premium rate. Upon enrollment, You will attest to [Your][an Enrollee's] tobacco use. If You report false or incorrect information to Us [or the Exchange] about [Your][an Enrollee's] tobacco use upon enrollment, We may retroactively apply the appropriate tobacco rating factor to [Your][the] Premium as if the correct information had been accurately reported from the Effective Date for Coverage.

Section 5.2 Payment of Premium. The Subscriber is responsible for paying the Premium to Us on a monthly basis. The first Premium is due and payable on the Effective Date of this Contract. Subsequent Premium payments

are due and payable on or before the first day of each month thereafter that this Contract is in effect. Payment must be made on or before each due date. Even if You have not received a bill from Us, You are still obligated to pay, at a minimum, the amount of the prior bill. A service charge in the maximum allowable amount under law will be charged for any non-sufficient check used to pay the Premium.

Section 5.3 Adjustments to Premium. We reserve the right to change the Premium annually. You will receive 30 days notice of any change in Premiums.

Section 5.4 General Grace Period. Following payment of the initial Premium, a Grace Period of one (1) month shall be granted for the payment of any Premium. This Grace Period shall not extend beyond the date this Contract terminates. During the one (1) month Grace Period this Contract shall continue in force.

Any claims incurred and submitted during the grace period will not be considered for payment until Premium is received. If Premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of Coverage.

[Section 5.5 Three-Month Grace Period for Subscribers Receiving Advance Payments of the Premium Tax Credit.
For [a Subscriber][or Enrollee] receiving advance payments of the premium tax credit who has previously paid at least one full month's premium during the benefit year, a Grace Period of three (3) consecutive months shall be granted for the payment of any Premium.

During this 3-month Grace Period, We shall do all of the following listed below.

(1) Pay all claims for Covered Emergency and Health Services rendered to [the Subscriber][an Enrolled Dependent] during the first month of the Grace Period and may pend claims for Covered Emergency and Health Services rendered to the Subscriber in the second and third months of the Grace Period.
(2) Notify the Department of Health and Human Services of such non-payment.
(3) Notify Participating Providers of the possibility for denied claims when a Subscriber is in the second and third months of the Grace Period.

During this 3-month Grace Period, We shall do all of the following listed below.

(1) Continue to collect advance payments of the premium tax credit on behalf of the Subscriber from the Department of Treasury.
(2) Return advance payments of the premium tax credit on the behalf of the Subscriber for the second and third months of the Grace Period if the Subscriber exhausts the grace period.]

Section 5.6 Payment upon Termination. If Premium has been paid for any period of time after the termination date, We will refund that Premium to You. The refund will be for the period of time after Your Coverage ends. Also, if an [Enrollee][Enrolled Dependent] dies while this Contract is in force, We will refund the Premium paid for any period after the month of the [Enrollee's][Enrolled Dependent's] death to You or Your estate for that [Enrollee][Enrolled Dependent].

Article 6

PROCEDURES FOR OBTAINING HEALTH SERVICES

Our authorization does not guarantee Coverage for the Health Service or procedure reviewed. Benefits of this Contract are determined in accordance with all of the terms, conditions, limitations, and exclusions.

Section 6.1 Selection of a Primary Medical Provider. We require the designation of a Primary Medical Provider (PMP). You have the right to designate any PMP who is a Participating Provider in Your Service Area and who is available to accept [You and Your Enrolled Dependents][an Enrollee]. Until You make this designation, We will

designate a PMP for You. For information on how to select a PMP, and for a list of PMPs in Your Delivery System, contact the customer service telephone number on the back of your I. D. Card or refer to the provider directory on Our website, www.mdwisemarketplace.org. [For Children, you][You] may designate a pediatrician as the PMP.

[You do][An Enrollee does] not need Preauthorization or a referral from Us or from any other person (including a PMP) in order to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetrics or gynecology. The Participating Provider, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services or following a pre-approved treatment plan. For a list of Participating Providers who specialize in obstetrics or gynecology, contact the customer service telephone number on the back of your I.D. Card or refer to Our website, www.mdwisemarketplace.org.

Section 6.2 Preauthorization. The Health Services listed below do not require Preauthorization.

(A) Emergency Services.
(B) Preventive Services provided by a Participating Provider.

A Provider that provides [You][an Enrollee] with Emergency Services may not charge You except for an applicable Copay or Deductible.

All other Health Services must be made through Your PMP. [Your][An Enrollee's] PMP will determine whether Preauthorization is required. The following is a list of Health Services that require Preauthorization. This list is not exhaustive.

(A) Elective/Urgent Inpatient Admissions.
    (1) Medical.
    (2) Surgery.
    (3) Sub-acute rehabilitation and skilled nursing facility.
    (4) Inpatient behavioral health and substance abuse.
(B) Observation stay.
(C) Skilled nursing facility services.
(D) Hospice Care – Inpatient and Outpatient.
(E) Hysterectomy.
(F) Transplantation evaluations and procedures/surgery.
(G) Reduction mammoplasty surgery
(H) Reconstructive services/plastic surgery/potentially Cosmetic Procedures.
(I) Home Health Care Services.
(J) MRI, MRA, CT scans and PET scans.
(K) All Non-Participating Provider services.
(L) Durable Medical Equipment and supplies greater than $500 (total per claim) per rental or purchase.
(M) Prosthetics greater than $500/per prosthetic.
(N) Pharmacy Services, including,
    (1) Biotech Injectables
    (2) Enteral Products
    (3) As otherwise specified on the MDwise preferred drug list.
(O) Occupational Therapy (authorization required after the initial evaluation).
(P) Physical Therapy (authorization required after the initial evaluation).
(Q) Speech Therapy (authorization required after the initial evaluation).
(R) Transportation – non-emergent.
(S) Certain mental disorders/substance abuse.
(T) Outpatient services, including outpatient surgical procedures and certain other procedures.
(U) Pain management programs.

Section 6.3 Health Services by Participating Providers. Health Services rendered by Participating Providers are Covered if the Health Services meet all of the following conditions.

(A) Are ordered by a Participating Provider (including Health Services performed at Participating facilities),
(B) Provided by or under the direction of a Participating Provider,
(C) Medically Necessary, and
(D) Specified as Covered by this Contract.

Section 6.4 Verification of Participation Status. You must confirm that the Provider is a Participating Provider and whether the Participating Provider is a Provider in Tier 1 or Tier 2 before receiving Health Services. This is important since this Contract is aimed at providing Coverage for Health Services rendered by Participating Providers.

You must show the Participating Provider Your I.D. card before receiving Health Services.

If You do not identify [Yourself][an Enrolled Dependent] to the Participating Provider as an Enrollee within 90 days from the date Health Services are incurred a Participating Provider may bill You for Your Health Services, and You shall be responsible for 100% of the cost of Your Health Services.

The Provider needs to know that [You are][an Enrolled Dependent] an Enrollee in order to follow Our procedures, such as Prior Authorization. If failure to show Your I.D. card results in non-compliance with Our required procedures and Coverage is denied, You shall be responsible for 100% of the cost of Your Health Services.

Section 6.5 Health Services by a Non-Participating Provider. Non-Emergency Health Services rendered by a Non-Participating Provider will be Covered in the following circumstances only.

(A) Referral to Non-Participating Providers. The Allowed Amounts of non-Emergency Health Services provided by a Non-Participating Provider shall be Covered if all of the following conditions listed below are satisfied.

(1) The specific Health Services cannot be provided by or through Participating Providers,
(2) The services are Medically Necessary, and
(3) Your PMP referred You to the Non-Participating Provider.

The Non-Participating Provider must obtain written approval from US, in the form of a Prior Authorization,before You receive non-Emergency Health Services by a Non-Participating Provider. If Your Non-Participating Provider does not receive Prior Authorization, You will be responsible for all costs associated with those Health Services. Additional Health Services not authorized in the original request require a new authorization.

(B) National Committee for Quality Assurance (NCQA). Continuity of care with the Non-Participating Provider is required under current NCQA standards.

Section 6.6 Emergency Health Services. We will Cover Allowed Amounts for Emergency Health Services rendered by Participating or Non-Participating Providers. Such services must meet the requirements listed below.

(A) Provided during the course of the Emergency,
(B) Medically Necessary for evaluating and treating an Emergency condition, up to the point of Stabilization, and
(C) Provided by or under the direction of a Provider.

Health Services are not Covered if We determine that the situation was not an Emergency, as defined by this Contract.

Subsequent follow-up care by Non-Participating Providers after the condition is no longer an Emergency is not Covered without Our prior written approval.

Section 6.7 Inpatient Emergency Health Services by Non-Participating Providers. If [You are][an Enrollee is] hospitalized in a Non-Participating facility due to an Emergency, You must notify Us within 48 hours after Emergency Health Services are initially provided or as soon thereafter as is reasonably possible. You must make available full details of the Emergency Health Services received, at Our request.

Any continued stay in a Non-Participating facility after the condition is Stabilized and is no longer an Emergency (1) requires coordination by a Participating Provider, and (2) requires Our prior written authorization. We may elect to transfer You to a Participating Hospital once it is medically appropriate to do so.

Health Services rendered by Non-Participating Providers are not Covered if You (1) fail to notify Us within 48 hours of the initiation of Emergency Health Services or as soon as reasonably possible thereafter, or (2) choose to remain in a Non-Participating facility after We have notified You of the intent to transfer You to a Participating facility.

Section 6.8 Access to Health Services. Additional information on access to Health Services can be obtained through any means listed below.

(A) Our Participating Provider Directory.
(B) Our Enrollee newsletter.
(C) Our Customer Service Department at the number or website below.
1-855-417-5615www.mdwisemarketplace.org

Article 7

PROCEDURES FOR REIMBURSEMENT OF ALLOWED AMOUNTS

Section 7.1 Identification Card ("I.D. Card").

The Subscriber[, and spouse, if applicable,] will receive an I.D. Card. The I.D. Card will identify [any Dependents that are][each Dependent] Covered under the Contract. You may be charged a fee for additional or replacement cards.

Information on Your I.D. Card is needed for the Participating Provider to bill Us. *You must show Your I.D. Card every time You request Health Services[for an Enrolled Dependent]*. If You do not show the I.D. Card, Participating Providers have no way of knowing that [You are][the Dependent is] an Enrollee.

When failure to show an I.D. Card results in non-compliance with required procedures, Coverage may be denied.

Section 7.2 Participating Provider Services. We pay [Your] Participating Providers for [Your][an Enrollee's] Covered Health Services. You may be responsible for paying the Participating Provider for any applicable Copays, Coinsurance, or Deductibles included under this Contract. Please refer to the Schedule of Benefits for any applicable Deductible, Coinsurance or Copay information.

Section 7.3 Procedures for Health Services Received from Non-Participating Providers. If [You receive][an Enrollee receives] Health Services from a Non-Participating Provider, the rules below apply for claims submitted by You or by a Non-Participating Provider on Your behalf.

Claim Forms. You can locate Our claim forms on Our website, www.mdwisemarketplace.org, or You can notify us of a claim and We will mail You Our claim forms. If You do not receive Our usual claim forms within fifteen (15) days of this request, You may file a claim without them. The claims must contain written Claim Documentation.

Notice of Claim**.** You must inform Us of the claim within thirty (30) days of the date the Covered Health Service began or as soon as reasonably possible.

Claim Documentation. You must send Us written Claim Documentation within one hundred and eighty (180) days of the date the Covered Health Service began or as soon as reasonably possible. Claim Documentation furnished more than one (1) year late will not be accepted, unless You had no legal capacity in that year.

Cooperation By You. You or Your representative must fully cooperate with Us in determining Our rights and obligations under this Contract. You must cooperate as often as may be reasonably necessary. This means You or Your representative must do all of the following items, as requested.

(1) Sign, date and deliver to Us authorization to obtain any medical or other information, records, or documents We deem relevant from any person or entity.
(2) Give Us, or Our representatives, any medical or other information, records or documents We deem relevant.
(3) Answer, under oath or otherwise, any questions We deem relevant, which We or Our representative may ask.
(4) Furnish any other information, aid or assistance that We may require, including without limit, assistance in communicating with any person or entity (including requesting any person or entity to promptly give Us, or Our representative, any information, records or documents requested by Us).

If You or Your representative fails to give any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by Us unless and until We receive the item or information or You do the action We have requested, subject to the terms and conditions of this Contract.

In addition, failure on Your part or on the part of Your representative, to give Us any of the items or information requested or to take any action requested may result in the denial of Your claims.

Payment of Claims. Any payment made by Us in good faith under this Section shall fully discharge Our obligation to the extent of the payment. We reserve the right to deduct any overpayment made under this Contract from any future benefits payable under this Contract.

Foreign Claims Incurred for Emergency Care. Claims incurred outside the United States for Emergency Care and treatment must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper Claim Documentation.

Assignment. We will reimburse a Hospital or Provider if You assign in writing [Your][an Enrollee's] health insurance benefits, and We approve the assignment. Any assignment to a Hospital or Provider providing treatment, whether with or without Our approval, shall not confer upon such Hospital or Provider any right or privilege granted to You under this Contract except for the right to get benefits, if any, that We have determined are due and payable.

Physical Examination and Autopsy. We shall have the right and opportunity to examine [You][an Enrollee} while a claim is pending or while a dispute over a claim is pending. These examinations are made at Our expense and as often as We may reasonably require. We also have the right to have an autopsy made where the law does not prohibit it.

Legal Action. You may not bring any suit on a claim until at least sixty (60) days after the required Claim Documentation is given. You may not bring any suit more than three (3) years after the date Claim Documentation is required.

Section 7.4 Filing a Claim for Non-Participating Provider Services. If You need to file a claim under the procedures identified in Section 7.3, submit Your claim to the address below. The claim forms are available on our website, www.mdwisemarketplace.org.

MDwise, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

Be sure Your claim includes all of the information listed below.
(A) Your name and address.
(B) Patient's name, date of birth, and Enrollee I.D. number (shown on Your I.D. card).
(C) Name and address of the Non-Participating Provider of services.
(D) Diagnosis from the Provider.
(E) Bill which gives a CPT code, or description of each charge.
(F) Date the Injury or Sickness began.

Some claims may require more information before being processed. Benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

Section 7.5 Coverage through Non-custodial Parent. Whenever a Child under the age of 18 is an Enrolled Dependent under this Contract through a [Subscriber that is a] non-custodial parent, We shall, upon the custodial parent's written request do all of the following.

(A) Provide any information to the custodial parent that is necessary for the child to obtain benefits through this Contract.
(B) Permit the custodial parent, or the Provider with the custodial parent's approval, to submit claims for Covered Health Services without the non-custodial parent's approval.
(C) Pay claims submitted by the custodial parent or the Provider in accordance with (B) above, directly to the custodial parent or Provider.

Section 7.6 Payment of Claims. We shall pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for Your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. Claims submitted by Providers are also governed by Indiana Code § 27-13-36.2.

Article 8

GRIEVANCE PROCEDURES

Section 8.1 Who May File. You or Your Designated Representative may file any of the following.

(A) A Grievance.
(B) An Appeal.
(C) A request for an External Appeal.

In each of these review processes, Your notice to Us is considered to be filed on the date We first receive it orally or in writing.

Detailed information on how to submit all of the above may be found in this Contract, on Our website, in newsletters, and in medical management determination letters sent to Enrollees when a Health Service is denied. At least annually in a newsletter, We notify Enrollees about the Grievance and Appeal process and the availability of External Appeals.

Neither You nor Your Designated Representative will be subject to retaliation from Us for exercising Your rights to any of the review processes described in this Article. Also, We may not take any action against a Provider solely on the basis that the Provider represents You in any of the review processes described in this Article.

Section 8.2 Internal Grievance Procedure. The MDwise Customer Service Department is responsible for the processing of Grievances. All Grievances are thoroughly researched and documented, and as necessary, are referred for resolution beyond the Customer Services Department. You may file a Grievance in writing or by calling MDwise Customer Service directly and a Customer Service representative will assist You in filing the Grievance.

We must receive Your request to initiate the Grievance process within 180 days from the date We provide You an initial notice of denial. We will acknowledge Your Grievance, orally or in writing, within three business days of Our receipt of it.

In Your Grievance, You should express Your concerns in detail and provide copies of any supporting documents. You should provide us with the following information:

(A) Your Name [and the patient's name]
(B) [The patient's] Date of Birth
(C) Date of Grievance
(D) Type of Grievance
(E) Summary of the substance of the Grievance
(F) Summary of the actions taken.

We will document the substance of the Grievance and any actions taken.

You are permitted to review the Grievance claim file and to present evidence and testimony as part of the internal claims and appeals process.

The MDwise Customer Service Representative appointed to Your Grievance will conduct a thorough investigation of the facts of Your Grievance, including any aspects involving critical care, and make a decision regarding it. Other Providers or individuals We employ may be consulted before the decision is made.

Our decision regarding Your Grievance must be made as soon as possible. We will notify you in writing no later than

(A) 15 days after the date Your Grievance was filed, for a Pre-service Grievance, and
(B) 20 business days after Your Grievance is filed, for a Post-service Grievance,

when the issue is resolved and inform You of Your right to Appeal Our decision. If Your Grievance is considered an Urgent Grievance or Concurrent Care Claim, We will follow the timing requirements outlined in Sections 8.3 and 8.4 respectively.

If We are not able to make a decision by the applicable deadline due to reasons beyond Our control We will notify You in writing of the reason for the delay not more than 14 days after the date Your Grievance was filed, for a Pre-service Grievance, and not more than 19 business days after Your Grievance is filed, for a Post-service Grievance. We shall also issue You a written notification of the resolution of Your Grievance not more than 10 business days after notifying You of the reason for delay.

If We do not receive from You all of the information necessary to complete the review of Your Grievance, You will be afforded an extension of at least 45 days within which to provide Us with the specified information. We will resolve Your Grievance not more than 10 business days after We receive such necessary information.

We will provide You with any new or additional evidence considered, relied upon, or generated by Us in connection with the claim, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date. Before We issue a final decision based on a new or additional rationale, We will provide You with the rationale, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date.

If You are not satisfied with Our decision regarding Your Grievance, You have the right to file an Appeal with Us as set forth in Section 8.5 of this Contract.

Section 8.3 Urgent Grievance Procedure. If You are not satisfied with a decision We made either before or after You have filed a Grievance and Your situation meets the requirements of an Urgent Grievance, You have the right to use this Urgent Care procedure. Once identified as such, an Urgent Grievance will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

Your Urgent Grievance may be expressed to Us orally or in writing and should set forth all issues, comments, or other documented evidence that support it. We will treat Your Urgent Grievance pursuant to the procedure described in Section 8.2 and Section 8.4, except that We will shorten the time limits as follows.

We will acknowledge Your Urgent Grievance within 24 hours (and include any request for additional information, if appropriate).

We will decide Your Urgent Grievance as soon as possible, but no later than 72 hours after the receipt of the initial request for the Urgent Grievance. You will receive written or electronic notification of Our decision. We may notify You of Our decision orally, provided that a written or electronic notification is furnished to You no later than 3 days after the oral notification.

If You do not provide sufficient information for Us to determine whether or to what extent the benefits You seek are Covered or payable under the Contract, We will notify You within 24 hours of the specific information that You must submit for Us to answer Your Claim.

If You are notified that You need to provide additional information, You will have at least 48 hours in which to provide the additional information. We shall notify You of Our decision no later than 48 hours after We receive the requested information. If You do not provide the requested information, We shall notify You of Our decision no later than 48 hours after the end of the time that You were given to provide the information.

Section 8.4 Concurrent Care Procedure. If We reduce or terminate a Concurrent Care plan or course of treatment (other than by amending the Contract) before the end of the originally approved period of time or number of treatments, You will be notified sufficiently in advance of the reduction or termination to allow You to file a Grievance and Appeal of the decision before the benefit is reduced or terminated.

If Your request to extend a particular course of treatment beyond the period of time or number of treatments involves an Urgent Grievance,

(A) We will notify You of Our decision as soon as possible, taking into account the medical exigencies, and
(B) We will notify You of Our determination, whether adverse or not, within 24 hours of Our receipt of Your request, provided that Your request was made to Us at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Section 8.5 Internal Appeal Procedure. If You are not satisfied with Our decision regarding Your Grievance, You have the right to submit an Appeal to Us within 180 days of Our decision regarding Your Grievance. You may file an appeal in writing or You may call MDwise Customer Service directly and a Customer Service Representative will assist You in filing the Appeal. We will acknowledge Your Appeal, orally or in writing, within three business days of Our receipt of it.

We will continue to provide You with Coverage under this Contract pending the outcome of the Appeal.

You may request continuation of Health Services during the Appeal process if an authorized Health Service is being terminate, reduced or suspended before the expiration of the original authorization date. Pre-service authorization requests and re-authorization request after a number of approved number of days, services, or visits expired do not apply. In the event of request for Concurrent Care Claim reviews beyond original authorization, You and Your provider will be notified of the Appeals process, as indicated in Section 8.4.

We will document the substance of the Appeal and the actions taken.

Your representative may act on Your behalf with respect to requesting an Appeal and the procedures involved. We allow You the opportunity for representation by anyone You choose, including a provider or attorney. For Urgent Grievance Appeals, a health care practitioner with knowledge of Your condition may act as Your representative.

We will investigate the substance of the Appeal, including any aspects of clinical care involved.

Our Appeal Committee (the Committee) will resolve the Appeal. The Committee shall be comprised of qualified individuals who were not involved in the investigation or resolution of the Grievance or involved in the matters giving rise to it. If the Appeal concerns health care procedures, treatments, or services that have been proposed,

refused, or delivered, the Committee shall include one or more individuals who meet all of the following requirements

(A) Have knowledge of the Health Services at issue.
(B) Are in the same licensed profession as the Provider who proposed, refused or delivered the Health Service at issue.
(C) Are not involved in the matter giving rise to the appeal or the previous Grievance process.
(D) Do not have a direct business relationship with You or with the Provider who recommended the Health Service at issue.

You or Your Designated Representative may (A) appear in person before the Committee, or (B) communicate with the Committee through appropriate other means, if unable to attend in person.

You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

To support Your Appeal, You should submit to the Committee any written issues, arguments, comments, or other documented evidence. The Committee shall review all findings and pertinent documents, including any aspects of clinical care, whether or not We have considered them previously. The Committee will not afford any special deference to the original denial of Your Grievance. In no event shall Your claim that was previously denied under the terms of the Contract and upheld by an Appeals ruling be reconsidered by the Committee for review.

The Committee's decision regarding Your Appeal will be made as soon as possible and with regard to the clinical urgency of the Appeal, but not later than

(A) 30 days after the Appeal was filed, for Pre-Service Grievances.
(B) 45 days after the Appeal was filed, for Post-Service Grievances.

The Committee's decision regarding Your Appeal of an adverse benefit determination for an Urgent Grievance will be made not later than 72 hours after the receipt of Your request for review.

Section 8.6 External Review of Grievances. You may pursue an External Appeal if You are not satisfied with Our Appeal decision. An Independent Review Organization ("IRO") is available for Appeals that involve an Adverse Determination of the following:

(A) a Medically Necessary Service,
(B) a Utilization Review Determination, or
(C) the experimental or investigational nature of a proposed Health Service, or
(D) a decision to rescind Your Contract

If Your Appeal did not involve one of the above three areas, You are not entitled to an External Appeal. Requests for excluded benefits or exceeded benefits are not eligible for External Appeal. [Also, if You are a Medicare recipient and have a right to an external review under Medicare (42 U.S.C. 1395 *et seq.*, as amended from time to time), there is no right to request an External Appeal.]

If Your situation qualifies, You or Your representative must file a written request for an External Appeal with Us no later than 120 days after You receive notice of the Appeal decision.

You may not file more than one External Review appeal grievance.

You shall not be subject to retaliation for exercising Your right to an External Review.

You are permitted to utilize the assistance of other individuals, including providers, attorneys, friends, and family members throughout the External Review process.

You are permitted to submit additional information relating to the proposed Health Service as issue throughout the External Review process.

You are required to cooperate with the IRO by providing or authorizing the release of any necessary medical information that We have not already provided.

We shall cooperate with the selected IRO by promptly providing any information requested by the IRO.

You may request an Expedited Appeal if Your External Review is of a Grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize Your life or health, or Your ability to reach and maintain maximum function. If You request an Expedited Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 72 hours after Your Expedited Appeal is filed, and
(B) notify You within 24 hours of after making the determination.

If Your External Review is a Standard Grievance Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 15 business days after the Standard Grievance Appeal, and
(B) notify You within 72 hours of making the determination.

An Expedited External Review can occur concurrently with the Appeals process for Urgent Care and Concurrent Care Claims.

When making its determination, the IRO shall apply,

(A) standards of decision making that are based on objective clinical evidence, and
(B) the terms of Your Contract.

You shall not pay any of the costs associated with the services of an IRO. All of the costs must be paid by Us.

We shall notify You of the IRO's decision within 2 business days of receiving it, including the basis/rationale for the decision.

The IRO’s decision in an External Appeal is binding on Us, but You may have other legal remedies.

After You have received notification of the IRO’s determination regarding Your External Review, You may request the IRO provide You with all information reasonably necessary to enable You to understand the,

(A) effect of the determination on You, and
(B) manner in which We may be expected to response to the IRO’s determination.

We will authorize or provide disputed services promptly, and as expeditiously as Your health condition requires if the services were not furnished while the Appeal was pending and at any level reverses a decision to deny, limit or delay services.

Section 8.7. Suspension of the External Review Process. The External Appeal process will be suspended if the information You submit during the External Appeal is relevant to Our decision, and was not previously reviewed by Us during the Grievance or Appeal stages.

During the suspended External Review process, We will reconsider the new information You presented to Us and notify You of Our decision within the relevant timeframe listed below.

(A) 15 business days after the new information is provided to Us for a Standard Grievance Appeal, or
(B) 72 hours after the new information is provided to Us for an Expedited Appeal Grievance.

If We uphold the Grievance Appeal decision, You may request that the External Appeal resume.

Section 8.8 Contact Us. Questions regarding Your policy or Coverage should be directed to Our address, telephone number or website listed in this Section.

MDwise, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423
www.mdwisemarketplace.org
1-855-417-5615

Section 8.9 Indiana Department of Insurance. If You need the assistance of the governmental agency that regulates insurance, or have a complaint You have been unable to resolve with Your insurer, You may contact the Department of Insurance by mail, telephone or email the Indiana Department of Insurance at the contact information provided for in this Section.

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

Consumer Hotline – (800) 622-4461, (317) 232-2395

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

Section 8.10 Indiana Medical Malpractice Act. The review procedures described in this Article do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

Article 9

RENEWABILITY AND TERMINATION

Section 9.1 Renewability and Termination of Contract. We must renew or continue in force this Contract at Your option. We may terminate or refuse to renew this Contract only for the following reasons.

(A) Non-payment of premium, subject to the notice and Grace Periods defined in this Contract.
(B) We rescind coverage based upon fraud or an intentional misrepresentation of material fact made by You under the terms of the Contract.
(C) We receive a written request from You to terminate this Contract as provided in Section 9.6.
(D) [We receive notice from the Exchange that] [You][all Enrolled Dependents] are no longer eligible for coverage [under this Contract][through the Exchange].
(E) You obtain coverage from another [Qualified Health Plan through the Exchange][health plan] during an Open Enrollment period or a Special Enrollment period.
(F) [Our status as a Qualified Health Plan for the Exchange is terminated by the Exchange.]
(G) You no longer reside or live in Our Service Area.
(H) Death [of the Subscriber].

Section 9.2 Discontinuance of a Particular Type of Contract. We may discontinue a particular contract if We do all of the following.

(A) We provide You with written notice at least 90 days before the date the contract form will be discontinued.
(B) We offer You the option to purchase any other individual contract We currently offer.
(C) We act uniformly without regard to any health status-related factor of Enrollees or [Dependents of Enrollees] that may become eligible for Coverage.

Section 9.3 Discontinuance of All Coverage. We may discontinue all contracts in the individual market in Indiana if We do all of the following.

(A) We provide You and the Indiana Department of Insurance with written notice at least 180 days before the date Your Coverage will expire.
(B) We discontinue and do not renew all Contracts We issue or deliver for issuance in the State of Indiana in the individual market.
(C) We act uniformly without regard to any health status-related factor of Enrollees or Dependents of Enrollees that may become eligible for Coverage.

Section 9.4 Exception for Uniform Modification of Coverage. We may, at the time of renewal, modify this Contract if the modification is consistent with the laws of the state of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

Section 9.5. Notice and Effective Date of Termination. We shall provide You with written notice of our intent to terminate or not renew this Contract. This notice will identify the date upon which Your Coverage will cease. This date will be referred to as the "Effective Date of Termination".

Our notice to the Subscriber shall be deemed as notice to [the Subscriber's Enrolled Dependents][each Enrolled Dependent] and is sufficient if mailed to the Subscriber's address as it appears in Our records. Notice is effective when deposited in the United States mail with first class postage prepaid.

Termination of this Contract shall not prejudice any claim for Health Services rendered before the Effective Date of Termination. All requests for reimbursement, however, must be furnished as provided in Article 7.

Section 9.6 Process for Termination of Coverage By Written Request of Subscriber. You may terminate this Contract or Coverage for an Enrollee under this Contract with reasonable notice to [the Exchange or] Us. Reasonable notice is defined as fourteen (14) days prior to the requested Effective Date of Termination.

If You provide reasonable notice, the Effective Date of Termination is the date specified in Your notice. If You do not provide reasonable notice, the Effective Date of Termination is fourteen (14) days after We receive Your termination request, or an earlier date specified by Us if we are able to effectuate termination in fewer than fourteen (14) days.

If an Enrollee is newly eligible for Medicaid, the Children's Health Insurance Program for the state of Indiana, or the Basic Health Plan for state of Indiana (if such a plan is implemented), the Effective Date of Termination is the day before such coverage begins.

Section 9.7 Process for Termination of Coverage [Due to Loss of Eligibility].

(A) [Process for Termination of Coverage] When the [Enrolled Dependent] [Subscriber] is No Longer Eligible for Coverage [Under this Contract][Through the Exchange]. In the case of termination due to a [Subscriber][an Enrolled Dependent] no longer being eligible for Coverage [under this Contract][through the Exchange], the Effective Termination Date is the last day of the month following the month in which [the Subscriber loses eligibility][notice is sent to Us by the Exchange], unless the [Subscriber][Enrolled Dependent] requests an earlier Effective Termination Date.

(B) [Process for Termination of Coverage When a Dependent is No Longer Eligible Under the Contract. In the case of termination due to a Dependent no longer being eligible for Coverage under this Contract, the Effective Termination Date is the last day of the month following the day in which the Dependent loses eligibility.]

Section 9.8 Process for Termination of Coverage Due to Non-Payment of Premiums. In the case of termination due to non-payment of premiums by a Subscriber subject to the general Grace Period identified in Section 5.3 of this Contract, the Effective Date of Termination will be the earliest date of the last paid date of Coverage if (1) the Grace

Period expires and any Premiums remain unpaid, or (2) We receive written notice of termination from the Subscriber during the Grace period

[In the case of termination due to non-payment of premiums by a Subscriber subject to the 3-month Grace Period identified in Section 5.4 of this Contract, the Effective Date of Termination will be on the last day of the first month of the three-month Grace Period. The [Subscriber][Enrolled Dependent] will receive notice of termination of Coverage no later than thirty (30) days prior to this Effective Date of Termination.]

Section 9.9 Process for Termination of Coverage When the [Subscriber][Enrolled Dependent] Changes to Another [Qualified Health Plan][Health Plan] During an Open Enrollment Period or Special Enrollment Period. In the case of termination due to a [Subscriber][Enrolled Dependent] changing to another [Qualified Health Plan][health plan] during an Open Enrollment period or Special Enrollment period, the Effective Date of Termination under the Contract shall be the day before the Effective Date of coverage in the [Subscriber's][Dependent's] new [Qualified Health Plan][health plan].

Section 9.10 Continued Inpatient Hospital Benefits. We will continue inpatient Hospital benefits for [a Covered Person][an Enrollee] if (1) We terminate this Contract, and (2) [the Covered Person][an Enrollee is hospitalized for a medical or surgical condition on the Effective Date of Termination. Such continued benefits shall end on the earliest of the dates specified in (A) through (E) below.

(A) The date [the Covered Person][an Enrollee] is discharged from the Hospital.
(B) The date [the Covered Person][an Enrollee] is covered under other health coverage if that coverage covers the inpatient hospital benefits.
(C) Sixty (60) days after the date this Contract ends.
(D) The last day the required Premium has been paid, if the grace period expires and the Subscriber has not made the required payment.
(E) The date the Subscriber terminates Coverage for the Subscriber and any Enrolled Dependents.

This section does not apply if this Contract ends due to Our receivership.

[Section 9.11. Extended Coverage for Disabled Children. Coverage for a Child may continue beyond age 26 if all of the following factors exist.

(A) The Child is incapable of self-sustaining employment due to a mental or physical disability.
(B) The Child is primarily dependent upon the Subscriber for support and maintenance.
(C) We receive written proof of such incapacity and dependency from a Participating Provider, that is acceptable to Us, within 120 days of the Child reaching the age of 26.

This extended Coverage will continue so long as the Child remains so incapacitated and dependent, unless Coverage is otherwise ended by the terms of this Contract.

We may require proof from a Participating Provider that is satisfactory to Us of the Child's continued incapacity and dependency.]

Section 9.12 Reinstatement. If [Your][this] Contract was terminated for non-payment of Premium, You may request reinstatement of the Contract from [Us][the Exchange] within 30 days of the Effective Date of Termination. You must remit all premium that was due for the Coverage upon reinstatement. Upon receipt of the outstanding Premium [and notice from the Exchange][or Us,] We will reinstate Coverage as of the Effective Date of Termination.

Article 10

RECOVERY SOURCE/SUBROGATION

Section 10.1 Recovery Source. The following persons or entities are collectively referred to as a Recovery Source

or Recovery Sources.

(A) Any person alleged to have caused the Enrollee to suffer Sickness, Injuries or damages,
(B) The employer of the Enrollee, or
(C) Any person or entity obligated to provide benefits or payments to the Enrollee. This includes, but is not limited to, underinsured or uninsured motorist protection and liability insurance.

Section 10.2 Recovery. An amount owed by a Recovery Source pursuant to a settlement, judgment, or otherwise.

Section 10.3 Our Rights to Reimbursement, Recovery, and Subrogation. If You obtain a Recovery from a Recovery Source for a Sickness or Injury or other condition for which You have received Health Services, then We will not Cover such Health Services to the extent of such recovery. However, if We Covered such Health Services the conditions listed below apply.

(A) You shall reimburse Us immediately from a collected Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) Other costs incurred in obtaining or collecting the Recovery,

  regardless of whether or not that collected amount fully compensates You.
(B) For a Recovery not yet collected, You grant to Us a first priority lien against such Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) other costs incurred in obtaining and eventually collecting the Recovery,

  regardless of whether or not the Recovery fully compensates You. We may give notice of such lien to the Recovery Source. You also assign to Us any benefits that You may have under any car insurance policy or other sources in order to enforce Our rights under this Article.
(C) We are subrogated to Your rights to seek a Recovery from a Recovery Source under any legal or equitable theory that You could assert against that Recovery Source. At Our option, We may bring a lawsuit against the Recovery Source in Your name or take, in Our sole discretion, such other necessary and appropriate action to preserve or enforce Our rights under this Article.
(D) You grant to Us a first priority lien against any Recovery We obtain under this subsection, whether or not You are fully compensated by the Recovery, to the extent of 100% of the Covered Health Services and Our reasonable costs, including attorneys fees, of pursuing and collecting the Recovery.

All Recoveries will be deemed as compensation for Covered Health Services regardless of how the Enrollee or the Enrollee's legal representative defines it.

We shall be responsible only for those legal fees and expenses relative to Your Recovery to which We agree in writing.

If the Sick or Injured Enrollee is a minor, any Recovery shall be subject to this Article to the extent permitted by applicable law, regardless of whether such Enrollee's parent, trustee, guardian, or other representative has access to or control of the Recovery.

The Enrollee agrees that acceptance of Covered Health Services is constructive notice of this Article in its entirety and constitutes full consent to it.

Section 10.4 Your Full Cooperation Required. In order to protect Our rights under this Article, You shall cooperate by doing all of the actions listed below.

(A) Hold any collected Recovery in trust for Our benefit under this Article.
(B) Notify Us of a claim or suit against a Recovery Source within 60 days of the action and of a proposed settlement at least 30 days before it is entered. You shall not, without Our written approval, accept any settlement that does not fully compensate or reimburse Us. If You fail to notify Us in accordance with this section, We shall not be obligated to cover the Health Services that provide a basis for the claim, suit or settlement.
(C) Execute and deliver such documents as We may reasonably request including, but not limited to, documents to protect and perfect Our liens, to affect an assignment of benefits, and to release records.
(D) Provide Us, or any party acting on Our behalf, any facts We need to subrogate the claim in a timely

manner, but not more than one year after Our initial request for information or You will be responsible for any incurred claims.

(E) Provide such other cooperation and information as We may reasonably request including, but not limited to, responding to requests for information about an accident, Sickness or Injuries and making court appearances.

(F) Not prejudice Our rights.

Article 11

Coordination of Benefits

Section 11.1 Applicability. This Coordination of Benefit ("COB") section applies when an Enrollee has Coverage for Health Services under more than one "Plan," as defined below. The Order of Benefit Rules in Section 11.3 determines whether the benefits of this Contract are determined before or after those of another Plan. If the Order of Benefit Rules determines that this Contract is the "Primary Plan," as defined below, then the benefits of this Contract will not be reduced. If the Order of Benefit Rules determines that this Contract is the "Secondary Plan," as defined below, then the benefits of this Contract may be reduced.

Section 11.2 Definitions. The following definitions apply throughout this Article 11, but do not apply to the rest of the Contract:

(A) "**Allowable Expense**" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(B) "**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this COB provision or a similar provision takes effect.

(C) "**Plan**" means this Contract and any of the following arrangements that provide benefits or services for, or because of, medical or dental care or treatment:

(1) Employer insurance or Employer-type coverage, whether insured or uninsured. This includes prepayment, Employer practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

(3) Each arrangement described in (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(D) "**Plan Year**" means, for the initial Plan Year, the twelve-month period commencing with the date that Employer's coverage under this Contract becomes effective. Thereafter, it means the twelve-month period commencing on the anniversary of Employer's Coverage under this Contract.

(E) "**Primary**" or "**Primary Plan**" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If this Contract is Primary to another Plan, this Contract's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(F) "**Secondary**" or "**Secondary Plan**" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If this Contract is Secondary to another Plan, this Contract's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

Section 11.3 Order of Benefit Rules.

General. If there is a basis for benefits under this Contract and another Plan, this Contract is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those of this Contract, and (2) the rules of this Contract and the other Plan require this Contract to be the Primary Plan.

Specific Rules. The following rules will be applied in the order they appear to determine whether this Contract is Primary or Secondary to another Plan:

(1) Non-Dependent or Dependent. The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) Dependent Child or Parents not Separated or Divorced. If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(3) Dependent Child or Separated or Divorced. If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:
   a. the Plan of the parent with custody of the Child is Primary;
   b. the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and
   c. the Plan of the parent without custody of the child is the last Plan to be Primary.

   If a QMCSO states that a parent is responsible for the health care expense of a child, that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(4) Joint Custody. If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph (2), Dependent Child or Parents not Separated or Divorced will apply.

(5) Active or Inactive Employee. A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(6) Dependent of Active or Inactive Employee. A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-

off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) Continuation Coverage. If an individual has Continuation Coverage under this Contract and also has coverage under another Plan as an employee or dependent, the other Plan is Primary to this Contract. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) Longer or Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

Section 11.4 Effect on the Benefits of this Contract. Section 11.4 applies when the Order of Benefit Rules in Section 11.3 determine that this Contract is Secondary to one or more other Plans.

This Contract's benefits will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under this Contract in the absence of this COB provision; and
(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of COB provisions like this Contract's COB provisions, whether or not a claim is made.

The benefits of this Contract will be reduced so that they and the benefits payable under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this Contract.

Section 11.5 Facility of Payment. If another Plan provides a benefit that should have been paid or provided under this Contract, We may reimburse the Plan for the benefit. We may then treat the amount as if it were a benefit provided under this Contract and will not be responsible for providing that benefit again. This provision applies to the payment of benefits as well as to providing services. If services are provided, then We will reimburse the other Plan for the reasonable cash value of those services.

Section 11.6 Right of Recovery. If this Contract provides a benefit that exceeds the amount of benefit it should have provided under the terms of these COB provisions, We may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following.
(1) The individuals We have paid or for whom We have provided the benefit;
(2) Insurance Companies; or
(3) Other Organizations.

Article 12

GENERAL PROVISIONS

Section 12.1 Entire Contract. The Contract, the Appendix, and any Amendments make up the entire Contract of Coverage between You and Us.

All statements made by the Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce Coverage under this Contract or be used in defense of a legal action unless it is contained in the Application.

Section 12.2 Limitation of Action. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought unless brought within 3 years from the date the cause of action first arose.

[The Enrollee's][Your] damages shall be limited to recovery of actual benefits due under the terms of this Contract. [The Enrollee waives][You waive] any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

Section 12.3 Amendments and Alterations. No agent has authority to change this Contract or to waive any of its provisions. No person has authority to make oral changes to this Contract.

We will give You 60 days advance notice before any material modifications to this policy, including changes in preventive benefits.

Section 12.4 Relationship Between Parties. The relationships between MDwise and Participating Providers are ***solely*** contractual relationships between a payor (MDwise) and independent contractors (Participating Providers). Non-Participating Providers have no contractual relationship with Us, nor are they Our independent contractors.

Providers are not Our agents or employees. We and Our employees are not employees or agents of Providers.

The relationship between a Provider and any Enrollee is that of Provider and patient. The Provider is ***solely*** responsible for the services provided to any Enrollee. The Participating Pharmacy is ***solely*** responsible for the pharmacy services provided to any Enrollee.

Section 12.5 Second Opinion Policy. A second opinion may be required at Our discretion prior to the scheduling of certain Health Services. We will advise You if a proposed Health Service is subject to the second opinion policy. If so, You must consult with a second Participating Provider prior to the scheduling of the service.

You must (1) contact Us to obtain a list of Participating Providers who are authorized to render a second opinion, and (2) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider.

You must obtain the second opinion within 31 days of the first opinion or as soon thereafter as is reasonably possible. Second opinions We have arranged as described above are provided at no cost to You.

A second opinion may also be obtained at the request of an Enrollee, subject to separate benefit restrictions and/or Copays/Coinsurance described elsewhere in this Contract.

Section 12.6 Wellness and Cost Containment Programs. We may implement wellness or cost containment programs for Enrollees. Such programs may Cover services and supplies that would not otherwise be Covered. Such programs are in Our sole discretion. They may be discontinued at any time without prior approval from other parties.

Section 12.7 Confidentiality of Non-Public Personal Information. As required by the Gramm-Leach-Bliley Financial Services Modernization Act of 1999, We provide You with notice that We protect the nonpublic personal information that We receive about You and Your Dependents. We obtain certain nonpublic information about You through this Contract. This includes information from You on Applications or other forms, and information about Your transactions with Us, Our affiliates, or others. We have always been committed to maintaining the confidentiality of Your information and we take the following steps to protect our nonpublic personal information

(A) We restrict access to information to authorize individuals who need to know this information in order to provide services and products to You or relating to Your Contract.
(B) We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard Your information.
(C) We do not disclose this information about You or any former customers, except as permitted by law.
(D) We make disclosures to affiliates, as applicable, as permitted by law.

Section 12.8 Confidentiality of Medical Information

By accepting Coverage, You authorize and direct any person or institution that has attended, examined, or treated You to furnish Us any and all related information and records. Such must be provided to Us at any reasonable time,

upon Our request.

We and Our designees have the right to any and all records concerning Health Services as necessary to accomplish any of action listed below.

(A) To implement and administer the terms of this Contract,
(B) For appropriate medical review or other quality assessment, or
(C) For purposes of health care research.

Any information We obtain that pertains to Your diagnosis, treatment or health is confidential. We shall not disclose such information to any person except to fulfill Our obligations as described above, or as required by state or federal law.

Examples of when We may release such information as required by law are listed below.

(A) Upon Your express written consent.
(B) When a Child under the age of 18 is an Enrolled Dependent through a custodial parent, non-custodial parent, step-parent or legal guardian, except when the minor child has lawfully obtained Covered Health Services without the consent or notification of a parent or legal guardian.
(C) Under a statute or court order for the protection of evidence or the discovery of evidence, in the event of litigation between You and MDwise in which the information is pertinent.

We may claim any legal right against disclosure of the information that the Provider who supplied it may claim.

Section 12.9 Records. The Subscriber shall furnish Us with all information and proof that We may reasonably require with regard to any matters pertaining to this Contract.

The following items shall be open for Our inspection at any reasonable time (1) all documents furnished by an Enrollee in connection with the Coverage, and (2) any other records pertinent to Coverage under this Contract.

Both MDwise and Participating Providers may charge You reasonable fees to cover costs for completing medical abstracts or for other forms which You request.

Section 12.10 Examination of Enrollees. We may reasonably require that You be examined if a question or dispute about the provision of or payment for Health Services arises. The exam will be performed by a Participating Provider acceptable to Us. We will pay for the exam.

Section 12.11 Typographical or Administrative Error. Typographical or administrative errors shall not deprive an Enrollee of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

Section 12.12 Right of Recovery. If We pay for Health Services or benefits that, according to the terms of the Contract, should not have been paid, We reserve the right to recover such amounts from [You}[an Enrollee], the Provider to whom they have been paid, or any other appropriate party.

Section 12.13 Notice. Our notice to the Subscriber is deemed notice to all Enrolled Dependents. Such notice includes notice of termination of this Contract.

Our notice is sufficient if mailed to the Subscriber's address shown in Our records at the time of the mailing. Notice is deemed delivered when deposited in the United States mail with first class postage prepaid, unless otherwise stated in this Contract.

Any notice from You concerning this Contract must be sent to Our address listed in this Section.

MDwise, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

Section 12.14 Contract is Not Worker's Comp Insurance. The Coverage provided under the Contract does not replace, supplement or provide a substitute for benefits to which an Enrollee is entitled under worker's comp, occupational disease, and similar laws.

The Contract does not Cover Health Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's comp, occupational disease and similar laws, even when the circumstances below are present.

(A) If the Enrollee's employer is not properly insured or self-insured under such laws.
(B) When an Enrollee refuses to use his or her employer's designated Provider.
(C) When an Enrollee has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

An Enrollee must contact his employer or its worker's comp or occupational disease insurer for the provision or payment of such Health Services and expenses.

Section 12.15 Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on its Effective Date shall apply.

Any Contract provision which, on this Contract's Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

Section 12.16 Non-Discrimination. In compliance with state and federal law, We shall not discriminate on the basis of age, gender, color, race, disability, marital status, sexual preference, religious affiliation, or public assistance status.

We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care.

We shall not, with respect to any person and based upon any health factor or the results of Genetic Screening or Testing (1) refuse to issue or renew Coverage, (2) cancel Coverage, (3) limit benefits, or (4) charge a different Premium.

Section 12.17 General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within Our control (1) We will Cover Health Services as provided in this Contract to the extent that facilities and personnel are then available, and (2) We shall have no liability or obligation for delay or failure to provide Health Services due to lack of available facilities or personnel.

[Section 12.18 Medicare. Any Health Services Covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare, We will calculate benefits as if they had enrolled.

The benefits under this Contract for Enrollees age 65 and older or Enrollees otherwise eligible for Medicare do not duplicate any benefit for which Enrollees are entitled under Medicare, except when federal law requires Us to be the primary payor.

Where Medicare is the primary payor, all sums payable by Medicare for Health Services provided to Enrollees shall be reimbursed by or on behalf of the Enrollees to Us to the extent We have made payment for such Health Services.]

MDwise [BENEFIT PLAN] Schedule of Benefits

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copays, maximums and other limits that apply when You receive Covered Health Services from a Provider. Please refer to the "Benefits and Covered Health Services" article of this Contract for a more complete explanation of the specific Health Services Covered by the Contract. All Covered Health Services are subject to the conditions, exclusions, limitations, terms and provisions of this Contract including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Enrollee's responsibility for Covered Health Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Health Services must be provided by a Participating Provider. Services provided by Non-Participating providers are Not Covered and the cost of services will be Your responsibility unless otherwise specified in this Contract.

Coinsurance and Deductibles, as well as any maximums, are calculated based upon the Allowed Amount, not the Provider's charge.

Under certain circumstances, if We pay the Provider amounts that are Your responsibility, such as Deductibles, Copays or Coinsurance, We will collect such amounts directly from the Provider who will in turn collect them from you. You agree that the Provider has the right to collect such amounts from You.

Essential Health Benefits provided within this Contract are not subject to lifetime or annual dollar limitations. Certain non-Essential Health Benefits, however, may be subject to either lifetime and/or annual dollar limitations.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories.

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services and chronic disease management, and
- Pediatric vision services.

Such benefits shall be consistent with those set forth under the ACA and any regulations issued pursuant thereto.

BENEFIT PERIOD – Calendar Year
DEPENDENT AGE LIMIT – Until the Child attains age 26
CONTRACT SERVICE AREA: _____

MDWISE MARKETPLACE [BENEFIT PLAN]

DEDUCTIBLE		
	Tier 1	**Tier 2**
Per Enrollee	[$0-$5,500]	[$0-$6,600]
Per Family	[$0-$11,000]	[$0-$13,200]

The amounts paid toward the Tier 1 Deductible are concurrent with and apply toward the Tier 2 Deductible. The Deductible applies to all Covered Health Services except for office visits for primary care physicians and all specialist visits, Generic drugs, and preventive care. Copays do not apply toward the Deductible. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Deductible.

OUT-OF-POCKET LIMIT		
	Tier 1	**Tier 2**
Per Enrollee	[$0-$6,600]	[$0-$6,600]
Per Family	[$0-$13,200]	[$0-$13,200]

The Out-of-Pocket Limit includes all Deductibles, Copays and Coinsurance amounts You incur in a Benefit Period. The amounts paid toward the Tier 1 Out-of-Pocket Limit are concurrent with and apply toward the Tier 2 Out-of-Pocket Limit. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Out-of-Pocket Limit. Once the Enrollee and/or family Out-of-Pocket Limit is satisfied, no additional Copays/Coinsurance will be required for the Enrollee and/or family for the remainder of the Benefit Period.

Any amounts that You are responsible for paying for Health Services rendered by a Non-Participating Provider are separate from and do not apply to the Deductible and Out-of-Pocket Limits.

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Ambulance Services	[$0-$500]Copay Per Transport	[$0-$500] Copay Per Transport	$200 Copay per transport
Behavioral Health Services			
Inpatient Services	[0%-35%]Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Outpatient Services	[$0-$90] Copay per visit	[$0-$150] Copay per visit	Not Covered without Prior Authorization
Physician Home Visits & Office Services	[$0-$90] Copay per v$isit	[$0-$150] Copay per visit	Not Covered without Prior Authorization
Dental Services (only when related to accidental injury or for certain Enrollees requiring general anesthesia)	[$0-$750] Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	[$0-$750] Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Diabetic Equipment, Education, & Supplies	Copays / Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the "Specialty Care" or "Primary Care Provider" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.		Not Covered without Prior Authorization
Diagnostic Services			
Laboratory and Pathology Services	[$0-$75] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Radiology Services including MRI, CT, PET, Ultrasound	[$0-$300] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$400] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
X-Ray Services	[$0-$75] Copay per visit Copays/Coinsurance may change based on setting where the	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
	Covered Health Services are received.	where the Covered Health Services are received.	
Emergency Room Services Copay/Coinsurance is waived if You are admitted.	[$0-$750] Copay per visit	[$0-$750] Copay per visit	[$0-$750] Copay per visit
Home Care Services	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Annual Visit Limitation for Home Care	90 visits, combined Tier 1 and Tier 2 Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 90 visits
Annual Visit Limitation for Private-Duty Nursing	82 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 82 visits

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Lifetime Visit Limitation for Private-Duty Nursing	164 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 164 visits
Hospice Services	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Inpatient and Outpatient Professional Services	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Inpatient Facility Services	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Annual Limitation for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2 combined limitation of 60 days
Annual Limitation for Skilled Nursing Facility	90 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2 combined

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			limitation of 90 days.
Mammograms (Outpatient – Diagnostic & Routine)	For Mammogram Health Services recommended by the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF, see the "Preventive Care Services" provision in this Schedule. For all other Mammogram Health Services, see the "Diagnostic Services" provision in this Schedule.		Not Covered without Prior Authorization
Maternity Services	Copays/Coinsurance may change based on setting where the Covered Health Services are received.		Not Covered without Prior Authorization
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Participating Pharmacy)	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
	Note – Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are Covered the same as any other Medically Necessary items and Health Services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract. **Note –** If durable medical equipment or appliances are obtained through Your Primary Care Physician or another Participating Physician's office, Urgent Care Center Services, Outpatient Services, Home Care Services the Copay/Coinsurance listed above will apply		

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
	in addition to the Copay/Coinsurance in the setting where Covered Services are received.		
Outpatient Services			
Other Outpatient Services	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
	Note – Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copay/Coinsurance regardless of setting where Covered Services are received.		
Outpatient Surgery Hospital/Alternative Care Facility	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization
Physician Home Visits and Office Services			
Primary Medical Provider (PMP)	$0 Copay per visit PMP visits are not subject to the Deductible	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any Provider that is not Your chosen (or assigned) PMP is	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any Provider that is

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
		considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.	not Your chosen (or assigned) PMP is considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.
Specialty Care Physician (SCP)	[$0-$90] Copay per visit	[$0-$150] Copay per visit	Not Covered without Prior Authorization
	Note – Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations Covered under "Preventive Care Services" in the Contract) received in a Physician's office are subject to the Other Outpatient Services Copay / Coinsurance.		
Allergy Services	[$0-$90] Copay if visit	[$0-$150] Copay if visit	Not Covered without Prior Authorization
	[0%-35%] Coinsurance for Serum	[0%-50%] Coinsurance for Serum	Not Covered without Prior Authorization
	Coinsurance will be applied to allergy serum when the injection(s) is billed by itself. The office visit Copay will apply if an office visit is billed with an allergy injection. No Copay if injection administered by a nurse.		
Preventive Care Services	No Copay	No Copay	Not Covered without Prior Authorization
Surgical Services	[0%-35%] Coinsurance	[0%-50%] Coinsurance	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Therapy Services	[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
	Note – If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.		
Annual Visit Limitation			
Physical Therapy (Limits apply separately to	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
Rehabilitative and Habilitative Services)			Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Occupational Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Speech Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Manipulation Therapy	12 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			combined limitation of 12 visits
Cardiac Rehabilitation	36 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 36 visits
Pulmonary Rehabilitation	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Urgent Care Center Services	[$0-$100] Copay per visit	[$0-$200] Copay per visit	Not Covered without Prior Authorization
Pediatric Vision			
Pediatric Eyewear	No Copay	Not Available	Not Covered without Prior Authorization
Lenses	Limit 1 pair per year.	Not Available	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Frame	Limit 1 per year from Pediatric Exchange collection.	Not Available	Not Covered without Prior Authorization
Contact Lenses	• Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) • Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) • Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) • Dailies (one month supply) = 30 lenses per eye (total 60 lenses)	Not Available	Not Covered without Prior Authorization

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following.

- **Cornea and kidney transplants, and**
- **Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Enrollee cost shares.

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES		
	Participating Transplant Provider	**Non-Participating Transplant Provider**
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (the number of days will vary depending on the type of transplant received and the Participating Transplant Provider Agreement. Contact the Transplant Case Manager for specific Participating Transplant Provider information) for services received at or coordinated by a Participating Transplant Provider Facility.	Starts one day prior to Covered Transplant Procedure and continues to the date of discharge.
Deductible	Not applicable.	Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will not apply to Your Out-of-Pocket Limit.
Covered Transplant Procedure During The Transplant Benefit Period	During the Transplant Benefit Period, No Copay/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and	During the Transplant Benefit Period, You will pay 50% of the Allowed Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Participating Transplant Provider Facility will not apply to Your Out-of-Pocket Limit.

	Office Services depending where the service is performed.	If the Provider is Non-Participating Provider for this Contract, You will be responsible for the Covered Health Services which exceed Our Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
	Participating Transplant Provider Professional and Ancillary (non-Hospital) Providers	**Non-Participating Transplant Provider Professional and Ancillary (non-Hospital) Providers**
Covered Transplant Procedure During the Transplant Benefit Period	No Copay/Coinsurance up to the Allowed Amount.	You are responsible for 50% of the Allowed Amount. These charges will not apply to Your Out-of-Pocket Limit.
Transportation and Lodging	[0%-35%] coinsurance Covered, as approved by the Contract, up to a $10,000 benefit limit	Not Covered for Transplants received at a Non-Participating Transplant Provider Facility
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	[0%-35%] Coinsurance Covered, as approved by the Contract, up to a $30,000 benefit limit	Covered, as approved by the Contract, up to a $30,000 benefit limit. You will be responsible for 50% of search charges. These charges will not apply to Your Out-of-Pocket Limit.
Live Donor Health Services	Covered as determined by the Contract.	Covered as determined by the Contract. These

		charges will not apply to Your Out-of-Pocket Limit.

PRESCRIPTION DRUGS	
Days Supply Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limitation and Utilization Guidelines	
Retail Pharmacy (Participating & Non-Participating)	30
Mail Service	90
Tier 4 Drugs	30* *Some Tier 4 drugs may be available in 90 day supply via mail service.
Participating Retail Pharmacy Prescription Drug Copay/Coinsurance	
Tier 1Prescription Drugs	[$0-$30] Copay per Prescription Order Tier 1 drugs are not subject to the Deductible
Tier 2Prescription Drugs	[$0-$85] Copay per Prescription Order Tier 2 drugs are not subject to the Deductible.
Tier 3 Prescription Drugs	[0%-35%] Coinsurance per Prescription Order
Tier 4 Prescription Drugs	[0%-35%] Coinsurance per Prescription Order; See Participating Retail/Specialty Mail Service Information below.
Non-Participating Retail Pharmacy and Non-Participating Pharmacy Prescription Drug Copay	
Non-Participating Retail Pharmacy and Non-Participating Pharmacy Prescription Drug Copay	Not Covered without Prior Authorization
Orally Administered Cancer Chemotherapy	
Orally Administered Cancer Chemotherapy	[0%-35%] Coinsurance for retail; [0%-35%] Coinsurance for mail order As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to Coverage for cancer chemotherapy that is administered intravenously or by injection.

Note – Prescription Drugs will always be dispensed as ordered by Your Physician. You may request, or Your Physician may order, the Tier 2 or Tier 3 Drug. However, if a Tier 1 Drug is available, You will be responsible for the difference in the cost between the Tier 1 Drug and Tier 2 or Tier 3 Drug. If a Tier 1 Drug is not available, or if Your Physician writes "Dispense as Written" or “Do not Substitute” on Your Prescription, You will be required to pay the applicable Tier 2 or Tier 3 Copay/Coinsurance. You will not be charged the difference in cost between the Tier 1 Drug and Tier 2 or Tier 3 Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in Our sole discretion, to remove certain higher cost Generic Drugs from this policy.

Note – No Copay/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Allowed Amount when obtained from a Participating Pharmacy. These supplies are Covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Participating Pharmacy. Diabetic test strips are Covered subject to applicable Prescription Drug Copay/Coinsurance.]

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[Individual/Child-Only/On/Off Exchange] Contract

(Herein called this Contract)

issued by

[MDwise, Inc.][MDwise Marketplace, Inc.]
P.O. Box 441423
Indianapolis, Indiana 46244-1423

An Indiana Not-for-Profit Health Maintenance Organization

AGREEMENT AND CONSIDERATION

[MDwise Marketplace Plan]

[MDwise, Inc.][MDwise Marketplace, Inc.] (herein referred to as MDwise, We, Us, and Our) has issued a Contract to You [to provide coverage for a Dependent]. Persons Covered under this Contract are considered to be Enrollees of MDwise. [This Contract provides Coverage only for Enrolled Dependents. The Subscriber is never Covered under this Contract.]

This Contract sets forth in detail [Your][the] rights and obligations [of the Subscriber and Dependent] as [an][the] Enrollee. It is important that You **READ THIS CONTRACT CAREFULLY.** You should familiarize Yourself with its terms and conditions before receiving Health Services.

This Contract is made in consideration of the [Subscriber's][Enrollee's] Application [submitted through the Exchange] and payment of the required Premium. The [Subscriber's][Enrollee's] Application is made a part of this Contract by this reference.

This Contract shall take effect on the date specified below. This Contract will be continued in force by the payment of the required Premium when due, subject to the termination provisions of this Contract. We shall fund all benefits payable under this Contract.

This Contract is delivered in and governed by the laws of the State of Indiana. All Coverage under this Contract shall begin at 12:00 midnight and end at 11:59:59 p.m. Eastern Standard Time.

Information regarding this Contract may be obtained by contacting Us at: [1-855-417-5615 or www.MDwisemarketplace.org]. If the Enrollee has material modifications or questions related to their health insurance coverage, contact the [Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596].

Authorized Representative

TEN-DAY FREE LOOK

The Subscriber has the right to examine this Contract for 10 days from the date You received the Contract. If, for any reason, the Subscriber does not want this Contract, he or she may return it to Us within 10 days from the date You received the Contract. The Contract will be deemed delivered when deposited in the United States mail with first class postage prepaid, or when it is personally delivered, to the address shown above. Upon return, this Contract will be deemed void and any Premium will be refunded. Any Health Services received during this 10-day period are solely the responsibility of the Subscriber if the Contract is deemed void. In making this decision, You should review the enrollment date restrictions of the Open Enrollment to identify any conditions for enrolling in a different Qualified Health Plan.

[DISCLAIMER: The ACA includes provisions to lower premiums and reduce cost-sharing for individuals with low to modest incomes through Advance Payment Premium Tax Credits and Cost-Sharing Reductions. Such affordability programs are available only for health insurance coverage issued through the Indiana Marketplace. Please be advised that this Contract does not qualify for these affordability programs because it is not issued through the Indiana Marketplace.]

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FOREWORD

Introduction

The [Subscriber and] Enrolled Dependents, [if any], are Enrollees of MDwise. [You][Enrollees] will be Covered as provided by this [Individual][Child-Only] Contract. (Referred to herein as this Contract.)

This Contract replaces and supersedes any Contract that We may have previously issued to the Subscriber [or Enrollee]. This Contract is an individual product and is not subject to the Employee Retirement Income Security Act of 1974, as amended.

How To Use This Contract

This Contract must be read in its entirety for a clear meaning. Many of its provisions are interrelated. You may get a false impression if You read just one or two provisions.

Certain terms used in this Contract are defined. Defined terms will be capitalized in this Contract. The meaning of defined terms should be taken into account in interpreting this Contract.

This Contract may be amended from time to time. When that happens, We will send You a new Contract or Amendment pages for this Contract. Keep this Contract in a safe place for Your future reference.

Obtaining Health Services

As an Enrollee You must obtain Health Services directly from Participating Providers. The only exceptions are those listed below.

(A) Emergency Health Services, and
(B) Health Services that meet all 3 requirements below:
~~a.~~(1) are not available through Participating Providers~~,~~
~~b.~~(2) have been recommended by a Participating Provider, and
~~c.~~(3) We have approved in advance ~~in writing~~ through written ~~p~~Prior ~~a~~Authorization.

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You are responsible for verifying the participation status of a Provider before receiving Health Services.

If You fail to check a Provider's participation status as required and as a result use a Non-Participating Provider (1) the Health Services, other than Emergency Services, will not be Covered, and (2) You will be responsible for paying for such services.

The participation status of a Provider may change from time to time. So it is important that You check the status each time before receiving Health Services.

We can give You the information You need in order to locate a Participating Provider. You can verify a Provider's participation status by contacting Us or by referencing Our provider directory at www.mdwisemarketplace.org.

~~In the event We require You to receive Health Services through a single Participating Provider, We will notify You in writing of the termination of that single Participating Provider, any other Participating Provider seen by You in the previous year, and any hospital.~~

Except for Emergency Health Services, Your ~~p~~Provider is ~~are~~ responsible for obtaining a ~~written Referral~~ ~~p~~Prior ~~a~~Authorization before receiving any Health Services from a Non-Participating Provider. A ~~Referral~~ ~~p~~Prior ~~a~~Authorization to a Non-Participating Provider must be initiated in writing by ~~a Participating~~that Provider and approved in writing by Us prior to the time of the service. ***Your providers failure to obtain the required ~~Referral~~ ~~p~~Prior ~~a~~Authorization will result in the Health Services not being Covered. You will be responsible for paying for such services. It is your responsibility to confirm that the appropriate authorization was obtained prior to services.***

Coverage for some Health Services is subject to Our prior written approval. Non participating and Participating Providers are responsible for obtaining Our Prior Authorization for such services on Your behalf.

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Contact Us

Your satisfaction as an Enrollee is very important to Us. Please contact Us if You have a question or concern about Your Coverage or procedures You must follow. You can reach Our Customer Service Department during normal business hours at [1-855-417-5615, or www.MDwisemarketplace.org.]

Article 1

DEFINITIONS

This Article defines the terms used throughout this Contract. It is not intended to set forth Covered or Non-Covered Health Services.

"Adverse Benefit Determination" – a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Enrollee's eligibility to participate in the Contract, as well as any rescission of Coverage under this Contract or any decision to deny Coverage in an initial eligibility determination.

"Allowed Amount" – Reasonable and Customary Charges for Health Services incurred while Coverage is in effect.

"Affordable Care Act" or "ACA" - the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.

"Alternate Facility" - a Non-Hospital health care facility that, pursuant to the law of the jurisdiction in which treatment is received provides one of the following.

A. One (1) or more of the following on an outpatient basis surgical services, Emergency Health Services, rehab services, lab services, diagnostic services, or
B. Provides on an inpatient or outpatient basis Behavioral Health and Mental Health Services or Chemical Dependency Services, if Covered under the Contract.

An Alternate Facility may include an attachment to a Hospital but does not include a Provider's office.

"Appeal"- an oral or written request for Us to change Our decision regarding a Grievance or a claims dispute.

"Autism Spectrum Disorder" - a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Health and Mental Health" - a physical or behavioral condition having an emotional or psychological origin or effect. Behavioral Health and Mental Health includes behavioral or emotional disorders as well as chemical dependency.

"Brand Name Drug" - a prescription drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

"CMS" - the Centers for Medicare and Medicaid Services.

"Calendar Year" - January 1 through December 31 of any given year.

"Chemical Dependency" - alcoholism and chemical or drug dependency.

"Child" – child of the Subscriber or Subscriber's spouse, including the following listed below.

1) Natural child,
2) Stepchild,
3) Legally adopted child,
4) Child placed for the purpose of adoption, or
5) Child placed under legal guardianship or legal custody.

"CHIP" – the Children's Health Insurance Program, as implemented by the Federal Balanced Budget Act of 1997.

"Claim Documentation" – information required by Us to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, Explanation Of Benefit (EOB)/Explanation Of Payment (EOP) medical bills or records, other Contract information, and network repricing information.

"Coinsurance" - a percentage of the Allowed Amount that You must pay for certain covered Health Services. (See also Copay.)

"Confinement" and **"Confined"** - an uninterrupted stay following formal admission to a Hospital, Inpatient Transitional Care Unit, or Alternate Facility. Confinement and Confined refer to inpatient care.

"Contract" – this Contract that includes the Application [of the Subscriber][for Coverage] and any ~~A~~amendments to this Contract signed by Our executive officer. Such items constitute the entire agreement regarding the benefits, exclusions and other conditions between MDwise and the Subscriber.

"Contract Month" - calendar month.

"Copays" or **"Copay"** - a dollar amount that You must pay directly to a Provider for certain Covered Health Services. Such dollar amount is in addition to the Premium. (See also Coinsurance.)

"Cosmetic Procedures" - procedures that improve physical appearance but do not correct or materially improve a physical function. Cosmetic Procedures include, but are not limited to, drug treatment, plastic surgery, and nutritional procedures and treatments.

"Cover" - pay for Health Services to the extent they are Covered under this Contract.

"Coverage" or **"Covered"** - Your right to payment for Health Services, subject to the terms, conditions, limitations and exclusions of this Contract.

"Covered Person" or **"Enrollee"** - the Subscriber or an Enrolled Dependent, but only while the person is Covered under this Contract. References to You and Your throughout this Contract are references to a Covered Person or Enrollee.

"Custodial Care"- Non-health-related services such as assistance in activities of daily living or health-related services that do not seek to cure, are provided when the medical condition of the Enrollee is not changing, and do not require administration by skilled, licensed medical personnel.

"Deductible" - the amount an Enrollee must pay in a Calendar Year for Covered Health Services before We will pay. Copays do not apply toward the Deductible. Coinsurance does apply toward the Deductible.

"Delivery System" - a defined group of Participating Providers, linked through a contract to each Delivery System, which supply a full range of Health Services. The Delivery System contracts with Us to provide Health Services to Enrollees who have selected the Delivery System for providing and coordinating all Covered Health Services.

Your PMP's Delivery System will be Your Delivery System. Your Delivery System may be referred to throughout this Contract as "Tier 1" and the Delivery System that is not Your Delivery System, may be referred to as "Tier 2."

"Dental Care" - all services provided by or under the direction of a Dentist. Such services include preventive care and all other care of the teeth and the surrounding tissues, correction of a faulty meeting of the teeth, and surgical procedures that involve the hard or soft tissues of the mouth.

"Dentist" - any Provider, D.D.S., or medical dentistry, D.M.D., who is duly licensed and qualified to provide Dental Care under the laws of the jurisdiction in which treatment is received.

"Dependent" - a person who is [either the Subscriber's legal spouse or] a Child until he or she attains age [26][21].

"Designated Representative"- an individual You have appointed to assist or represent You with a Grievance, Appeal or External Appeal. This person may include, but not be limited to Providers, attorneys, friends or family members. You must identify Your Designated Representative to Us in writing in order to prevent the disclosure of Your medical information to unauthorized persons.

"Designated Transplant Facility" - a Hospital or Alternate Facility that has entered into an agreement with or on Our behalf to render Health Services for Covered transplants. The facility may or may not be located within Our Service Area.

"Durable Medical Equipment" or "DME" - medical equipment that meets the following requirements.

(A) Can withstand repeated use and is not disposable,
(B) Is used to serve a medical purpose,
(C) Is generally not useful to a person in the absence of a Sickness or Injury,
(D) Is appropriate for use in the home, and
(E) Is the most cost-effective type of medical apparatus appropriate for the condition.

"Effective Date"- the date when Your Coverage begins under this Contract.

"Effective Date of Termination" - the date when Your Coverage ends under this Contract.

"Eligible [Subscriber][Dependent]" – an individual who satisfies the eligibility requirements to enroll as a [Subscriber][Dependent], as set forth in Article 2 of this Contract.

"Emergency" - a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to do any of the following.

(A) Place an Enrollee's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(B) Result in serious impairment to the Enrollee's bodily functions, or
(C) Result in serious dysfunction of a bodily organ or part of the Enrollee.

"Enrolled Dependent"[or "Enrollee"] – a Dependent who is enrolled for Coverage under this Contract.

"Enrollee" – a person who is enrolled for coverage under this Contract.

"Essential Health Benefits" – those benefits identified by CMS as Essential Health Benefits and included in the benchmark plan identified by the state of Indiana.

"Experimental, Investigational or Unproven" - services, treatments, supplies, drugs, devices or procedures We have determined to be any one or more of the following at the time a Coverage determination for any particular case is made.

(A) Considered by any government agency or subdivision or the CMS Medicare Coverage Issues Manual to be experimental, investigational, not reasonable and necessary, or any similar finding. Government agencies and subdivisions include, but are not limited to the U.S. Food and Drug Administration and the Agency for Healthcare Research and Quality.
(B) Not covered under Medicare reimbursement laws, regulations, or interpretations, on the basis that such are experimental, investigational, unproven, not reasonable and necessary, or any similar finding.
(C) Not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use.
(D) Not identified as appropriate for the proposed use in the American Hospital Formulary Service, the U.S. Pharmacopoeia Dispensing Information, or the American Medical Drug Evaluations.
(E) Subject to review and approval by any institutional review board for the proposed use.
(F) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the U.S. Food and Drug Administration regulations (regardless of whether the trial is actually subject to U.S. Food and Drug Administration oversight).

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(G) Not demonstrated through prevailing peer reviewed medical literature to be safe and effective for treating or diagnosing the condition for which it is proposed.

Determinations regarding whether a particular service, treatment, supply, drug, device or procedure is considered to be Experimental, Investigational or Unproven are made by Our Medical Director under Our procedural guidelines.

"External Appeal" - a voluntary Appeal process in which an Internal Review Organization reviews certain Appeal decisions We made and determines whether to uphold or reverse them.

"FDA" - the United States Food and Drug Administration.

[**"Federally Facilitated Exchange" or "Exchange"** - the health benefit exchange established by the Affordable Care Act for the state of Indiana. You can reach the Exchange at the following toll free number, email, website or mailing address.

Health Insurance Marketplace
200 Independence Ave. SW
Washington, DC 20201
www.healthcare.gov
1-800-318-2596]

"Formulary" - a list of Prescription Drugs that We prefer for dispensing to Enrollees. We will review and change the list from time to time.

"Genetic Screening or Testing" - a laboratory test that is a direct test of a person's genes or chromosomes to detect abnormalities or defects.

"Grace Period" - applicable period of time identified in Sections 5.~~3~~4 and 5.~~4~~5

"Grievance" - an oral or written complaint submitted in accordance with Our formal Grievance procedure by the Enrollee or on behalf of the Enrollee regarding any aspect of Our organization relating to the Enrollee.

"Health Services" - medical or health care services, whether or not Covered under this Contract, which include but are not limited to medical evaluation, diagnosis, treatments, procedures, drugs, therapies, devices, and supplies.

"Home Health Care Services" - Health Services provided by a Home Health Agency authorized to provide such services under the law of the jurisdiction in which treatment is received.

"Hospice Care Agency" - an agency or organization that meets all of the requirements listed below.

(A) Is certified to render Hospice Care,
(B) provides twenty-four hour care, seven days a week,
(C) is under the direct supervision of a Participating Provider, and
(D) maintains written records of the services provided.

"Hospice Care or Services" - a program of care that meets all of the requirements listed below.

(A) Is provided by a licensed Hospice Care Agency,
(B) focuses on palliative rather than curative treatment, and
(C) provides supportive measures to an Enrollee with a prognosis of less than six months to live.

"Hospice Facility"– a facility that is licensed and operated in accordance with the law of jurisdiction in which treatment is received, and provides twenty-four (24) hour nursing services.

"Hospital" - an institution that meets all of the requirements listed below.

(A) Is operated under the law,
(B) is primarily engaged in providing Health Services on an inpatient basis,
(C) provides for the care and treatment of injured or sick people,
(D) has medical, diagnostic and surgical facilities,

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(E) is operated by or under the supervision of a staff of Providers,
(F) has 24-hour nursing services, and
(G) is licensed as a Hospital in the jurisdiction in which it operates.

A Hospital is not primarily a place for rest, Custodial Care, or care of the aged. A Hospital is not an Inpatient Transitional Care Unit, nursing home, convalescent home or similar institution.

"Independent Review Organization or IRO" - an organization certified by the Indiana Department of Insurance to conduct External Appeals.

"Maternity Services" – all Health Services related to Pregnancy including all of the following listed below.
(A) Prenatal and postnatal care, including newborn hearing test,
(B) childbirth, and
(C) early termination of Pregnancy.

"MDwise" - MDwise, Inc. references to We, Us, and Our throughout this Contract are references to MDwise.

"Medicaid" - Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs, as amended from time to time.

"Medical Director" - a licensed Provider of medicine or osteopathy appointed by Us to provide medical review of Health Services proposed or rendered for Enrollees.

"Medically Necessary" - Health Services that We have determined to be ***all*** of the following listed below.
(1)(A) Medically appropriate and necessary to meet the Enrollee's basic health needs,
(2)(B) the most cost-effective method of treatment and rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Health Service,
(3)(C) consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and healthcare coverage organizations and governmental agencies,
(4)(D) accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered at a frequency and duration considered by the medical community as medically appropriate,
(5)(E) required for reasons other than the comfort or convenience of the Enrollee or his or her Provider,
(6)(F) of a demonstrated medical value in treating the condition of the Enrollee, and
(7)(G) consistent with patterns of care found in established managed care environments for treatment of the particular health condition.

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The definition of Medically Necessary used in this Contract relates only to Coverage, and may differ from the way in which a Provider engaged in the practice of medicine may define Medically Necessary.

The fact that a Provider has performed or prescribed a Health Service does not mean that it is Medically Necessary. Nor does the fact that a particular Health Service may be the only option available for a particular condition mean that it is Medically Necessary. We retain the right to make all final decisions as to which Health Services are or were Medically Necessary, subject to the procedures specified in this Contract.

"Medicare" – the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended from time to time.

"Non-Covered" – those Health Services not Covered under the terms of this Contract.

"Non-Restorative Condition" - a condition where You will not (1) return to the state You were in prior to an Injury or an illness, or (2) achieve a state or perform a function(s) that never existed.

"Non-Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has not entered into an agreement with Your Delivery System or one of Our Delivery Systems.

"Open Enrollment" - an annual period [set by the Exchange] during which individuals eligible to enroll [in Qualified Health Plans] may enroll [in a Qualified Health Plan or may change Qualified Health Plans][in this Contract].

"Orthotic" - an appliance or apparatus used to support, align, or correct deformities or to improve the function of movable parts of the body, such as but not limited to braces or splints.

"Out-of-Pocket Limit" - the maximum amounts of Coinsurance and Copays an Enrollee must pay each Calendar Year for Covered Health Services. Once this limit is met, Coinsurance or Copays for such Services are not required for the rest of that Calendar Year. Amounts paid for Coinsurance, Copays and the Deductibles apply toward the Out-of Pocket Limit.

"Participating Pharmacy" - a pharmacy that has entered into an agreement with Us, or our Pharmacy Benefits Manager, to provide Prescription Drug services to Enrollees, and includes any subcontractors of such Participating Pharmacy

"Participating Provider" - a Physician, specialist, Hospital, laboratory, health care service provider, or other institution to who/which has entered into an agreement with Your Delivery System or one of Our Delivery Systems, and includes any subcontractors of such Participating Providers.

Participating Providers within Your Delivery System are considered Tier 1 Participating Providers. Participating Providers that are not in Your Delivery System, but that are in one of Our Delivery Systems are considered Tier 2 Participating Providers.

"Physician" - a license medical provider, holding an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) degree.

"Post-service Grievance~~Claim~~" - any Grievance that involves Health Services that have already been provided.

"Premium" - the fee ~~w~~We charge for each [Subscriber and] Enrolled Dependent Covered under this Contract. The Premium is paid in consideration for the benefits and services provided by Us under this Contract.

"Prescription Drug" - a drug that has been approved by the FDA, and under federal or state law can only be dispensed with a prescription. These are known as legend drugs. Prescription Drugs also include insulin, diabetic supplies, and inhaler aid devices.

"Pre-service Grievance~~Claim~~" - a Grievance that must be decided before an Enrollee can obtain Health Services Covered under the Contract.

"Primary Medical Provider" or **"PMP"** – a Participating Provider in Your Delivery System practicing and duly licensed as a Physician in family practice, internal medicine, gynecology, obstetrics, or pediatrics, and who has agreed to assume primary responsibility for Your medical care under this Contract.

"Preauthorization" - the process of obtaining approval from Us that a Health Service, treatment plan, Prescription Drug, or DME is medically necessary prior to those services being rendered. "Preauthorization" may also be referred to as "Prior Authorization."

"Provider" - a Doctor, Hospital, Inpatient Transitional Care Unit, Home Health Care Agency, pharmacy, or other health care institution or practitioner licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

[**"Qualified Health Plan" -** a health plan offered on the Exchange that satisfies the requirements set forth under the ACA (42 U.S.C. 18021(a)(1)).]

"Reasonable and Customary Charge" - the amount paid for a Health Service in a geographic area based on what

Providers in the area usually charge for the same or similar Health Service.

"Reconstructive Surgery" - any surgery incidental to any of the following listed below.

(A) An injury,
(B) A Sickness, or
(C) Congenital defects and birth abnormalities.

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Reconstructive Surgery for congenital defects and birth abnormalities includes but is not limited to orthodontic and oral surgery involved in the management of cleft lip and cleft palate for an Enrollee.

Reconstructive Surgery includes the following reconstruction for a Covered mastectomy (1) all stages of reconstruction of the breast on which the mastectomy has been performed, and (2) surgery and reconstruction of the other breast to produce symmetry, in the manner determined by the attending Provider and the Enrollee to be appropriate, subject to the provisions of this Contract.

"Routine Care Costs" - the cost of Medically Necessary services related to the care method that is under evaluation in a clinical trial. The term does not include any of the following listed below.

(A) The health care service, item, or investigational drug that is the subject of the clinical trial.
(B) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
(C) Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
(D) An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
(E) Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where a clinical trial is conducted.
(F) A service, item, or drug that is provided by a clinical trial sponsor free of charge for any new patient.
(G) A service, item, or drug that is eligible for reimbursement from a source other than an enrollee's individual contract or group contract, including the sponsor of the clinical trial.

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"Routine Immunization" - an immunization administered to the age-appropriate general population and recommended by the (A) Centers for Disease Control and Prevention (CDC), (B) American Academy of Pediatrics, and (C) American Academy of Family Physicians.

"Semi-private Room" - a room with two or more beds in a Hospital, an Approved Inpatient Transitional Care Unit, or an Alternate Facility.

"Service Area" - the geographic area We serve, as defined in the Schedule of Benefits. For this product the "Service Area" may not include Our licensed Service Area in its entirety, as approved by the Indiana Department of Insurance.

"Skilled Nursing Care" - services from licensed nurses in Your own home or in a nursing home.

"Special Enrollment" - periods during which individuals eligible to enroll [under this Contract][in Qualified Health Plans] may enroll in [a Qualified Health Plan, or may change Qualified Health Plans][in this Contract], as a result of triggering events provided in Section 2.5 [and as determined by the Exchange].

~~**"Specialty Pharmacy"** - a Participating Pharmacy that has entered into an agreement with Us to provide Specialty Drug services to Enrollees.~~

"Stabilize" - to provide Health Services to an Enrollee in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the Enrollee's condition is not likely to occur.

This includes Emergency Health Services provided to an Enrollee in a Hospital's care setting throughout or during the following discharge, transfer to another health care facility, or transfer to the Hospital's inpatient setting.

"Subscriber" - an individual whose name is on the Contract and [is][has] enrolled [an Eligible Dependent] for

Coverage under this Contract. [The term Subscriber does not include Enrolled Dependents][A Subscriber is the legal parent or legal guardian of the Enrolled Dependent. A Subscriber does not have Coverage under this Contract].

"Urgent Care" - the treatment of an unexpected Sickness or Injury that is not life or limb threatening but requires prompt medical attention.

"Urgent Care Center" - a licensed medical service center that provides Urgent Care.

"Urgent ~~Care~~ Grievance~~Claim~~" - a request for a Health Service that, if subject to the time limits applicable to Post-service ~~Claims~~ Grievances or Pre-Service ~~Claims~~ Grievances would do either of the following.

(A) Would seriously jeopardize Your life, health or ability to reach and maintain maximum function, or

(B) In the opinion of physicians familiar with Your condition, would subject You to severe pain that cannot be adequately managed unless We approve the Claim.

Once identified as such, an Urgent ~~Care Claim~~ Grievance will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

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Article 2

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Section 2.1 Eligibility of [the Subscriber] and Dependents. To be eligible to enroll as a [Subscriber\[Dependent], You must be all of the following listed below.

(A) Under age [65][21].
(B) Residing in Our Service Area.
(C) A legal resident of Indiana.
(D) Not eligible for or enrolled in Medicare, Medicaid or CHIP.
(E) Not covered by any other group or individual health benefit plan.
(F) [Eligible for Coverage on the Exchange]
~~(D)~~(G) [Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective].
~~(E)~~(H) ~~Not eligible for or enrolled in Medicare, Medicaid or CHIP.~~

[To be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the Exchange application completed by the Subscriber, and meet the definition of Dependent as well as all Dependent eligibility criteria established under this Contract and by the Exchange.]

We shall not require any person to submit to Genetic Screening or Testing, or use the results of such in determining eligibility for enrollment, inquire as to the results of Genetic Screening or Testing, or make an adverse decision against any person based on such results.

Section 2.2 Pre-Existing Conditions and Nondiscrimination. No Eligible Subscriber or Dependent will be refused enrollment based on health~~,~~ status, health care needs, expected length of life, quality of life, genetic information, previous medical information, disability or age.

Section 2.3 Enrollment and Effective Date for Coverage. Sections 2.4 through 2.5~~6~~ provide information on how [an Eligible] Subscriber may enroll [an Eligible Dependent] in this Contract during the applicable enrollment periods [set by the Exchange] and the Effective Dates for Coverage for such enrollments. Regardless of how [an Eligible] Subscriber enrolls [an Eligible Dependent] in this Contract, enrollment is subject to Our receiving initial payment of Premium. No Coverage shall be Effective before this Contract takes effect. No Dependent shall be Covered until [You are Covered][enrolled for Coverage].

The Effective Date of this Contract is stated on Page 1.

~~**Section 2.4 Initial Open Enrollment and Effective Date for Coverage.** This Section 2.4 explains how an Eligible Subscriber enrolls for Coverage during the initial Open Enrollment period set by the Exchange and sets forth the Effective Date for Coverage for such enrollment.~~

~~**(A) Enrollment during Initial Open Enrollment.** The initial Open Enrollment period begins October 1, 2013 and extends through March 31, 2014. An Eligible Subscriber can enroll for Coverage by submitting a completed application to the Exchange during the initial Open Enrollment period. The Exchange will notify Us of Your selection and transmit to Us all of the information necessary to enroll You for Coverage. If We do not receive the initial selection during initial Open Enrollment, the person can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.~~

~~If a person qualifies as a Dependent but does not enroll when the Eligible Subscriber first applies for enrollment, the Dependents can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.~~

~~As stated in Section 2.1, to be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the application completed by the Subscriber and submitted to the Exchange, and meet all Dependent eligibility criteria established by Us.~~

~~(B) **Effective Date for Coverage for Initial Open Enrollment.** The Effective Date for Coverage for You and Your Enrolled Dependents, if any, is determined by the date the Exchange receives Your selection according to the applicable timeframes listed below.~~

~~(A) If the selection is received by the Exchange before December 15, 2013, the Effective Date for Coverage will be January 1, 2014.~~

~~(B) If the selection is received by the Exchange between the first and the fifteenth day of January, February, or March during the initial Open Enrollment period, the Effective Date for Coverage will be of the first day of the following month.~~

~~(C) If the selection is received by the Exchange between the sixteenth and the last day of December, January, February or March during the initial Open Enrollment period, the Effective Date for Coverage will be the first day of the second following month.~~

Section 2.4~~5~~ Annual Open Enrollment and Effective Date for Coverage. This Section 2.~~5~~4 explains how an Eligible Subscriber enrolls[an Eligible Dependent] for Coverage during the Open Enrollment periods [set by the Exchange] ~~after the initial Open Enrollment period~~ and sets forth the Effective Date for Coverage for such enrollment.

(A) Enrollment during Open Enrollment. During an Open Enrollment period, an Eligible Subscriber can enroll for Coverage by submitting a completed application to [Us}[the Exchange] during Open Enrollment. [The Exchange will notify Us of Your selection and transmit to Us all of the information necessary to enroll You for Coverage.] If We do not receive the selection during Open Enrollment, the eligible person can only enroll for Coverage during the next Open Enrollment period or during a Special Enrollment period, whichever is applicable.

[If a person qualifies as a Dependent but does not enroll when the Eligible Subscriber first applies for enrollment, the Dependents can only enroll for Coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.]

[As stated in Section 2.1, to be eligible for Coverage and to enroll as a Dependent, the Dependent must be listed on the application completed by the Subscriber and submitted to [Us][the Exchange], and meet all Dependent eligibility criteria established by Us.]

(B) Effective Dates for Coverage during Annual Open Enrollment. For applications received during any annual Open Enrollment period, Coverage will be effective [according to the dates listed below][on the

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date identified by the Exchange].

(1) If the selection is received by [Us][the Exchange] between the first and the fifteenth day of the ~~January, February, or March during the initial~~ Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or ~~of~~ the first day of the following month.

~~(1)~~(2) If the selection is received by [Us][the Exchange] between the sixteenth and the last day of ~~December, January, February or March during~~ the ~~initial~~ Open Enrollment month/period, the Effective Date for Coverage will be the latter of January 1 or the first day of the second following month.

Section 2.5~~6~~ Special Enrollment and Effective Date for Coverage. This Section 2.5~~6~~ explains how an Eligible Subscriber may enroll for Coverage during a Special Enrollment period [set by the Exchange] and sets forth the Effective Date for Coverage for such enrollment.

Special Enrollment period Effective Dates for Coverage depend on the type of event, the date of request for a special enrollment period, and the date of plan selection. [CMS][We] will determine enrollee eligibility for all special enrollment periods.

[For additional information on Special Enrollment period set by the Exchange and how to enroll in or change Qualified Health Plans during a Special Enrollment period, You may contact the Exchange at [1-800-318-2596] or visit the Exchange website at [www.healthcare.gov.]

(A) [Special Enrollment Triggering Events.

(1) Loss of Minimum Essential Coverage.

(2) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.

(3) Obtaining status as a United States citizen, national, or lawfully present individual.

(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.

(5) Violation of a Qualified Health Plan of a material provision of its contract.

(6) Newly eligible or ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(7) Relocation to a new service area of the Exchange.

(8) An Indian, as defined in Section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.

(9) Demonstration to the Exchange, in accordance with the guidelines established by the United States Department of Health and Human Services, that You or Your Dependent satisfy other exceptional circumstances provided by the Exchange.

(10) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

(A) [Special Enrollment Triggering Events.

(1) Involuntary loss of Minimum Essential Coverage for any reason other than fraud, failure to pay Premium, or misrepresentation of material fact.

(2) Loss of Minimum Essential Coverage due to dissolution of marriage.

(3) Gaining or becoming a Dependent through marriage, birth, adoption, or placement for adoption.

(4) Enrollment or non-enrollment in a Qualified Health Plan was unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or the United States Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Exchange. In such instances, the Exchange may take action as may be necessary to correct or eliminate the effects of such errors, misrepresentations, or inactions.

(5) Violation of a Qualified Health Plan of a material provision of its contract.

(6) Newly ineligible for advance payments of the premium tax credit or cost-sharing reductions.

(7) Relocation to a new service area of the Exchange.

(8) The Exchange determines that enrollment or non-enrollment in a Qualified Health Plan, or an incorrect determination of ineligibility for advance payments of the premium tax credit or cost-sharing reductions was the result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. (For purposes of this provision, misconduct includes, but is not limited to failure on the part of the non-Exchange entity to comply with all applicable state or federal standards, as determined by the Exchange.]

~~(A)~~(B) **New Dependents as a Result of Marriage or Loss of Essential Minimum Coverage.** If [You have][the Subscriber has] a new Dependent as a result of marriage, or due to [Your][the] Dependent's loss of essential minimum coverage, [You][the Subscriber] may elect to enroll [Your][the new] Dependent in this Contract, provided [You request][the Subscriber requests] enrollment within 60 days of the date of marriage or loss of essential minimum coverage. The Effective Date for Coverage will be on the first day of the month following the date of marriage or loss of essential minimum coverage. If We receive [an application form][notification from the Exchange] to add [Your][the new] Dependent more than 60 days after this qualifying event, We will not be able to enroll that person until the next Open Enrollment period.

(C) **New Dependents as a Result of Birth, Adoption, or Placement for Adoption.** If You have a new Dependent as a result of birth, adoption, or placement for adoption, Your new Dependent will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption or placement for adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for Your Dependent beyond 31 days, provided You submit [an application form to Us][a form through the Exchange] to add Your Dependent to the Contract and pay the required premium. The form must be submitted to [Us][the Exchange] within 60 days after the date of birth or adoption. If the form is not submitted to [us][the Exchange] within 60 days after the date of birth or adoption, Coverage will cease on the expiration of the 31 day period provided above.

[If an Enrolled Dependent has a child as a result of birth, adoption, or placement for adoption, the Enrolled Dependent's child will be Covered for an initial period of 31 days from the date of birth or adoption. The Effective Date for Coverage will be upon the earlier of the date of birth, adoption, or placement for adoption or date of entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue for the Enrolled Dependent's child beyond 31 days, provided: (1) the child is placed under legal guardianship or legal custody of the Subscriber or the Subscriber's spouse and the child otherwise satisfies the eligibility requirements to enroll as a Dependent as set forth in this Article 2; (2) the Subscriber submits a form [to Us][through the Exchange] to add the child to the Contract within 60 days after the date of birth or adoptions; and (3) the Subscriber pays the required premium.]

~~(B)~~(D) **[CHIP.** Eligible Dependents may also enroll under either of the two additional circumstances identified in (1) and (2).

(1) The Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility.

(2) The Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

You must request Special Enrollment for Your Dependent within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive notification to add Your Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, We will not be able to enroll that person until the next Open Enrollment period.]

~~(C)~~(E) **Other Qualifying Events.** For all other Special Enrollment qualifying events[identified by the Exchange], the Effective Date for Coverage for [You and Your] Enrolled Dependents, [if any], is determined based on the date [We receive][the Exchange] receives Your selection according to the applicable timeframes listed below.

(1) If the selection is received [by Us] [by the Exchange] between the first and the fifteenth day of the month, the Effective Date for Coverage will be of the first day of the following month.

(2) If the selection is received by [Us}][the Exchange] between the sixteenth and the last day of the month, the Effective Date for Coverage will be of the first day of the second following month.

Section 2.6~~7~~ Notify Us [or the Exchange] of Eligibility Changes. The Subscriber is responsible for notifying Us [or the Exchange] in writing of any change in eligibility that affects [the Subscriber or the][any] Enrolled Dependents. We [or the Exchange] must be notified no later than 30 days from the date of the event. We have the right to bill the Subscriber for the cost of any Health Services We have paid during the period of time the person was not enrolled under the Contract.

A change in the eligibility [of the Enrolled Dependent] may be any of the following listed below.

~~(D)~~(A) [A determination of ineligibility made by the Exchange.]

~~(E)~~(B) [Any change with respect to the eligibility standards specified by the Exchange for which You are required to notify the Exchange.]

~~(F)~~(C) Address change.

~~(G)~~(D) [Marriage.

~~(H)~~(E) Divorce.]

~~(I)~~(F) Death.

~~(J)~~(G) [Birth of a Dependent].

~~(K)~~(H) [Change in disability status of a Dependent.]

~~(L)~~(I) Dependent Child] is no longer eligible because they have reached the limiting age.

Section 2.~~8~~7 Service Area Requirements. [Subscribers][Dependents] must live in Our Service Area. ~~Covered Health Services must be received from a Participating Provider, except for (A) Emergency Health Services, or (B) Referral Prior Authorized Health Services.~~

Article 3

BENEFITS AND COVERED HEALTH SERVICES

Subject to the Exclusions sets forth in this Contract and the terms and conditions of this Contract, We will Cover the following Medically Necessary Health Services [for an Enrolled Dependent].

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copay, and Benefit Limitation information.

You are responsible for any fees incurred for Non-Covered Health Services.

Section 3. 1 Ambulance Services. Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians, paramedics, or other certified medical professionals from or between any of the following listed below.

- From Your home, scene of accident or medical Emergency to a Hospital,
- Between Hospitals,
- Between a Hospital and Skilled Nursing Facility, or
- From a Hospital or Skilled Nursing Facility to Your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when You are not transported will be Covered if Medically Necessary.

Ambulance services are a Covered Health Service only when Medically Necessary, except when ordered by an employer, school, fire or public safety official and the Enrollee is not in a position to refuse, or when an Enrollee is required by Us to move from a Non-Participating Provider to a Participating Provider.

Ambulance trips must be made to the closest local facility that can give Covered Health Services appropriate for Your condition. If none of these facilities are in Your local area, You are Covered for trips to the closest facility outside Your local area.

Non-Covered Services for Ambulance include any of the following.

- Trips to a Physician's office or clinic, or a morgue or funeral home.
- Ambulance usage when another type of transportation can be used without endangering the Enrollee's health.
- Ambulance usage for the convenience of the Enrollee, family or Provider.

Section 3.2 Behavioral Health and Mental Health Services.

- Inpatient services. Medical management, individual or group psychotherapy, psychological testing, family counseling with family members to assist in Your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
- Observation stays. Overnight stays in behavioral health hospital facilities that do not meet inpatient levels of Medical Necessity, but do meet observation level based on nationally accepted criteria.
- Partial hospitalization. An intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
- Intensive Outpatient Treatment or Day Treatment. A structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
- Outpatient Treatment or Individual or Group Treatment. Office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

~~Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.~~

To assist You in obtaining appropriate and quality care, We will ask Your Provider to submit a treatment plan to Us within 48 hours of an inpatient or observation level of care, or after You have had an initial outpatient evaluation and nine (9) subsequent visits in an outpatient setting. We may discuss the goals of treatment and changes in the treatment plan, including alternative courses of treatment, with Your Provider in order to manage Your benefits effectively and efficiently.

Non-Covered Behavioral Health Services include all of the following.

- Supervised living or halfway houses.

- Health Services or care provided by a residential treatment center, school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, outward bound programs, even if psychotherapy is included.
- Health Services related to non-compliance of care if the Enrollee ends treatment for Substance Abuse against the medical advice of a Provider.

Section 3.3 Dental Health Services Related to Accidental Injury. Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are Covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Treatment for pain is only Covered if it is the result of an accidental injury. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Health Services for Accidental Dental include, but are not limited to all of the following.

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia.

Section 3.4 Other Dental Health Services. Anesthesia and Hospital charges for dental care, for an Enrollee less than 19 years of age or an Enrollee who is physically or mentally disabled, are Covered if the Enrollee requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Enrollee's condition under general anesthesia. This Coverage does not apply to treatment for temporal mandibular joint disorders (TMJ). Extraction of teeth to prepare the jaw for radiation treatment or neoplastic disease is Covered.

Routine dental care is not a Covered Health Service under this Contract.

Section 3.5 Diabetic Equipment, Education and Supplies. Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when all of the following requirements listed below are met.

- Ordered in writing by a Physician or a podiatrist.
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Health Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes pursuant to Sections 3.13, 3.16, and 3.17.

Section 3.6 Diagnostic Health Services. Diagnostic Health Services are tests or procedures performed when You have specific symptoms, to detect or monitor Your condition. Coverage for Diagnostic Health Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to those listed below.

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- Computer Tomography and Computer Axial Tomography Scans (CAT).

- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Health Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy necessary (e.g. intravenous dye) to perform tests are Covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Diagnostic Breast Cancer Screening Mammography. The following breast cancer screening mammography Health Services are Covered Diagnostic Health Services.

- If the female Enrollee is at least 35 years of age, she may have one (1) Covered baseline breast cancer screening mammography performed before she becomes 40 years of age.
- If the Enrollee is less than 40 years of age and is high risk, she may have one (1) breast cancer screening mammography performed every year.
- Any additional mammography views that are required for proper evaluation..
- Ultrasound services, if determined Medically Necessary by the physician treating the Enrollee.

A woman is considered "high risk" if she meets at least one (1) of the following.

(1) Has a personal history of breast cancer.
(2) Has a personal history of breast disease proven benign by biopsy.
(3) Has a mother, sister, or daughter who has had breast cancer.
(4) Is at least 30 years of age and has not given birth.

Diagnostic Colorectal Cancer Screening. Colorectal cancer screening is a Covered Diagnostic Health Service for an Enrollee under the age of fifty (50) if the Enrollee is at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society. Colorectal cancer screening means examinations and laboratory tests for cancer for any nonsympomatic Enrollee, in accordance with the current American Cancer Society guidelines.

Diagnostic Prostate Cancer Screening. If an Enrollee is at least 50 years of age, one (1) prostate specific antigen test is Covered annually. If an Enrollee is less than 50 years of age and is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, one (1) prostate specific antigen test is Covered annually.

For Diagnostic Health Services other than those approved to be received in a Physician's office, You may be required to use Our Participating independent laboratory or medical diagnostic service Provider.

Section 3.7 Emergency Health Care Services. Benefits for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever You are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copay/Coinsurance for that Emergency Room visit will be waived. For an Inpatient admission following Emergency Care, Precertification is not required. However, Your Physician or the Inpatient facility -must seek authorization for your admission ~~notify Us or verify that Your Physician has notified Us of Your admission~~ within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, Your ~~p~~Provider will be notified whether the Inpatient setting is appropriate and considered ~~m~~Medically ~~n~~Necessary.~~, and if appropriate, the number of days considered Medically Necessary. By calling Us,~~If ~~p~~Prior ~~a~~Authorization is not obtained within 48 hours of your admission You may be ~~You may avoid~~ financially responsible~~ility~~ for Your~~any~~ Inpatient care. ~~that is determined to be not Medically Necessary under Your Contract. If Your Provider is a Non-Participating Provider, You will be financially responsible for any care We determine is not Medically Necessary.~~

Care and treatment provided once You are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Participating Provider beyond that needed to evaluate or Stabilize Your condition in an Emergency may be Covered if We authorize the continuation of care and it is Medically Necessary. Transfer to a Participating Provider will be made available to persons receiving post-stabilization care in a Non-Participating Provider facility.

Section 3.8 Urgent Care Center Services. An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. ~~If You call Your Physician prior to receiving care for an Urgent Care medical problem and Your Physician provides written authorization that You to go to an emergency room, Your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.~~

Section 3.9 Home Care Services. Health Services performed by a Home Health Care Agency or other Provider in Your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Enrollee must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Health Services include the following.

- Intermittent Skilled Nursing Services by an R.N. or L.P.N.
- Medical/Social Services.
- Diagnostic Health Services.
- Nutritional Guidance.
- Home Health Aide Services. The Enrollee must be receiving skilled nursing or therapy. Health Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide Health Services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Massage, Music, and Manipulation Therapy which will not be Covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

Non-Covered Home Health Care Services include the following.

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services as such services are Covered under Therapy Services.
- Helpful environmental materials such as hand rails, bath stools ramps, telephones, air conditioners, and similar services, appliances and devices.
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.

- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if Your ~~p~~Provider obtains prior approval from Our Home Infusion Therapy Administrator. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Section 3.10 Hospice Services. Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician and hospice medical director. Covered Health Services will continue if the Enrollee lives longer than six months, provided the hospice medical director or other hospice doctor recertifies that You are terminally ill.

Covered Hospice Services include the following list.

- Skilled Nursing Services by an R.N. or L.P.N.
- Diagnostic Health Services to determine need for palliative care.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances directed at palliative care.
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide functioning within home health care guidelines.

Non-Covered Hospice Services include services provided by volunteers and housekeeping services.

Section 3.11 Inpatient Services. Inpatient Services include all of the following.

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for Room, Board and General Nursing Services,
- Ancillary (related) services, and
- Professional Health Services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room if it is Medically Necessary that You use a private room. You will be required to supplement the difference in cost if a private room is desired, but not Medically Necessary.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive Health Services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and Health Services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Health Services.
- Therapy Services.

Professional Health Services

Medical care visits limited to one visit per day by any one Physician.

- Intensive medical care for constant attendance and treatment when Your condition requires it for a prolonged time.

- Concurrent care for a medical condition by a Physician who is not Your surgeon while You are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of Your condition requires the skills of separate Physicians.
- Consultation which is a personal bedside examination by another Physician when ordered by Your Physician. Staff consultations required by Hospital rules, consultations requested by the patient, routine radiological or cardiographic consultations, telephone consultations, EKG transmittal via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

When an Enrollee is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copay per admission in the Schedule of Benefits is waived for the second admission.

Section 3.12 Maternity Services. Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. Maternity Services are used for normal or complicated pregnancy and ordinary routine nursery care for a healthy newborn. In order to aid in facilitating a pregnant Enrollee's prenatal care, she is required to notify Us of her pregnancy within 7 days of the date that she becomes aware that she is pregnant.

If the Enrollee is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Participating Provider to have Covered Maternity Services paid at the Delivery System level. If the Enrollee is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Delivery System level if the Enrollee is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date.

Covered Maternity Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period.

If a newborn child is required to stay as an Inpatient past the mother's discharge date, the Health Services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copay.

Coverage for the Inpatient postpartum stay for You and Your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care and Postnatal Care.

Covered Maternity Services include post-delivery care visits at Your residence by a Physician or Nurse performed no later than 48 hours following You and Your newborn child's discharge from the Hospital. Coverage for this visit includes all of the following listed below.

1. Parent education,
2. Assistance and training in breast or bottle feeding, and
3. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

We will Cover an examination given at the earliest feasible time to Your newborn child for the detection of the following disorders.

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia.
- Galactosemia.
- Maple Syrup urine disease.
- Homocystinuria.
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health.
- Physiologic hearing screening examination for the detection of hearing impairments.

- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.
- HIV testing in infants exposed to HIV/AIDS.
- Pulse oximetry screening examination for the detection of low oxygen levels.

Section 3.13 Medical Supplies, Durable Medical Equipment and Appliances.

- Medical and surgical supplies –Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose as well as Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera and Remicade. Covered Health Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.
  - Covered Health Services include the following.
    1. Allergy serum extracts
    2. Chem strips, Glucometer, Lancets
    3. Clinitest
    4. Needles/syringes
    5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Health Services
    6. Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.
  - Non-Covered Health Services include the following.
    1. Adhesive tape, band aids, cotton tipped applicators
    2. Arch supports
    3. Doughnut cushions
    4. Hot packs, ice bags
    5. vitamins
    6. medijectors

- Durable Medical Equipment - The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Contract will not pay for rental for a longer period of time than it would cost to purchase equipment. Rentals may be required for a 30-90 day period prior to purchase in order to determine response to treatment and/or compliance with equipment. The cost for delivering and installing the equipment are Covered Health Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental, or the equipment is owned by the Enrollee, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is Covered.

  - Covered Health Services include the following.
    1. Hemodialysis equipment
    2. Crutches and replacement of pads and tips
    3. Pressure machines
    4. Infusion pump for IV fluids and medicine
    5. Glucometer
    6. Tracheotomy tube
    7. Cardiac, neonatal and sleep apnea monitors
    8. Augmentive communication devices are Covered when We approve based on the Enrollee's condition.
    9. CPAP machines when indicated for sleep apnea.
  - Non-Covered items include the following.
    1. Air conditioners

2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Enrollee is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

- Prosthetics – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Health Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are Covered.

  - Covered Health Services include, the following.
    1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
    2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
    3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
    4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
    5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Health Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are Covered when they replace the function of the human lens for conditions caused by cataract surgery or injury, the first pair of contact lenses or eyeglasses are Covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Enrollee selects eyeglasses and frames, then reimbursement for both lenses and frames will be Covered.
    6. Cochlear implant.
    7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
    8. Restoration prosthesis (composite facial prosthesis).
    9. Wigs (the first one following cancer treatment resulting in hair loss, not to exceed one per Benefit Period).

  - Non-Covered Prosthetic appliances include the following.
    1. Dentures, replacing teeth or structures directly supporting teeth.
    2. Dental appliances.
    3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
    4. Artificial heart implants.
    5. Wigs (except as described above following cancer treatment).
    6. Penile prosthesis in men suffering impotency resulting from disease or injury.

- Orthotic Devices – The initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also Covered. The casting is Covered when an orthotic appliance is billed with it, but not if billed separately.

    - Covered Health Services for Orthotic Devices include the following.
        1. Cervical collars.
        2. Ankle foot orthosis.
        3. Corsets (back and special surgical).
        4. Splints (extremity).
        5. Trusses and supports.
        6. Slings.
        7. Wristlets.
        8. Built-up shoe.
        9. Custom made shoe inserts.
    - Orthotic appliances may be replaced once per year per Enrollee when Medically Necessary in the Enrollee's situation. However, additional replacements will be allowed for Enrollees under age 18 due to rapid growth, or for any Enrollee when an appliance is damaged and cannot be repaired.
    - Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.
    - Non-Covered Health Services for Orthotic Devices include the following.
        1. Orthopedic shoes (except therapeutic shoes for diabetics).
        2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
        3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
        4. Garter belts or similar devices.

- Prosthetic limbs & Orthotic custom fabricated brace or support –
    - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be Covered if they satisfy both requirements listed below.
        1. Determined by Your Physician to be Medically Necessary to restore or maintain Your ability to perform activities of daily living or essential job related activities, and
        2. Not solely for comfort or convenience.
    - Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the Coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.
    - Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are Covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract.

Replacements and Repairs. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be Covered, as approved by Us.

The repair, adjustment or replacement of the purchased equipment, supply or appliance is Covered if all of the following requirements are satisfied.

- The equipment, supply or appliance is a Covered Service.
- The continued use of the item is Medically Necessary.
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be Covered if any of the following are satisfied.

- The equipment, supply or appliance is worn out or no longer functions.
- Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
- The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include those listed below.

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

Section 3.14 Outpatient Services. Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Contract. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us.

When Diagnostic Health Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copay is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these Health Services.

Section 3.15 Autism Spectrum Disorder Services.
Coverage is provided for the treatment of Autism Spectrum Disorders. Treatment is limited to Health Services prescribed by Your Physician in accordance with a treatment plan.

- Autism Spectrum Disorder, as defined in the definition section of the Policy, means a neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Coverage for Health Services will be provided as prescribed by Your treating Physician in accordance with the treatment plan.
- Any exclusion or limitation in this Contract in conflict with the Coverage described in this provision will not apply.
- Coverage for Autism Spectrum Disorders will not be subject to dollar limits, Deductibles, Copay or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copays or Coinsurance provisions that apply to physical illness under this Contract.

Section 3.16 Physician Home Visits and Office Services. Covered Health Services include care provided by a Physician in their office or Your home. Refer to the Sections 3.2, 3.9, 3.12, and 3.17 for Health Services Covered by the Contract. For Emergency Care refer to Sections 3.7 and 3.8.

- Office Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copay is required.

- Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in Your home.

- Diagnostic Health Services when required to diagnose or monitor a symptom, disease or condition.

- Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

- Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Section 3.17 Preventive Care Services. Preventive Care Services include, Outpatient services and Office Services. Screenings and other Health Services are Covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

- Enrollees who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Health Services benefit.
- Preventive Care Services in this section shall meet requirements as determined by federal and state law.
- Health Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF.

Section 3.18 Routine Care Costs as Part of a Cancer or Other Life-Threatening Disease or Condition Clinical Trial. Routine Care Costs as part of an ~~approved~~ Approved ~~clinical~~ Clinical ~~trial~~ Trial ~~for the prevention, detection, or treatment of cancer or other life-threatening disease or condition~~ if the Health Services are otherwise Covered Health Services under this Contract ~~and the clinical trial is performed according to all of the following standards~~.

An Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions that meets one of the following.

~~Using a particular care method to prevent, diagnose, or treat a cancer or other life-threatening disease or condition for which:~~

- ~~there is no clearly superior, non-investigational alternative care method, and~~
- ~~available clinical or preclinical data provides reasonable basis from which to believe that the care method used in the research study is at least as effective as any non-investigational alternative care method.~~

~~2. In a facility where personnel providing the care method to be followed in the research study have:~~

- ~~received training in providing the care method,~~
- ~~expertise in providing the type of care required for the research study, and~~
- ~~experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise, and~~

~~3.~~1. ~~To scientifically determine the best care method to prevent, diagnose, or treat the cancer or other life-threatening disease or condition, and~~The trial is approved or funded by one, or a combination, of the following:

- A National Institutes Health institute,~~;~~
- A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center,~~;~~
- The ~~federal~~ United States Food and Drug Administration,~~;~~
- The United States Department of Veterans Affairs, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
- The United States Department of Defense, if the clinical trial complies with the standards set forth at IC 27-13-7-20.2(b) and 42 USC 300gg-8(d).
- The United States Department of Energy, if the clinical trial complies with the standards set forth in 42 USC 300gg-8(d).
- The Centers of Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare and Medicaid Services.
- The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 C.F.R. 146.103~~, or~~.
- A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.
- A qualified non-governmental research entity in guidelines issued by the National Institutes of health for center support grants.

2. A study or investigation done as part of an investigational new drug application reviewed by the U.S. Food and Drug Administration.
~~4.~~3. A study or investigation done for drug trials which are exempt from the investigational new drug application.

Your PMP must provide Us with written authorization for Your participation in a Cancer Clinical Trial.

Routine Costs as part of an Approved ~~cancer~~ Cclinical T~~t~~rial does not include any of the following.

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial,
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration.
- Transportation, lodging, food, or other expense for the patient, or a family member or companion of the patient, that is associated with the travel to or from a facility providing the cancer clinical trial.
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient.
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

The term "life threatening condition" means any disease or condition from which death is likely unless the disease or condition is treated.

Section 3.19 Surgical Services. Coverage for Surgical Services when provided as part of Physician Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to the list below.

- Performance of accepted operative and other invasive procedures.
- The correction of fractures and dislocations.
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary.
- Usual and related pre-operative and post-operative care.
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

- Covered Surgical Services include the following.
  - Operative and cutting procedures.
  - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy.
  - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services. Certain Reconstructive Services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are Covered. Reconstructive Services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Contract. Covered Reconstructive Services are limited to the following list.

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further Coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or Younger.
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia.
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect.

- Tongue release for diagnosis of tongue-tied.
- Congenital disorders that cause skull deformity such as Crouzon's disease.
- Cleft lip.
- Cleft palate.

Mastectomy Notice. An Enrollee who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive Coverage for all of the following listed below.

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Section 3.20 Sterilization. Sterilization is a Covered Service.

Section 3.21 Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder. Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders if provided within Our guidelines.

Section 3.22 Therapy Services. When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, Coverage for these Therapy Services is limited to the following list.

- Physical Medicine Therapy Services. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.
    - Physical Therapy Services including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Physical Therapy Services include but are not limited to maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness, repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients), range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities, general exercise programs, diathermy, ultrasound and heat treatments for pulmonary conditions, diapulse, work hardening.
    - Speech Therapy Services for the correction of a speech impairment.
    - Occupational Therapy Services for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Occupational Therapy Services include but are not limited to supplies (looms, ceramic tiles, leather, utensils), therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again, general exercises to promote overall fitness and flexibility, therapy to improve motivation, suction therapy for newborns (feeding machines), soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial, adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
    - Manipulation Therapy Services includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy Services as specified in the Schedule of Benefits. Manipulation Therapy Services rendered in the home as part of Home Care Services are not Covered.
- Other Therapy Services

- Cardiac Rehabilitation Services to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not Covered.
- Pulmonary Rehabilitation Services to restore an individual's functional status after a pulmonary or cardiac event, or to improve respiratory capacity in persons with chronic lung conditions.
- Chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- Dialysis Treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of Coverage the Contract will not require You to receive dialysis treatment at a Participating Provider dialysis facility if that facility is further than 30 miles from Your home. If You require dialysis treatment and the nearest Participating Provider dialysis facility is more than 30 miles from Your home, the Contract will allow You to receive treatment at a Participating Provider dialysis facility nearest to Your home as Covered Health Service.
- Radiation Therapy Services for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, treatment planning.
- Inhalation Therapy Services for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Inhalation Therapy Services include but are not limited to, introduction of dry or moist gases into the lungs, nonpressurized inhalation treatment, intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive airway pressure ventilation (CPAP), continuous negative pressure ventilation (CNP), chest percussion, therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers, broncho-pulmonary drainage and breathing exercises.
- Pulmonary Rehabilitation Services to restore an individual's functional status after an illness or injury. Covered Pulmonary Rehabilitation Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also Covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary Rehabilitation Services in the acute Inpatient rehabilitation setting is not a Covered Health Service.
- Nutritional Counseling Services that are Medically Necessary or that are ordered by a Participating Provider. Limit of twelve (12) sessions annually.

Section 3.23 Physical Medicine and Rehabilitation Services. A structured therapeutic program under the supervision of a physical medicine and rehabilitation specialist and developed treatment plan of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical Medicine and Rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

~~Non-Covered Physical Medicine and Rehabilitation Services include the following.~~

- ~~Admission to a Hospital mainly for physical and/or occupational therapy.~~
- ~~Long term rehabilitation in an Inpatient setting.~~

Long term rehabilitation for longer than 60 days in an inpatient setting is not a Covered Service.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Health Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing

services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Health Service.

Section 3.24 Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services. The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below **do not apply** to the following list.

- Cornea and kidney transplants, and
- Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Enrollee cost shares.

Covered Transplant Procedure. Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period**.** Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Transplant Provider agreement. Contact the Case Manager for specific Participating Transplant Provider information for Health Services received at or coordinated by a Participating Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Transplant Provider Facility.

Prior Approval and Precertification. In order to maximize Your benefits, We strongly encourage You to call Our transplant department to discuss benefit Coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We may require additional work-ups and/or treatments before determining eligibility for the transplant benefit (e.g. psychotherapy). We will assist You in maximizing Your benefits by providing Coverage information, including details regarding what is Covered and whether any clinical Coverage guidelines, medical policies, Participating Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of Your I.D. Card. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are Covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging. The Contract will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Enrollee receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Enrollee must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed.

Non-Covered Services for transportations and lodging include the following.

- Child care.
- Mileage within the medical transplant facility city.
- Rental cars, buses, taxis, or shuttle services, except as specifically approved by Us.
- Frequent Flyer miles.

- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- Telephone calls.
- Laundry.
- Postage.
- Entertainment.
- Interim visits to a medical care facility while waiting for the actual transplant procedure.
- Travel expenses for donor companion/caregiver.
- Return visits for the donor for a treatment of a condition found during the evaluation.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Section 3.25 Prescription Drug Benefits.

Pharmacy Benefits Manager**.** The pharmacy benefits available to You under this Contract are managed by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which We contract to manage Your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, ~~a Specialty pharmacy,~~ and provides clinical management services. The management and other services the PBM provides include, among others, making recommendations to, and updating, the Covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and, operating a Mail Service pharmacy~~, and a Participating Specialty Drug Pharmacy~~. The PBM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, Drug interactions or Drug/pregnancy concerns.

You may request a copy of the Covered Prescription Drug list by calling the Customer Service telephone number on the back of Your I.D. Card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage. You may request a list of Pharmacies in the PBM network by calling the customer service number listed on the back of Your I.D. Card.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Health Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Contract can determine Medical Necessity. The Contract may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Health Services will be limited based on Medical Necessity, quantity and/or age limits established by the Contract, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit Coverage. At the time You fill a prescription, the Participating Pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee which is reviewed and adopted by Us. We, or the PBM may contact Your Provider if additional information is required to determine whether Prior Authorization should be granted. We communicate the results of the decision to both You and Your Provider.

If Prior Authorization is denied, You have the right to appeal through the appeals process outlined in Article 8.

For a list of the current Drugs requiring Prior Authorization, please contact the Pharmacy Customer Service telephone number on the back of Your I.D. card. The Covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the Covered Prescription Drug list is not a guarantee of Coverage under Your Contract. Refer to the Prescription Drug benefit sections in this Contract for information on Coverage, limitations and exclusions. Your Participating Provider or Participating Pharmacist may check with Us to verify Covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Contract.

- Therapeutic Substitution of Drugs is a program approved by Us and managed by the PBM. This is a voluntary program designed to inform Enrollees and Physicians about possible alternatives to certain prescribed Drugs. We, or the PBM, may contact You and Your prescribing Physician to make You aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only You and Your Physician can determine whether the therapeutic substitute is appropriate for You. For questions or issues involving therapeutic Drug substitutes, call the Customer Service telephone number on the back of Your I.D. card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

- Step Therapy. Step therapy protocol means that an Enrollee may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Enrollees access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Participating ~~Specialty~~ Pharmacies**.** The PBM's Participating ~~Specialty~~ Pharmacies are available to Enrollees who use medically necessary drugs~~Specialty Drugs. "Specialty Drugs" are Prescription Legend Drugs which are any of the following listed below.~~
~~Are only approved to treat limited patient populations, indications or conditions, or~~
~~Are normally injected, infused or require close monitoring by a physician or clinically trained individual, or~~
~~Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.~~

~~Participating Specialty Pharmacies may fill both retail and mail service Specialty Drug Prescription Orders, subject to a day supply limit for Retail and Mail Service, and subject to the applicable Coinsurance or Copay shown in the Schedule of Benefits.~~

Participating mail service pharmacies have toll free access to registered pharmacists to answer your questions. Participating ~~S~~specialty p~~P~~harmacies have dedicated patient care coordinators to help You manage Your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists. ~~to answer questions regarding Your medications.~~

You may obtain a list of the Participating ~~Specialty~~ Pharmacies, and Covered ~~Specialty~~ Drugs, by calling the Customer Service telephone number on the back of Your ID card, or review the lists on Our website at *www.mdwisemarketplace.org*.

Covered Prescription Drug Benefits include the following.

- Prescription Legend Drugs.
- ~~Specialty Drugs.~~
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are Covered when obtained through an eligible Pharmacy.
- If certain supplies, equipment or appliances are not obtained by Mail Service or from a Participating Pharmacy then they are Covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits and may be subject to applicable DME Copays or Coinsurance.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Non-Covered Prescription Drug Benefits

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.

- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by Us or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for Coverage under the Medical Supplies benefit, they are Covered Health Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Health Services.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Refills of lost or stolen medications.
- Refills earlier than 72 hours before Your next refill is due.
- Refills on expired Prescription Drugs.
- Certain brand name Prescription Drugs, for which there are lower cost clinically equivalent alternatives available, are not Covered, unless otherwise required by law or approved by Us. "Clinically equivalent" means Drugs that, for the majority of Enrollees, can be expected to produce similar therapeutic outcomes for a disease or condition.

Deductible/Coinsurance/Copay. Each Prescription Order may be subject to a Deductible and Coinsurance/Copay. If the Prescription Order includes more than one Covered Drug, a separate Coinsurance/Copay will apply to each Covered Drug.

Days Supply. The number of days supply of a Drug which You may receive is limited. The days supply limit applicable to Prescription Drug Coverage is shown in the Schedule of Benefits. If You are going on vacation and You need more than the days supply allowed for under this Contract, You should ask Your Pharmacist to call the PBM and request an override for one additional refill. This will allow You to fill Your next prescription early. If You require more than one extra refill, please call the Pharmacy Customer Service telephone number on the back of Your I.D. Card.

Prescription Drug Classifications. Your Copay/Coinsurance amount may vary based on whether the Prescription Drug~~, including Covered Specialty Drugs,~~ has been classified by Us as a ~~Generic~~Tier 1, ~~Preferred Brand~~Tier 2, ~~Non-Preferred Brand~~Tier 3, ~~and Specialty~~ or Tier 4 Prescription Drug. The determination of Prescription Drug class is made by Us based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, and where appropriate certain clinical economic factors.

- ~~Generic Prescription~~ Tier 1Drugs have the lowest ~~Coinsurance or~~ Copay. This class will contain low cost and preferred medications that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- ~~Preferred Brand Prescription~~ Tier 2 Drugs will have a higher ~~Coinsurance or~~ Copay than Tier 1 ~~Generic~~ Prescription Drugs. This class will contain preferred medications that may be Generic, single source, or multi-source Brand Drugs.
- ~~Non-Preferred Brand~~ Tier 3Prescription Drugs will have a ~~higher~~ required Coinsurance ~~or Copay than Preferred Brand Prescription Drugs~~payment after You have hit your Deductible. This class will contain non-preferred and high cost medications. This will include medications considered Generic, single source brands, and multi-source brands.
- ~~Specialty~~ Tier 4 Prescriptions are subject to a day supply limit for Retail and Mail Service, and are subject to the applicable Coinsurance shown in the Schedule of Benefits. Coinsurance payment will occur after You have hit your Deductible. Tier 4 Drugs are Prescription Legend Drugs which are any of the following listed below.
    - Are only approved to treat limited patient populations, indications or conditions, or
    - Are normally injected, infused or require close monitoring by a physician or clinically trained individual, or
    - Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

~~Prescription Drugs will have a higher Coinsurance or Copay than Non-Preferred Brand Prescription Drugs.~~

Class and Formulary Assignment Process. We have established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of Prescription Drug class assignments and formulary inclusion are made by Us based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives, generic availability, the degree of utilization of one Drug over another in Our patient population, and where appropriate, certain clinical economic factors.

We retain the right at Our discretion to determine Coverage for dosage formulations in terms of Covered dosage administration methods (for example, by mouth, injections, topical, or inhaled) and may Cover one form of administration and exclusion or place other forms of administration in another tier.

Special Programs. From time to time We may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, ~~Generic~~ Tier 1 Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copays or Coinsurance for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program. The Half-Tablet Program will allow Enrollees to pay a reduced Copay on selected "once daily dosage" medications. The Half-Tablet Program allows an Enrollee to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Enrollee's decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of Your I.D. Card.

Section 3.26 Payment of Prescription Drug Benefits. The amount of benefits paid is based upon whether You receive the Covered Health Services from a Participating Pharmacy~~, including a Participating Specialty Pharmacy~~, a Non-Participating Pharmacy, or the PBM's Mail Service Program. It is also based upon how We have classified the Prescription Drug ~~or Specialty Drug~~. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

The amounts for which You are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copay/Coinsurance for which You are responsible.

Your Copay(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Contract from Drug manufacturers or similar vendors. For Covered Health Services provided by a Participating ~~or Specialty Drug Participating~~ Pharmacy or through the PBM's Mail Service, You are responsible for all Deductibles and/or Copay/Coinsurance amounts.

For Covered Health Services provided by a Non-Participating Pharmacy, You will be responsible for the amount(s) shown in the Schedule of Benefits.

How to Obtain Prescription Drug Benefits. How You obtain Your benefits depends upon whether You go to a Participating or a Non-Participating Pharmacy.

- Participating Pharmacy – Present Your written Prescription Order from Your Physician, and Your I.D. Card to the pharmacist at a Participating Pharmacy. The Pharmacy will file Your claim for You. You will be charged at the point of purchase for applicable Deductible and/or Copay/Coinsurance amounts. If You do not present Your I.D. Card, You will have to pay the full retail price of the prescription. If You do pay the full charge, ask Your pharmacist for an itemized receipt and submit it to Us with a written request for refund.
- ~~Specialty~~Tier 4 Drugs - You or Your Physician can order Your ~~Specialty~~Tier 4 Drugs directly from a ~~Specialty~~ Participating Pharmacy, simply call the Pharmacy Customer Service telephone number on the back of Your ID card.
- Non-Participating Pharmacy – You are responsible for payment of the entire amount charged by the Non-Participating Pharmacy~~, including a Non-Participating Specialty Pharmacy~~. You must submit a Prescription Drug claim form for reimbursement consideration. These forms are available from Us, the PBM, or from the Group. You must complete the top section of the form and ask the Non-Participating Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, You must attach an itemized receipt to the claim form and submit to Us or the PBM. The itemized receipt must show all of those items listed below.
    - Name and address of the Non-Participating Pharmacy.
    - Patient's name.
    - Prescription number.
    - Date the prescription was filled.
    - Name of the Drug.
    - Cost of the prescription.
    - Quantity of each Covered Drug or refill dispensed.
- You are responsible for the amount shown in the Schedule of Benefits.
- The Mail Service Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from Your Physician, or have Your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copay amounts to the Mail Service when You request a prescription or refill.

Drug Exception Program. This is a program designed to allow Enrollees to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary. The Drug Exception Program is separate from and in addition to the Grievance Procedures set forth in Article 8. Please call the Customer Service number on the back of your I.D. Card for more information on the Drug Exception Program and how to request and gain access to clinically appropriate Prescription Drugs that are not covered on the Formulary.

Section 3.27 Pediatric ~~Eyewear~~ Vision Benefits. Pediatric ~~eyewear~~ vision services are~~is~~ Covered under this Contract for Enrollees under the age of 19. Adult eyewear is not Covered under this Contract.

- A complete pediatric eye exam, including dilation if professional indicated

- One pair of eyeglass lenses. Lenses include single vision, bifocal, trifocal or lenticular. You may choose plastic or polycarbonate lenses and scratch resistant coating.
- One pair of eyeglass frames.
- Contact lenses in lieu of eyeglasses.
- Low vision services including a comprehensive low vision exam, optical/non-optical aids, and supplemental testing.

Please refer to the Schedule of Benefits for detailed information. ~~Adult eyewear is not Covered under this Contract.~~

Article 4

EXCLUSIONS

Section 4.1 We do not provide Coverage for any of the following.

1. Health Services that are not Medically Necessary.
2. Health Services that are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available for a condition will not make it eligible for Coverage if We deem it to be Experimental/Investigative.
3. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
4. Health Services that are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
5. Any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
6. A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
7. Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
8. Court ordered testing or care unless Medically Necessary.
9. Health Services for which You have no legal obligation to pay in the absence of this or like Coverage.
10. Physician or Other Practitioners' charges for consulting with Enrollees by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Enrollee except as otherwise described in this Contract.
11. Surcharges for furnishing and/or receiving medical records and reports.
12. Charges for doing research with Providers not directly responsible for Your care.
13. Charges that are not documented in Provider records.
14. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
15. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
16. Health Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
17. Health Services prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
18. Completion of claim forms or charges for medical records or reports unless otherwise required by law.

19. Mileage, lodging and meals costs, and other Enrollee travel related expenses, except as authorized by Us or specifically stated as a Covered Health Service.
20. Health Services for which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Enrollee had applied for Parts A, B and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare Parts B and D, We will calculate benefits as if they had enrolled.
21. Charges in excess of Our Allowed Amounts.
22. Health Services incurred prior to Your Effective Date.
23. Health Services incurred after the termination date of this Coverage except as specified elsewhere in this Contract.
24. Any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts) or for the removal of tattoos. Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not Covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Enrollee was Covered by another carrier/self funded plan prior to Coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to myocardial infarction, pulmonary embolism, thrombophlebitis, and exacerbation of co-morbid conditions.
25. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
26. Custodial Care, convalescent care or rest cures.
27. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Enrollee's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
28. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
29. Services at a residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a
30. Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
31. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
32. Wilderness camps.
33. Routine foot care (including the cutting and removal of corns and calluses), Nail trimming, cutting and debriding, Hygienic and preventive maintenance foot care, including, but not limited to the following list.
    1. Cleaning and soaking the feet.
    2. Applying skin creams in order to maintain skin tone.
    3. Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
34. Surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses.
35. Dental treatment, regardless of origin or cause, except as specified elsewhere in this Contract. "Dental treatment" includes but is not limited to Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including, but not limited to the list below.
    1. Extraction, restoration and replacement of teeth.
    2. Medical or surgical treatments of dental conditions.
    3. Services to improve dental clinical outcomes.
36. Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Health Service.

37. Dental implants.
38. Dental braces.
39. Dental x-rays, supplies and appliances and all associated expense, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following listed below.
    1. Transplant preparation.
    2. Initiation of immunosuppresives.
    3. Direct treatment of acute traumatic injury, cancer or cleft palate.
40. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
41. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as Covered in this Contract. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
42. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not Covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Contract or any previous [MDwise Contract], and it applies if the surgery was performed while the Enrollee was Covered by a previous carrier/self funded plan prior to Coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to myocardial infarction, excessive nausea/vomiting, pneumonia, and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.
43. Marital counseling.
44. Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
45. Vision orthoptic training.
46. Hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Contract.
47. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
48. Services to reverse voluntarily induced sterility.
49. Diagnostic testing or treatment related to infertility.
50. Personal hygiene, environmental control, or convenience items including but not limited to the following list.
    1. Air conditioners, humidifiers, air purifiers,
    2. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals,
    3. Charges for non-medical self-care except as otherwise stated,
    4. Purchase or rental of supplies for common household use, such as water purifiers,
    5. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds,
    6. Infant helmets to treat positional plagiocephaly,
    7. Safety helmets for Enrollees with neuromuscular diseases, or
    8. Sports helmets.
51. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
52. Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Contract.
53. Care received in an emergency room which is not Emergency Care, except as specified in this Contract. This includes, but is not limited to suture removal in an emergency room.

54. Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
55. Self-help training and other forms of non-medical self care, except as otherwise provided in this Contract.
56. Examinations relating to research screenings.
57. Stand-by charges of a Physician.
58. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
59. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
60. Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility, Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
61. Manipulation Therapy services rendered in the home as part of Home Care Services.
62. For any new FDA Approved Drug Product or Technology **(including but not limited to medications, medical supplies, or devices)** available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the date the product or technology is first dispensed in the marketplace. The Contract may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
63. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
64. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
65. Abortion, except in the following cases.
    1. The pregnant woman became pregnant through an act of rape or incest.
    2. An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.
66. Any services or supplies provided to a person not Covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
67. Surgical treatment of gynecomastia.
68. Treatment of hyperhidrosis (excessive sweating).
69. Any service for which You are responsible under the terms of this Contract to pay a Copay, Coinsurance or Deductible, and the Copay, Coinsurance or Deductible is waived by any Participating Provider.
70. Human Growth Hormone for children born small for gestational age. It is only a Covered Health Service in other situations when allowed by Us through Prior Authorization.
71. Complications directly related to a service or treatment that is a Non-Covered Health Service under this Contract because it was determined by Us to be Experimental/Investigational or non Medically Necessary. Directly related means that the Health Service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
72. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
73. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
74. Treatment of telangiectatic dermal veins (spider veins) by any method.

75. Reconstructive Health Services except as specifically stated in Section 3.19 of this Contract, or as required by law.
76. Nutritional and/or dietary supplements, except as provided in this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
77. Non-preventive medical nutritional therapy from a Non-Participating Provider.
78. Health Services from a Non-Participating Provider, except as specified elsewhere in this Contract.

Section 4.2 Experimental/Investigative Health Services Exclusion. We do not provide Coverage for any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the Health Service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply satisfies any or all of the following listed below.

- Cannot be legally marketed in the United States without the final approval of the FDA, or other licensing or regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply.
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any Health Service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Health Service is Experimental/Investigative, We will consider the information described below and assess whether all of the following are met.

- The scientific evidence is conclusory concerning the effect of the Health Service on health outcomes,
- The evidence demonstrates the Health Service improves net health outcomes of the total population for whom the Health Service might be proposed by producing beneficial effects that outweigh any harmful effects,
- The evidence demonstrates the Health Service has been shown to be as beneficial for the total population for whom the Health Service might be proposed as any established alternatives, and
- The evidence demonstrates the Health Service has been shown to improve the net health outcomes of the total population for whom the Health Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

Off-Label Drug Treatment. Coverage for a Drug used in an anticancer chemotherapeutic regimen will not be deemed Experimental/Investigative if both of the following conditions are met.

~~(8)~~(1) The Drug is recognized for treatment of the indication in at least one standard reference compendium.

~~(9)~~(2) The Drug is recommended for the particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

However, such a Drug may be deemed Experimental/Investigative if the FDA has determined the Drugs' use to be contraindicated or the Drug has not been approved by the FDA for any indication.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list, which is not all inclusive.

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof, or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies, or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Documents of an IRB or other similar body performing substantially the same function, or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply, or
- Medical records, or
- The opinions of consulting Providers and other experts in the field.

Article 5

PREMIUM PAYMENT

Section 5.1 Premium Rate. Your Premium rate is determined using the following acceptable rating factors: age, tobacco use, family size, and geography.

[Your][An Enrollee's] tobacco use impacts the determination of [Your][the] Premium rate. Upon enrollment, You will attest to [Your][an Enrollee's] tobacco use. If You report false or incorrect information to Us [or the Exchange] about [Your][an Enrollee's] tobacco use upon enrollment, We may retroactively apply the appropriate tobacco rating factor to [Your][the] Premium as if the correct information had been accurately reported from the Effective Date for Coverage.

Section 5.2 Payment of Premium. The Subscriber is responsible for paying the Premium to Us on a monthly basis. The first Premium is due and payable on the Effective Date of this Contract. Subsequent Premium payments are due and payable on or before the first day of each month thereafter that this Contract is in effect. Payment must be made on or before each due date. Even if You have not received a bill from Us, You are still obligated to pay, at a minimum, the amount of the prior bill. A service charge in the maximum allowable amount under law will be charged for any non-sufficient check used to pay the Premium.

Section 5.3 Adjustments to Premium. We reserve the right to change the Premium annually. You will receive 30 days notice of any change in Premiums.

Section 5.4 General Grace Period. Following payment of the initial Premium, a Grace Period of one (1) month shall be granted for the payment of any Premium. This Grace Period shall not extend beyond the date this Contract terminates. During the one (1) month Grace Period this Contract shall continue in force.

Any claims incurred and submitted during the grace period will not be considered for payment until Premium is received. If Premium is not received within the Grace Period, claims incurred during the Grace Period will be denied and this Contract will automatically terminate retroactive to the last paid date of Coverage.

[Section 5.5 Three-Month Grace Period for Subscribers Receiving Advance Payments of the Premium Tax Credit.
For [a Subscriber][or Enrollee] receiving advance payments of the premium tax credit who has previously paid at least one full month's premium during the benefit year, a Grace Period of three (3) consecutive months shall be granted for the payment of any Premium.

During this 3-month Grace Period, We shall do all of the following listed below.

(1) Pay all claims for Covered Emergency and Health Services rendered to [the Subscriber][an Enrolled Dependent] during the first month of the Grace Period and may pend claims for Covered Emergency and Health Services rendered to the Subscriber in the second and third months of the Grace Period.

(2) Notify the Department of Health and Human Services of such non-payment.

(3) Notify Participating Providers of the possibility for denied claims when a Subscriber is in the second and third months of the Grace Period.

During this 3-month Grace Period, We shall do all of the following listed below.

(1) Continue to collect advance payments of the premium tax credit on behalf of the Subscriber from the Department of Treasury.

(2) Return advance payments of the premium tax credit on the behalf of the Subscriber for the second and third months of the Grace Period if the Subscriber exhausts the grace period.]

Section 5.6 Payment upon Termination. If Premium has been paid for any period of time after the termination date, We will refund that Premium to You. The refund will be for the period of time after Your Coverage ends. Also, if an [Enrollee][Enrolled Dependent] dies while this Contract is in force, We will refund the Premium paid for any period after the month~~date~~ of the [Enrollee's][Enrolled Dependent's] death to You or Your estate for that [Enrollee][Enrolled Dependent].

Article 6

PROCEDURES FOR OBTAINING HEALTH SERVICES

Our authorization does not guarantee Coverage for the Health Service or procedure reviewed. Benefits of this Contract are determined in accordance with all of the terms, conditions, limitations, and exclusions.

Section 6.1 Selection of a Primary Medical Provider. We require the designation of a Primary Medical Provider (PMP). You have the right to designate any PMP who is a Participating Provider in Your Service Area and who is available to accept [You and Your Enrolled Dependents][an Enrollee]. Until You make this designation, We will designate a PMP for You. For information on how to select a PMP, and for a list of PMPs in Your Delivery System, contact the customer service telephone number on the back of your I. D. Card or refer to the provider directory on Our website, www.mdwisemarketplace.org. [For Children, you][You] may designate a pediatrician as the PMP.

[You do][An Enrollee does] not need Preauthorization or a referral from Us or from any other person (including a PMP) in order to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetrics or gynecology. The Participating Provider, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services or following a pre-approved treatment plan. For a list of Participating Providers who specialize in obstetrics or gynecology, contact the customer service telephone number on the back of your I.D. Card or refer to Our website, www.mdwisemarketplace.org.

Section 6.2 Preauthorization. The Health Services listed below do not require Preauthorization.

(A) Emergency Services.

(B) Preventive Services provided by a Participating Provider.

A Provider that provides [You][an Enrollee] with Emergency Services may not charge You except for an applicable Copay or Deductible.

All other Health Services must be made through Your PMP. [Your][An Enrollee's] PMP will determine whether Preauthorization is required. The following is a list of Health Services that require Preauthorization. This list is not exhaustive.

(A) Elective/Urgent Inpatient Admissions.

(1) Medical.
(2) Surgery.
(3) Sub-acute rehabilitation and skilled nursing facility.
(4) Inpatient behavioral health and substance abuse.

(B) Observation stay.
(C) Skilled nursing facility services.
(D) Hospice Care – Inpatient and Outpatient.
(E) Hysterectomy.
(F) Transplantation evaluations and procedures/surgery.
(G) Reduction mammoplasty surgery
(H) Reconstructive services/plastic surgery/potentially Cosmetic Procedures.
(I) Home Health Care Services.
(J) MRI, MRA, CT scans and PET scans.
(K) All Non-Participating Provider services.
(L) Durable Medical Equipment and supplies greater than $500 (total per ~~item~~claim) per rental or purchase.
(M) Prosthetics greater than $500/per prosthetic.
(N) Pharmacy Services, including,
(1) Biotech Injectables
(2) Enteral Products
(3) As otherwise specified on the MDwise preferred drug list.
(O) Occupational Therapy (authorization required after the initial evaluation).
(P) Physical Therapy (authorization required after the initial evaluation).
(Q) Speech Therapy (authorization required after the initial evaluation).
(R) Transportation – non-emergent.
(S) Certain ~~M~~mental disorders/substance abuse.
(T) Outpatient services, including outpatient surgical procedures and certain other procedures.
(U) Pain management programs.

Section 6.3 Health Services by Participating Providers. Health Services rendered by Participating Providers are Covered if the Health Services meet all of the following conditions.

~~(C)~~(A) Are ordered by a Participating Provider (including Health Services performed at Participating facilities),
~~(D)~~(B) Provided by or under the direction of a Participating Provider,
~~(E)~~(C) Medically Necessary, and
~~(F)~~(D) Specified as Covered by this Contract.

Section 6.4 Verification of Participation Status. You must confirm that the Provider is a Participating Provider and whether the Participating Provider is a Provider in Tier 1 or Tier 2 before receiving Health Services. This is important since this Contract is aimed at providing Coverage for Health Services rendered by Participating Providers.

You must show the Participating Provider Your I.D. card before receiving Health Services.

If You do not identify [Yourself][an Enrolled Dependent] to the Participating Provider as an Enrollee within 90 days from the date Health Services are incurred a Participating Provider may bill You for Your Health Services, and You shall be responsible for 100% of the cost of Your Health Services.

The Provider needs to know that [You are][an Enrolled Dependent] an Enrollee in order to follow Our procedures, such as Prior Authorization. If failure to show Your I.D. card results in non-compliance with Our required procedures and Coverage is denied, You shall be responsible for 100% of the cost of Your Health Services.

Section 6.5 Health Services by a Non-Participating Provider. Non-Emergency Health Services rendered by a Non-Participating Provider will be Covered in the following circumstances only.

(A) Referral to Non-Participating Providers. The Allowed Amounts of non-Emergency Health Services provided by a Non-Participating Provider shall be Covered if all of the following conditions listed below

are satisfied.

(1) The specific Health Services cannot be provided by or through Participating Providers,
(2) The services are Medically Necessary, and
(3) Your PMP referred You to the Non-Participating Provider.

~~You~~ ~~t~~The ~~n~~Non-~~p~~Participating ~~p~~Provider must obtain written approval from US, in the form of a ~~p~~Prior ~~a~~Authorization,~~referral from Us and Your PMP~~ before You receive~~receiving~~ non-Emergency Health Services ~~ordered or provided~~ by a Non-Participating Provider. If Your N~~n~~on-~~p~~Participating ~~p~~Provider does not receive ~~p~~Prior ~~a~~Authorization, You will be responsible for all costs associated with those Health Services. Additional Health Services not authorized in the original request~~referral~~ require a new authorization~~referral~~.

(B) National Committee for Quality Assurance (NCQA). Continuity of care with the Non-Participating Provider is required under current NCQA standards.

Section 6.6 Emergency Health Services. We will Cover Allowed Amounts for Emergency Health Services rendered by Participating or Non-Participating Providers. Such services must meet the requirements listed below.

(A) Provided during the course of the Emergency,
(B) Medically Necessary for evaluating and treating an Emergency condition, up to the point of Stabilization, and
(C) Provided by or under the direction of a Provider.

Health Services are not Covered if We determine that the situation was not an Emergency, as defined by this Contract.

Subsequent follow-up care by Non-Participating Providers after the condition is no longer an Emergency is not Covered without Our prior written approval.

Section 6.7 Inpatient Emergency Health Services by Non-Participating Providers. If [You are][an Enrollee is] hospitalized in a Non-Participating facility due to an Emergency, You must notify Us within 48 hours after Emergency Health Services are initially provided or as soon thereafter as is reasonably possible. You must make available full details of the Emergency Health Services received, at Our request.

Any continued stay in a Non-Participating facility after the condition is Stabilized and is no longer an Emergency (1) requires coordination by a Participating Provider, and (2) requires Our prior written authorization. We may elect to transfer You to a Participating Hospital once it is medically appropriate to do so.

Health Services rendered by Non-Participating Providers are not Covered if You (1) fail to notify Us within 48 hours of the initiation of Emergency Health Services or as soon as reasonably possible thereafter, or (2) choose to remain in a Non-Participating facility after We have notified You of the intent to transfer You to a Participating facility.

Section 6.8 Access to Health Services. Additional information on access to Health Services can be obtained through any means listed below.

(A) Our Participating Provider Directory.
(B) Our Enrollee newsletter.
(C) Our Customer Service Department at the number or website below.
1-855-417-5615~~1-800-XXX-XXXX~~
www.mdwisemarketplace.org

Article 7

PROCEDURES FOR REIMBURSEMENT OF ALLOWED AMOUNTS

Section 7.1 Identification Card ("I.D. Card").

The Subscriber[, and spouse, if applicable,] will receive an I.D. Card. The I.D. Card will identify [any Dependents that are][each Dependent] Covered under the Contract. You may be charged a fee for additional or replacement cards.

Information on Your I.D. Card is needed for the Participating Provider to bill Us. *You must show Your I.D. Card every time You request Health Services[for an Enrolled Dependent]*. If You do not show the I.D. Card, Participating Providers have no way of knowing that [You are][the Dependent is] an Enrollee.

When failure to show an I.D. Card results in non-compliance with required procedures, Coverage may be denied.

Section 7.2 Participating Provider Services. We pay [Your] Participating Providers for [Your][an Enrollee's] Covered Health Services. You may be responsible for paying the Participating Provider for any applicable Copays, Coinsurance, or Deductibles included under this Contract. Please refer to the Schedule of Benefits for any applicable Deductible, Coinsurance or Copay information.

Section 7.3 Procedures for Health Services Received from Non-Participating Providers. If [You receive][an Enrollee receives] Health Services from a Non-Participating Provider, the rules below apply for claims submitted by You or by a Non-Participating Provider on Your behalf.

Claim Forms. You can locate Our claim forms on Our website, www.mdwisemarketplace.org, or You can notify us of a claim and ~~w~~We will mail You Our claim forms. If ~~y~~You do not receive Our usual claim forms within fifteen (15) days of this request, You may file a claim without them. The claims must contain written Claim Documentation.

Notice of Claim**.** You must inform Us of the claim within thirty (30) days of the date the Covered Health Service began or as soon as reasonably possible.

Claim Documentation. You must send ~~u~~Us written Claim Documentation within one hundred and eighty (180) days of the date the Covered Health Service began or as soon as reasonably possible. Claim Documentation furnished more than one (1) year late will not be accepted, unless You had no legal capacity in that year.

Cooperation By You. You or Your representative must fully cooperate with Us in determining Our rights and obligations under this Contract. You must cooperate as often as may be reasonably necessary. This means You or Your representative must do all of the following items, as requested.

(1) Sign, date and deliver to Us authorization to obtain any medical or other information, records, or documents We deem relevant from any person or entity.
(2) Give Us, or Our representatives, any medical or other information, records or documents ~~w~~We deem relevant.
(3) Answer, under oath or otherwise, any questions We deem relevant, which We or Our representative may ask.
(4) Furnish any other information, aid or assistance that We may require, including without limit, assistance in communicating with any person or entity (including requesting any person or entity to promptly give Us, or Our representative, any information, records or documents requested by Us).

If You or Your representative fails to give any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by Us unless and until We receive the item or information or You do the action ~~w~~We have requested, subject to the terms and conditions of this Contract.

In addition, failure on Your part or on the part of Your representative, to give ~~u~~Us any of the items or information requested or to take any action requested may result in the denial of Your claims.

Payment of Claims. Any payment made by Us in good faith under this Section shall fully discharge Our obligation to the extent of the payment. We reserve the right to deduct any overpayment made under this Contract from any future benefits payable under this Contract.

Foreign Claims Incurred for Emergency Care. Claims incurred outside the United States for Emergency Care and treatment must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper Claim Documentation.

Assignment. We will reimburse a Hospital or Provider if You assign in writing [Your][an Enrollee's] health insurance benefits, and We approve the assignment. Any assignment to a Hospital or Provider providing treatment, whether with or without Our approval, shall not confer upon such Hospital or Provider any right or privilege granted to You under this Contract except for the right to get benefits, if any, that We have determined are due and payable.

Physical Examination and Autopsy. We shall have the right and opportunity to examine [You][an Enrollee} while a claim is pending or while a dispute over a claim is pending. These examinations are made at Our expense and as often as We may reasonably require. We also have the right to have an autopsy made where the law does not prohibit it.

Legal Action. You may not bring any suit on a claim until at least sixty (60) days after the required Claim Documentation is given. You may not bring any suit more than three (3) years after the date Claim Documentation is required.

Section 7.4 Filing a Claim for Non-Participating Provider Services. If You need to file a claim under the procedures identified in Section 7.3, submit Your claim to the address below. The claim forms are ~~also~~ available on our website, www.mdwisemarketplace.org.

MDwise, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423

Be sure Your claim includes all of the information listed below.

~~(B)~~(A) Your name and address.
~~(C)~~(B) Patient's name, date of birth, and Enrollee I.D. number (shown on Your I.D. card).
~~(D)~~(C) Name and address of the Non-Participating Provider of services.
~~(E)~~(D) Diagnosis from the Provider.
~~(F)~~(E) Bill which gives a CPT code, or description of each charge.
~~(G)~~(F) Date the Injury or Sickness began.

Some claims may require more information before being processed. Benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

Section 7.5 Coverage through Non-custodial Parent. Whenever a Child under the age of 18 is an Enrolled Dependent under this Contract through a [Subscriber that is a] non-custodial parent, We shall, upon the custodial parent's written request do all of the following.

(A) Provide any information to the custodial parent that is necessary for the child to obtain benefits through this Contract.
(B) Permit the custodial parent, or the Provider with the custodial parent's approval, to submit claims for Covered Health Services without the non-custodial parent's approval.
(C) Pay claims submitted by the custodial parent or the Provider in accordance with (B) above, directly to the custodial parent or Provider.

Section 7.6 Payment of Claims. We shall pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. You will

receive a copy of that request for additional information, for Your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. Claims submitted by Providers are also governed by Indiana Code § 27-13-36.2.

Article 8

GRIEVANCE PROCEDURES

Section 8.1 Who May File. You or Your Designated Representative may file any of the following.

(A) A Grievance.
(B) An Appeal.
(C) A request for an External Appeal.

In each of these review processes, Your notice to Us is considered to be filed on the date We first receive it orally or in writing.

Detailed information on how to submit all of the above may be found in this Contract, on Our website, in newsletters, and in medical management determination letters sent to Enrollees when a Health Service is denied. At least annually in a newsletter, We notify Enrollees about the Grievance and Appeal process and the availability of External Appeals.

Neither You nor Your Designated Representative will be subject to retaliation from Us for exercising Your rights to any of the review processes described in this Article. Also, We may not take any action against a Provider solely on the basis that the Provider represents You in any of the review processes described in this Article.

Section 8.2 Internal Grievance ~~Claim~~ Procedure. The MDwise Customer Service Department is responsible for the processing of Grievances. All Grievances are thoroughly researched and documented, and as necessary, are referred for resolution beyond the Customer Services Department. You may file a Grievance in writing or by calling MDwise Customer Service directly and a Customer Service representative will assist You in filing the Grievance.

We must receive Your request to initiate the Grievance process within 180 days from the date We provide You an initial notice of denial. We will acknowledge Your Grievance, orally or in writing, within three business days of Our receipt of it.

In Your Grievance, You should express Your concerns in detail and provide copies of any supporting documents. You should provide us with the following information:

(A) Your Name [and the patient's name]
(B) [The patient's] Date of Birth
(C) Date of Grievance
(D) Type of Grievance
(E) Summary of the substance of the Grievance
(F) Summary of the actions taken.

We will document the substance of the Grievance and any actions taken.

You are permitted to review the Grievance claim file and to present evidence and testimony as part of the internal claims and appeals process.

The MDwise Customer Service Representative appointed to Your Grievance will conduct a thorough investigation of the facts of Your Grievance, including any aspects involving critical care, and make a decision regarding it. Other Providers or individuals We employ may be consulted before the decision is made.

Our decision regarding Your Grievance must be made as soon as possible. We will notify you in writing no later than

(A) 15 days after the date Your Grievance was filed, for a Pre-service ~~Claim~~Grievance, and

(B) 20 business days after Your Grievance is filed, for a Post-service ~~Claim~~Grievance,

when the issue is resolved and inform You of Your right to Appeal Our decision. If Your Grievance is considered an Urgent Grievance~~Care Claim~~ or Concurrent Care Claim, We will follow the timing requirements outlined in Sections 8.3 and 8.4 respectively.

If We are not able to make a decision by the applicable deadline due to reasons beyond Our control We will notify You in writing of the reason for the delay not more than 14 days after the date Your Grievance was filed, for a Pre-service ~~Claim~~Grievance, and not more than 19 business days after Your Grievance is filed, for a Post-service ~~Claim~~Grievance. We shall also issue You a written notification of the resolution of Your Grievance not more than 10 business days after notifying You of the reason for delay.

If We do not receive from You all of the information necessary to complete the review of Your Grievance, You will be afforded an extension of at least 45 days within which to provide ~~the~~ Us with the specified information. We will resolve Your Grievance not more than ~~2~~10 business days after We receive such necessary information.

We will provide You with any new or additional evidence considered, relied upon, or generated by Us in connection with the claim, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date. Before We issue a final decision based on a new or additional rationale, We will provide You with the rationale, free of charge and as soon as possible and sufficiently in advance of the date on which we notify you of Our determination to give You reasonable opportunity to respond prior to that date.

~~We will notify You in writing of the resolution of the grievance within 5 business days after the resolution.~~

If You are not satisfied with Our decision regarding Your Grievance, You have the right to file an Appeal with Us as set forth in Section 8.5 of this Contract.

Section 8.3 Urgent Grievance~~Care Claim~~ Procedure. If You are not satisfied with a decision We made either before or after You have filed a Grievance and Your situation meets the requirements of an Urgent Grievance~~Care Claim~~, You have the right to use this Urgent Care procedure. Once identified as such, an Urgent Grievance~~Care Claim~~ will be subject to only one review before becoming eligible for the External Appeal process described in Section 8.6.

Your Urgent Grievance~~Care Claim~~ may be expressed to Us orally or in writing and should set forth all issues, comments, or other documented evidence that support it. We will treat Your Urgent Grievance~~Care Claim~~ pursuant to the procedure described in Section 8.2 and Section 8.4, except that We will shorten the time limits as follows.

We will acknowledge Your Urgent ~~Care Claim~~Grievance within 24 hours (and include any request for additional information, if appropriate).

We will decide Your Urgent ~~Care Claim~~Grievance as soon as possible, but no later than 72 hours after the receipt of the initial request for the Urgent Grievance~~Care Claim~~. You will receive written or electronic notification of Our decision. We may notify You of Our decision orally, provided that a written or electronic notification is furnished to You no later than 3 days after the oral notification.

If You do not provide sufficient information for Us to determine whether or to what extent the benefits You seek are Covered or payable under the Contract, We will notify You within 24 hours of the specific information that You must submit for Us to answer Your Claim.

If You are notified that You need to provide additional information, You will have at least 48 hours in which to provide the additional information. We shall notify You of Our decision no later than 48 hours after We receive the

requested information. If You do not provide the requested information, We shall notify You of Our decision no later than 48 hours after the end of the time that You were given to provide the information.

Section 8.4 Concurrent Care ~~Claim~~ Procedure. If We reduce or terminate a Concurrent Care plan or course of treatment (other than by amending the Contract) before the end of the originally approved period of time or number of treatments, You will be notified sufficiently in advance of the reduction or termination to allow You to file a Grievance and Appeal of the decision before the benefit is reduced or terminated.

If Your request to extend a particular course of treatment beyond the period of time or number of treatments involves an Urgent Grievance~~Care Claim~~,

(A) We will notify You of Our decision as soon as possible, taking into account the medical exigencies, and
(B) We will notify You of Our determination, whether adverse or not, within 24 hours of Our receipt of Your request, provided that Your request was made to Us at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Section 8.5 Internal Appeal Procedure. If You are not satisfied with Our decision regarding Your Grievance, You have the right to submit an Appeal to Us within 180 days of Our decision regarding Your Grievance. You may file an appeal in writing or You may call MDwise Customer Service directly and a Customer Service Representative will assist You in filing the Appeal. We will acknowledge Your Appeal, orally or in writing, within three business days of Our receipt of it.

We will continue to provide You with Coverage under this Contract pending the outcome of the Appeal.

You may request continuation of Health Services during the Appeal process if an authorized Health Service is being terminate, reduced or suspended before the expiration of the original authorization date. Pre-service authorization requests and re-authorization request after a number of approved number of days, services, or visits expired do not apply. In the event of request for Concurrent Care Claim reviews beyond original authorization, You and Your provider will be notified of the Appeals process, as indicated in Section 8.4.

We will document the substance of the Appeal and the actions taken.

Your representative may act on Your behalf with respect to requesting an Appeal and the procedures involved. We allow You the opportunity for representation by anyone You choose, including a provider or attorney. For Urgent ~~Care Claim~~Grievance Appeals, a health care practitioner with knowledge of Your condition may act as Your representative.

We will investigate the substance of the Appeal, including any aspects of clinical care involved.

Our Appeal Committee (the Committee) will resolve the Appeal. The Committee shall be comprised of qualified individuals who were not involved in the investigation or resolution of the Grievance or involved in the matters giving rise to it. If the Appeal concerns health care procedures, treatments, or services that have been proposed, refused, or delivered, the Committee shall include one or more individuals who meet all of the following requirements

(A) Have knowledge of the Health Services at issue.
(B) Are in the same licensed profession as the Provider who proposed, refused or delivered the Health Service at issue.
(C) Are not involved in the matter giving rise to the appeal or the previous Grievance process.
(D) Do not have a direct business relationship with You or with the Provider who recommended the Health Service at issue.

You or Your Designated Representative may (A) appear in person before the Committee, or (B) communicate with the Committee through appropriate other means, if unable to attend in person.

You will have access free of charge, upon request, to copies of all relevant documents, records, and other information, as described by applicable U. S. Department of Labor regulations.

To support Your Appeal, You should submit to the Committee any written issues, arguments, comments, or other documented evidence. The Committee shall review all findings and pertinent documents, including any aspects of clinical care, whether or not We have considered them previously. The Committee will not afford any special deference to the original denial of Your Grievance. In no event shall Your claim that was previously denied under the terms of the Contract and upheld by an Appeals ruling be reconsidered by the Committee for review.

The Committee's decision regarding Your Appeal will be made as soon as possible and with regard to the clinical urgency of the Appeal, but not later than

(A) 30 days after the Appeal was filed, for Pre-Service ~~Claims~~Grievances.
(B) 45 days after the Appeal was filed, for Post-Service ~~Claims~~Grievances.

The Committee's decision regarding Your Appeal of an adverse benefit determination for an Urgent Grievance~~Care Claim~~ will be made not later than 72 hours after the receipt of Your request for review.

~~We will notify You in writing of the Committee's decision within 5 business days after it is decided.~~

Section 8.6 External Review of Grievances. You may pursue an External Appeal if You are not satisfied with Our Appeal decision. An Independent Review Organization ("IRO") is available for Appeals that involve an Adverse Determination of the following:

(A) a Medically Necessary Service,
(B) a Utilization Review Determination, or
(C) the experimental or investigational nature of a proposed Health Service, or
(D) a decision to rescind Your Contract

If Your Appeal did not involve one of the above three areas, You are not entitled to an External Appeal. Requests for excluded benefits or exceeded benefits are not eligible for External Appeal. [Also, if You are a Medicare recipient and have a right to an external review under Medicare (42 U.S.C. 1395 *et seq.*, as amended from time to time), there is no right to request an External Appeal.]

If Your situation qualifies, You or Your representative must file a written request for an External Appeal with Us no later than 120 days after You receive notice of the Appeal decision.

You may not file more than one External Review appeal grievance.

You shall not be subject to retaliation for exercising Your right to an External Review.

You are permitted to utilize the assistance of other individuals, including providers, attorneys, friends, and family members throughout the External Review process.

You are permitted to submit additional information relating to the proposed Health Service as issue throughout the External Review process.

You are required to cooperate with the IRO by providing or authorizing the release of any necessary medical information that We have not already provided.

We shall cooperate with the selected IRO by promptly providing any information requested by the IRO.

You may request an Expedited Appeal if Your External Review is of a Grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize Your life or health, or Your ability to reach and maintain maximum function. If You request an Expedited Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 72 hours after Your Expedited Appeal is filed, and
(B) notify You within 24 hours of after making the determination.

If Your External Review is a Standard Grievance Appeal then the IRO shall,

(A) make a determination to uphold or reverse Our decision regarding Your Appeal within 15 business days after the Standard Grievance Appeal, and

(B) notify You within 72 hours of making the determination.

An Expedited External Review can occur concurrently with the Appeals process for Urgent Care and Concurrent Care Claims.

When making its determination, the IRO shall apply,
(A) standards of decision making that are based on objective clinical evidence, and
(B) the terms of Your Contract.

You shall not pay any of the costs associated with the services of an IRO. All of the costs must be paid by Us.

We shall notify You of the IRO's decision within 2 business days of receiving it, including the basis/rationale for the decision.

The IRO's decision in an External Appeal is binding on Us, but You may have other legal remedies.

After You have received notification of the IRO's determination regarding Your External Review, You may request the IRO provide You with all information reasonably necessary to enable You to understand the,
(A) effect of the determination on You, and
(B) manner in which We may be expected to response to the IRO's determination.

We will authorize or provide disputed services promptly, and as expeditiously as Your health condition requires if the services were not furnished while the Appeal was pending and at any level reverses a decision to deny, limit or delay services.

Section 8.7. Suspension of the External Review Process. The External Appeal process will be suspended if the information You submit during the External Appeal is relevant to Our decision, and was not previously reviewed by Us during the Grievance or Appeal stages.

During the suspended External Review process, We will reconsider the new information You presented to Us and notify You of Our decision within the relevant timeframe listed below.
(A) 15 business days after the new information is provided to Us for a Standard Grievance Appeal, or
(B) 72 hours after the new information is provided to Us for an Expedited Appeal Grievance.

If We uphold the Grievance Appeal decision, You may request that the External Appeal resume.

Section 8.8 Contact Us. Questions regarding Your policy or Coverage should be directed to Our address, telephone number or website listed in this Section.

MDwise, Inc.
P.O. Box 441423
Indianapolis, Indiana 46244-1423
www.mdwisemarketplace.org
1-855-417-5615

Section 8.9 Indiana Department of Insurance. If You need the assistance of the governmental agency that regulates insurance, or have a complaint You have been unable to resolve with Your insurer, You may contact the Department of Insurance by mail, telephone or email the Indiana Department of Insurance at the contact information provided for in this Section.

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

Consumer Hotline – (800) 622-4461, (317) 232-2395

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

Section 8.10 Indiana Medical Malpractice Act. The review procedures described in this Article do not govern any issue covered in whole or in part by the Indiana Medical Malpractice Act. All such claims must be brought in accordance with applicable Indiana law.

Article 9

RENEWABILITY AND TERMINATION

Section 9.1 Renewability and Termination of Contract. We must renew or continue in force this Contract at Your option. We may terminate or refuse to renew this Contract only for the following reasons.

(A) Non-payment of premium, subject to the notice and Grace Periods defined in this Contract.
(B) We rescind coverage based upon fraud or an intentional misrepresentation of material fact made by You under the terms of the Contract.
(C) We receive a written request from You to terminate this Contract as provided in Section 9.6.
(D) [We receive notice from the Exchange that] [You][all Enrolled Dependents] are no longer eligible for coverage [under this Contract][through the Exchange].
(E) You obtain coverage from another [~~q~~Qualified ~~h~~Health ~~p~~Plan through the Exchange][health plan] during an Open Enrollment period or a Special Enrollment period.
(F) [Our status as a Qualified Health Plan for the Exchange is terminated by the Exchange.]
(G) You no longer reside or live in Our Service Area.
(H) Death [of the Subscriber].

Section 9.2 Discontinuance of a Particular Type of Contract. We may discontinue a particular contract if We do all of the following.

(A) We provide You with written notice at least 90 days before the date the contract form will be discontinued.
(B) We offer You the option to purchase any other individual contract We currently offer.
(C) We act uniformly without regard to any health status-related factor of Enrollees or [Dependents of Enrollees] that may become eligible for Coverage.

Section 9.3 Discontinuance of All Coverage. We may discontinue all contracts in the individual market in Indiana if We do all of the following.

(A) We provide You and the Indiana Department of Insurance with written notice at least 180 days before the date Your Coverage will expire.
(B) We discontinue and do not renew all Contracts We issue or deliver for issuance in the State of Indiana in the individual market.
(C) We act uniformly without regard to any health status-related factor of Enrollees or Dependents of Enrollees that may become eligible for Coverage.

Section 9.4 Exception for Uniform Modification of Coverage. We may, at the time of renewal, modify this Contract if the modification is consistent with the laws of the state of Indiana and is effective uniformly for all persons who have coverage under this type of contract.

Section 9.5. Notice and Effective Date of Termination. We shall provide You with written notice of our intent to terminate or not renew this Contract. This notice will identify the date upon which Your Coverage will cease. This date will be referred to as the "Effective Date of Termination".

Our notice to the Subscriber shall be deemed as notice to [the Subscriber's Enrolled Dependents][each Enrolled Dependent] and is sufficient if mailed to the Subscriber's address as it appears in Our records. Notice is effective when deposited in the United States mail with first class postage prepaid.

Termination of this Contract shall not prejudice any claim for Health Services rendered before the Effective Date of Termination. All requests for reimbursement, however, must be furnished as provided in Article 7.

Section 9.6 Process for Termination of Coverage By Written Request of Subscriber. You may terminate this Contract or Coverage for an Enrollee under this Contract with reasonable notice to [the Exchange or] Us. Reasonable notice is defined as fourteen (14) days prior to the requested Effective Date of Termination.

If You provide reasonable notice, the Effective Date of Termination is the date specified in Your notice. If You do not provide reasonable notice, the Effective Date of Termination is fourteen (14) days after We receive Your termination request, or an earlier date specified by Us if we are able to effectuate termination in fewer than fourteen (14) days.

If an Enrollee is newly eligible for Medicaid, the Children's Health Insurance Program for the state of Indiana, or the Basic Health Plan for state of Indiana (if such a plan is implemented), the Effective Date of Termination is the day before such coverage begins.

Section 9.7 Process for Termination of Coverage [Due to Loss of Eligibility].

~~(D)~~**(A) [Process for Termination of Coverage] When the [Enrolled Dependent] [Subscriber] is No Longer Eligible for Coverage [Under this Contract][Through the Exchange].** In the case of termination due to a [Subscriber][an Enrolled Dependent] no longer being eligible for Coverage [under this Contract][through the Exchange], the Effective Termination Date is the last day of the month following the month in which [the Subscriber loses eligibility][notice is sent to Us by the Exchange], unless the [Subscriber][Enrolled Dependent] requests an earlier Effective Termination Date.

~~(E)~~**(B) [Process for Termination of Coverage When a Dependent is No Longer Eligible Under the Contract**. In the case of termination due to a Dependent no longer being eligible for Coverage under this Contract, the Effective Termination Date is the last day of the month following the day in which the Dependent loses eligibility.]

Section 9.8 Process for Termination of Coverage Due to Non-Payment of Premiums. In the case of termination due to non-payment of premiums by a Subscriber subject to the general Grace Period identified in Section 5.3 of this Contract, the Effective Date of Termination will be the earliest date of the last paid date of Coverage if (1) the Grace

Period expires and any Premiums remain unpaid, or (2) We receive written notice of termination from the Subscriber during the Grace period

[In the case of termination due to non-payment of premiums by a Subscriber subject to the 3-month Grace Period identified in Section 5.4 of this Contract, the Effective Date of Termination will be on the last day of the first month of the three-month Grace Period. The [Subscriber][Enrolled Dependent] will receive notice of termination of Coverage no later than thirty (30) days prior to this Effective Date of Termination.]

Section 9.9 Process for Termination of Coverage When the [Subscriber][Enrolled Dependent] Changes to Another [Qualified Health Plan][Health Plan] During an Open Enrollment Period or Special Enrollment Period. In the case of termination due to a [Subscriber][Enrolled Dependent] changing to another [Qualified Health Plan][health plan] during an Open Enrollment period or Special Enrollment period, the Effective Date of Termination under the Contract shall be the day before the Effective Date of coverage in the [Subscriber's][Dependent's] new [Qualified Health Plan][health plan].

Section 9.10 Continued Inpatient Hospital Benefits. We will continue inpatient Hospital benefits for [a Covered Person][an Enrollee] if (1) We terminate this Contract, and (2) [the Covered Person][an Enrollee is hospitalized for a medical or surgical condition on the Effective Date of Termination. Such continued benefits shall end on the earliest of the dates specified in (A) through (E) below.

(A) The date [the Covered Person][an Enrollee] is discharged from the Hospital.
(B) The date [the Covered Person][an Enrollee] is covered under other health coverage if that coverage covers the inpatient hospital benefits.
(C) Sixty (60) days after the date this Contract ends.
(D) The last day the required Premium has been paid, if the grace period expires and the Subscriber has not made the required payment.
(E) The date the Subscriber terminates Coverage for the Subscriber and any Enrolled Dependents.

This section does not apply if this Contract ends due to Our receivership.

[**Section 9.11. Extended Coverage for Disabled Children.** Coverage for a Child may continue beyond age 26 if all of the following factors exist.

(A) The Child is incapable of self-sustaining employment due to a mental or physical disability.
(B) The Child is primarily dependent upon the Subscriber for support and maintenance.
(C) We receive written proof of such incapacity and dependency from a Participating Provider, that is acceptable to Us, within 120 days of the Child reaching the age of 26.

This extended Coverage will continue so long as the Child remains so incapacitated and dependent, unless Coverage is otherwise ended by the terms of this Contract.

We may require proof from a Participating Provider that is satisfactory to Us of the Child's continued incapacity and dependency.]

Section 9.12 Reinstatement. If [Your][this] Contract was terminated for non-payment of Premium, You may request reinstatement of the Contract from [Us][the Exchange] within 30 days of the Effective Date of Termination. You must remit all premium that was due for the Coverage upon reinstatement. Upon receipt of the outstanding Premium [and notice from the Exchange][-or Us,] We will reinstate Coverage as of the Effective Date of Termination.

Article 10

RECOVERY SOURCE/SUBROGATION

Section 10.1 Recovery Source. The following persons or entities are collectively referred to as a Recovery Source

or Recovery Sources.

(A) Any person alleged to have caused the Enrollee to suffer Sickness, Injuries or damages,
(B) The employer of the Enrollee, or
(C) Any person or entity obligated to provide benefits or payments to the Enrollee. This includes, but is not limited to, underinsured or uninsured motorist protection and liability insurance.

Section 10.2 Recovery. An amount owed by a Recovery Source pursuant to a settlement, judgment, or otherwise.

Section 10.3 Our Rights to Reimbursement, Recovery, and Subrogation. If You obtain a Recovery from a Recovery Source for a Sickness or Injury or other condition for which You have received Health Services, then We will not Cover such Health Services to the extent of such recovery. However, if We Covered such Health Services the conditions listed below apply.

(A) You shall reimburse Us immediately from a collected Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) Other costs incurred in obtaining or collecting the Recovery,

  regardless of whether or not that collected amount fully compensates You.
(B) For a Recovery not yet collected, You grant to Us a first priority lien against such Recovery for 100% of the Health Services We Covered without a reduction for the fees and costs listed below.
  (1) Your attorney fees, and
  (2) other costs incurred in obtaining and eventually collecting the Recovery,

  regardless of whether or not the Recovery fully compensates You. We may give notice of such lien to the Recovery Source. You also assign to Us any benefits that You may have under any car insurance policy or other sources in order to enforce Our rights under this Article.
(C) We are subrogated to Your rights to seek a Recovery from a Recovery Source under any legal or equitable theory that You could assert against that Recovery Source. At Our option, We may bring a lawsuit against the Recovery Source in Your name or take, in Our sole discretion, such other necessary and appropriate action to preserve or enforce Our rights under this Article.
(D) You grant to Us a first priority lien against any Recovery We obtain under this subsection, whether or not You are fully compensated by the Recovery, to the extent of 100% of the Covered Health Services and Our reasonable costs, including attorneys fees, of pursuing and collecting the Recovery.

All Recoveries will be deemed as compensation for Covered Health Services regardless of how the Enrollee or the Enrollee's legal representative defines it.

We shall be responsible only for those legal fees and expenses relative to Your Recovery to which We agree in writing.

If the Sick or Injured Enrollee is a minor, any Recovery shall be subject to this Article to the extent permitted by applicable law, regardless of whether such Enrollee's parent, trustee, guardian, or other representative has access to or control of the Recovery.

The Enrollee agrees that acceptance of Covered Health Services is constructive notice of this Article in its entirety and constitutes full consent to it.

Section 10.4 Your Full Cooperation Required. In order to protect Our rights under this Article, You shall cooperate by doing all of the actions listed below.

~~(C)~~(A) Hold any collected Recovery in trust for Our benefit under this Article.
~~(D)~~(B) Notify Us of a claim or suit against a Recovery Source within 60 days of the action and of a proposed settlement at least 30 days before it is entered. You shall not, without Our written approval, accept any settlement that does not fully compensate or reimburse Us. If You fail to notify Us in accordance with this section, We shall not be obligated to cover the Health Services that provide a basis for the claim, suit or settlement.
~~(E)~~(C) Execute and deliver such documents as We may reasonably request including, but not limited to, documents to protect and perfect Our liens, to affect an assignment of benefits, and to release records.

~~(F)~~(D) Provide Us, or any party acting on Our behalf, any facts We need to subrogate the claim in a timely manner, but not more than one year after Our initial request for information or You will be responsible for any incurred claims.

~~(G)~~(E) Provide such other cooperation and information as We may reasonably request including, but not limited to, responding to requests for information about an accident, Sickness or Injuries and making court appearances.

~~(H)~~(F) Not prejudice Our rights.

Article 11

Coordination of Benefits

Section 11.1 Applicability. This Coordination of Benefit ("COB") section applies when an Enrollee has Coverage for Health Services under more than one "Plan," as defined below. The Order of Benefit Rules in Section 11.3 determines whether the benefits of this Contract are determined before or after those of another Plan. If the Order of Benefit Rules determines that this Contract is the "Primary Plan," as defined below, then the benefits of this Contract will not be reduced. If the Order of Benefit Rules determines that this Contract is the "Secondary Plan," as defined below, then the benefits of this Contract may be reduced.

Section 11.2 Definitions. The following definitions apply throughout this Article 11, but do not apply to the rest of the Contract:

(A) "**Allowable Expense**" means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a covered individual does not comply with the plan provisions, the amount of the reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

(B) "**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which an individual does not have Coverage under this Contract, or any part of a year before the date this COB provision or a similar provision takes effect.

(C) "**Plan**" means this Contract and any of the following arrangements that provide benefits or services for, or because of, medical or dental care or treatment:

(1) Employer insurance or Employer-type coverage, whether insured or uninsured. This includes prepayment, Employer practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
(3) Each arrangement described in (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(D) "**Plan Year**" means, for the initial Plan Year, the twelve-month period commencing with the date that Employer's coverage under this Contract becomes effective. Thereafter, it means the twelve-month period commencing on the anniversary of Employer's Coverage under this Contract.

(E) "**Primary**" or "**Primary Plan**" means the Plan that provides benefits for an individual before another Plan that covers the same individual. If this Contract is Primary to another Plan, this Contract's benefits will be determined before those of the other Plan without considering the other Plan's benefits.

(F) "**Secondary**" or "**Secondary Plan**" means the Plan that provides benefits for an individual after another Plan that covers the same individual. If this Contract is Secondary to another Plan, this Contract's benefits will be determined after those of the other Plan and may be reduced as a result of benefits provided by the other Plan.

Section 11.3 Order of Benefit Rules.

General. If there is a basis for benefits under this Contract and another Plan, this Contract is the Secondary Plan unless (1) the other Plan has rules coordinating its benefits with those of this Contract, and (2) the rules of this Contract and the other Plan require this Contract to be the Primary Plan.

Specific Rules. The following rules will be applied in the order they appear to determine whether this Contract is Primary or Secondary to another Plan:

(1) Non-Dependent or Dependent. The Plan that covers the individual as an active employee or inactive employee (i.e., laid-off or retired) rather than as a dependent is the Primary Plan except in the following situation. The Plan that covers the individual as a dependent is Primary to the Plan that covers the individual as an employee if the individual is also a Medicare beneficiary, and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is Secondary to the Plan covering the individual as a dependent and Primary to the Plan covering the individual as an employee.

(2) Dependent Child or Parents not Separated or Divorced. If two Plans cover the same child as a dependent of his parents, the Plan of the parent whose birthday falls earlier in a calendar year will be Primary. If both parents have the same birthday, then the Plan that has covered one parent longer will be the Primary Plan. However, if the other Plan has a rule based on gender instead of this birthday rule and, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

(3) Dependent Child or Separated or Divorced. If two or more Plans cover the same child as a dependent of divorced or separated parents the following rules apply unless a qualified medical child support order ("QMCSO"), as defined in ERISA, specifies otherwise:
   a. the Plan of the parent with custody of the Child is Primary;
   b. the Plan of the spouse of the parent with custody of the child is the next Plan to be Primary; and
   c. the Plan of the parent without custody of the child is the last Plan to be Primary.

   If a QMCSO states that a parent is responsible for the health care expense of a child, that parent's Plan is Primary as long as the administrator of the Plan has actual knowledge of the QMCSO. The plan of the other parent is the Secondary Plan. Until the plan administrator has actual knowledge of the QMCSO, then the rules stated in (a), (b), and (c) above apply for any Claim Determination Period or Plan Year during which benefits are paid or provided.

(4) Joint Custody. If a court order states that a child's parents have joint custody of the child but does not specify that one parent is responsible for the health care expenses of the child, the order of benefit rules in Paragraph (2), Dependent Child or Parents not Separated or Divorced will apply.

(5) Active or Inactive Employee. A Plan that covers an individual as an active employee is Primary to a Plan that covers the individual as an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(6) Dependent of Active or Inactive Employee. A Plan that covers an individual as a dependent of an active employee is Primary to a Plan that covers an individual as a dependent of an inactive employee (i.e., laid-off or retired). This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(7) Continuation Coverage. If an individual has Continuation Coverage under this Contract and also has coverage under another Plan as an employee or dependent, the other Plan is Primary to this Contract. This rule will be ignored if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits.

(8) Longer or Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that has covered the individual longer will be Primary to the Plan that has covered the individual for a shorter term.

Section 11.4 Effect on the Benefits of this Contract. Section 11.4 applies when the Order of Benefit Rules in Section 11.3 determine that this Contract is Secondary to one or more other Plans.

This Contract's benefits will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period:

(1) The benefits that would be payable for the Allowable Expenses under this Contract in the absence of this COB provision; and
(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of COB provisions like this Contract's COB provisions, whether or not a claim is made.

The benefits of this Contract will be reduced so that they and the benefits payable under the other Plans do not exceed the Allowable Expenses. Each benefit will be proportionally reduced and then charged against any applicable benefit limit of this Contract.

Section 11.5 Facility of Payment. If another Plan provides a benefit that should have been paid or provided under this Contract, We may reimburse the Plan for the benefit. We may then treat the amount as if it were a benefit provided under this Contract and will not be responsible for providing that benefit again. This provision applies to the payment of benefits as well as to providing services. If services are provided, then We will reimburse the other Plan for the reasonable cash value of those services.

Section 11.6 Right of Recovery. If this Contract provides a benefit that exceeds the amount of benefit it should have provided under the terms of these COB provisions, We may seek to recover the excess of the amount paid or the reasonable cash value of services provided from the following.
(1) The individuals We have paid or for whom We have provided the benefit;
(2) Insurance Companies; or
(3) Other Organizations.

Article 12

GENERAL PROVISIONS

Section 12.1 Entire Contract. The Contract, the Appendix, and any Amendments make up the entire Contract of Coverage between You and Us.

All statements made by the Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce Coverage under this Contract or be used in defense of a legal action unless it is contained in the Application.

Section 12.2 Limitation of Action. Requests for reimbursement are subject to the provisions of this Contract. No legal proceeding or action may be brought unless brought within 3 years from the date the cause of action first arose.

[The Enrollee's][Your] damages shall be limited to recovery of actual benefits due under the terms of this Contract. [The Enrollee waives][You waive] any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

Section 12.3 Amendments and Alterations. No agent has authority to change this Contract or to waive any of its provisions. No person has authority to make oral changes to this Contract.

We will give You 60 days advance notice before any material modifications to this policy, including changes in preventive benefits.

Section 12.4 Relationship Between Parties. The relationships between MDwise and Participating Providers are ***solely*** contractual relationships between a payor (MDwise) and independent contractors (Participating Providers). Non-Participating Providers have no contractual relationship with Us, nor are they Our independent contractors.

Providers are not Our agents or employees. We and Our employees are not employees or agents of Providers.

The relationship between a Provider and any Enrollee is that of Provider and patient. The Provider is ***solely*** responsible for the services provided to any Enrollee. The Participating Pharmacy is ***solely*** responsible for the pharmacy services provided to any Enrollee.

Section 12.5 Second Opinion Policy. A second opinion may be required at Our discretion prior to the scheduling of certain Health Services. We will advise You if a proposed Health Service is subject to the second opinion policy. If so, You must consult with a second Participating Provider prior to the scheduling of the service.

You must (1) contact Us to obtain a list of Participating Providers who are authorized to render a second opinion, and (2) arrange a consultation with the second Provider. The second Provider will not be affiliated with the first Provider.

You must obtain the second opinion within 31 days of the first opinion or as soon thereafter as is reasonably possible. Second opinions We have arranged as described above are provided at no cost to You.

A second opinion may also be obtained at the request of an Enrollee, subject to separate benefit restrictions and/or Copays/Coinsurance described elsewhere in this Contract.

Section 12.6 Wellness and Cost Containment Programs. We may implement wellness or cost containment programs for Enrollees. Such programs may Cover services and supplies that would not otherwise be Covered. Such programs are in Our sole discretion. They may be discontinued at any time without prior approval from other parties.

Section 12.7 Confidentiality of Non-Public Personal Information. As required by the Gramm-Leach-Bliley Financial Services Modernization Act of 1999, We provide You with notice that We protect the nonpublic personal information that We receive about You and Your Dependents. We obtain certain nonpublic information about You through this Contract. This includes information from You on Applications or other forms, and information about Your transactions with Us, Our affiliates, or others. We have always been committed to maintaining the confidentiality of Your information and we take the following steps to protect our nonpublic personal information

(A) We restrict access to information to authorize individuals who need to know this information in order to provide services and products to You or relating to Your Contract.
(B) We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard Your information.
(C) We do not disclose this information about You or any former customers, except as permitted by law.
(D) We make disclosures to affiliates, as applicable, as permitted by law.

Section 12.8 Confidentiality of Medical Information

By accepting Coverage, You authorize and direct any person or institution that has attended, examined, or treated You to furnish Us any and all related information and records. Such must be provided to Us at any reasonable time, upon Our request.

We and Our designees have the right to any and all records concerning Health Services as necessary to accomplish any of action listed below.

(A) To implement and administer the terms of this Contract,
(B) For appropriate medical review or other quality assessment, or
(C) For purposes of health care research.

Any information We obtain that pertains to Your diagnosis, treatment or health is confidential. We shall not disclose such information to any person except to fulfill Our obligations as described above, or as required by state or federal law.

Examples of when We may release such information as required by law are listed below.

(A) Upon Your express written consent.
(B) When a Child under the age of 18 is an Enrolled Dependent through a custodial parent, non-custodial parent, step-parent or legal guardian, except when the minor child has lawfully obtained Covered Health Services without the consent or notification of a parent or legal guardian.
(C) Under a statute or court order for the protection of evidence or the discovery of evidence, in the event of litigation between You and MDwise in which the information is pertinent.

We may claim any legal right against disclosure of the information that the Provider who supplied it may claim.

Section 12.9 Records. The Subscriber shall furnish Us with all information and proof that We may reasonably require with regard to any matters pertaining to this Contract.

The following items shall be open for Our inspection at any reasonable time (1) all documents furnished by an Enrollee in connection with the Coverage, and (2) any other records pertinent to Coverage under this Contract.

Both MDwise and Participating Providers may charge You reasonable fees to cover costs for completing medical abstracts or for other forms which You request.

Section 12.10 Examination of Enrollees. We may reasonably require that You be examined if a question or dispute about the provision of or payment for Health Services arises. The exam will be performed by a Participating Provider acceptable to Us. We will pay for the exam.

Section 12.11 Typographical or Administrative Error. Typographical or administrative errors shall not deprive an Enrollee of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

Section 12.12 Right of Recovery. If We pay for Health Services or benefits that, according to the terms of the Contract, should not have been paid, We reserve the right to recover such amounts from [You}[~~the~~ an Enrollee], the Provider to whom they have been paid, or any other appropriate party.

Section 12.13 Notice. Our notice to the Subscriber is deemed notice to all Enrolled Dependents. Such notice includes notice of termination of this Contract.

Our notice is sufficient if mailed to the Subscriber's address shown in Our records at the time of the mailing. Notice is deemed delivered when deposited in the United States mail with first class postage prepaid, unless otherwise stated in this Contract.

Any notice from You concerning this Contract must be sent to Our address listed in this Section.

MDwise, Inc.
P.O. Box 441423

Indianapolis, Indiana 46244-1423

Section 12.14 Contract is Not Worker's Comp Insurance. The Coverage provided under the Contract does not replace, supplement or provide a substitute for benefits to which an Enrollee is entitled under worker's comp, occupational disease, and similar laws.

The Contract does not Cover Health Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's comp, occupational disease and similar laws, even when the circumstances below are present.

~~(E)~~(A) If the Enrollee's employer is not properly insured or self-insured under such laws.
~~(F)~~(B) When an Enrollee refuses to use his or her employer's designated Provider.
~~(G)~~(C) When an Enrollee has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

An Enrollee must contact his employer or its worker's comp or occupational disease insurer for the provision or payment of such Health Services and expenses.

Section 12.15 Conformity with Statutes. The intent of this Contract is to conform to applicable laws and regulations in effect on the date this Contract became effective. The laws and regulations of the jurisdiction in which this Contract was delivered that are in effect on its Effective Date shall apply.

Any Contract provision which, on this Contract's Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

Section 12.16 Non-Discrimination. In compliance with state and federal law, We shall not discriminate on the basis of age, gender, color, race, disability, marital status, sexual preference, religious affiliation, or public assistance status.

We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care.

We shall not, with respect to any person and based upon any health factor or the results of Genetic Screening or Testing (1) refuse to issue or renew Coverage, (2) cancel Coverage, (3) limit benefits, or (4) charge a different Premium.

Section 12.17 General Conditions for Benefits. In the event of any major disaster or war, riot, civil insurrection, epidemic or any other emergency not within Our control (1) We will Cover Health Services as provided in this Contract to the extent that facilities and personnel are then available, and (2) We shall have no liability or obligation for delay or failure to provide Health Services due to lack of available facilities or personnel.

[**Section 12.18 Medicare.** Any Health Services Covered under both this Contract and Medicare will be paid according to Medicare secondary payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines. As a Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. For the purposes of the calculation of benefits, if the Enrollee has not enrolled in Medicare, We will calculate benefits as if they had enrolled.

The benefits under this Contract for Enrollees age 65 and older or Enrollees otherwise eligible for Medicare do not duplicate any benefit for which Enrollees are entitled under Medicare, except when federal law requires Us to be the primary payor.

Where Medicare is the primary payor, all sums payable by Medicare for Health Services provided to Enrollees shall be reimbursed by or on behalf of the Enrollees to Us to the extent We have made payment for such Health Services.]

MDwise ~~Silver 87%~~[BENEFIT PLAN] Schedule of Benefits

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copays, maximums and other limits that apply when You receive Covered Health Services from a Provider. Please refer to the "Benefits and Covered Health Services" article of this Contract for a more complete explanation of the specific Health Services Covered by the Contract. All Covered Health Services are subject to the conditions, exclusions, limitations, terms and provisions of this Contract including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Enrollee's responsibility for Covered Health Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Health Services must be provided by a Participating Provider. Services provided by Non-Participating providers are Not Covered and the cost of services will be Your responsibility unless otherwise specified in this Contract.

Coinsurance and Deductibles, as well as any maximums, are calculated based upon the Allowed Amount, not the Provider's charge.

Under certain circumstances, if We pay the Provider amounts that are Your responsibility, such as Deductibles, Copays or Coinsurance, We ~~may~~ will collect such amounts directly from ~~You~~ the ~~p~~Provider who will in turn collect them from you. You agree that ~~We~~ the ~~p~~Provider has~~ve~~ the right to collect such amounts from You.

Essential Health Benefits provided within this Contract are not subject to lifetime or annual dollar limitations. Certain non-Essential Health Benefits, however, may be subject to either lifetime and/or annual dollar limitations.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories.

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services and chronic disease management, and
- Pediatric vision services.

Such benefits shall be consistent with those set forth under the ACA and any regulations issued pursuant thereto.

BENEFIT PERIOD – Calendar Year
DEPENDENT AGE LIMIT – Until the Child attains age 26
CONTRACT SERVICE AREA: _____

MDWISE MARKETPLACE ~~"SILVER 87%"~~[BENEFIT PLAN]

DEDUCTIBLE		
	Tier 1	**Tier 2**
Per Enrollee	~~$250~~[$0-$5,500]	~~$1,500~~[$0-$6,600]
Per Family	[$0-$11,000]~~$750~~	~~$4,500~~[$0-$13,200]

The amounts paid toward the Tier 1 Deductible are concurrent with and apply toward the Tier 2 Deductible. The Deductible applies to all Covered Health Services except for office visits for primary care physicians and all specialist visits, Generic drugs, and preventive care. Copays do not apply toward the Deductible. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Deductible.

OUT-OF-POCKET LIMIT		
	Tier 1	**Tier 2**
Per Enrollee	~~$1,250~~[$0-$6,600]	~~$2,200~~[$0-$6,600]
Per Family	~~$2,500~~[$0-$13,200]	~~$4,400~~[$0-$13,200]

The Out-of-Pocket Limit includes all Deductibles, Copays and Coinsurance amounts You incur in a Benefit Period. The amounts paid toward the Tier 1 Out-of-Pocket Limit are concurrent with and apply toward the Tier 2 Out-of-Pocket Limit. Health Services from a Non-Participating Provider that have not received Prior Authorization do not apply toward the Out-of-Pocket Limit. Once the Enrollee and/or family Out-of-Pocket Limit is satisfied, no additional Copays/Coinsurance will be required for the Enrollee and/or family for the remainder of the Benefit Period.

Any amounts that You are responsible for paying for Health Services rendered by a Non-Participating Provider are separate from and do not apply to the Deductible and Out-of-Pocket Limits.

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Ambulance Services	~~$200 Copay per transport~~[$0-$500]Copay Per Transport	~~$200 Copay per transport~~[$0-$500] Copay Per Transport	$200 Copay per transport
Behavioral Health Services			
Inpatient Services	[0%-35%]~~5%~~ Coinsurance	~~20%~~[0%-50%] Coinsurance	Not Covered without Prior Authorization
Outpatient Services	~~$20~~[$0-$90] Copay per visit	~~$40~~[$0-$150] Copay per visit	Not Covered without Prior Authorization
Physician Home Visits & Office Services	[$0-$90] ~~$20~~ Copay per v$isit	[$0-$150]~~$40~~ Copay per visit	Not Covered without Prior Authorization
Dental Services (only when related to accidental injury or for certain Enrollees requiring general anesthesia)	[$0-$750~~$100~~] Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	[$0-$75~~10~~0] Copay per visit; $3,000 max/Benefit Period Copays / Coinsurance based on setting where Covered Services are received.	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
Diabetic Equipment, Education, & Supplies	Copays / Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the "Specialty Care" or "Primary Care Provider" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.		Not Covered without Prior Authorization
Diagnostic Services			
Laboratory and Pathology Services	~~$20~~[$0-$75] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	~~$40~~[$0-$150] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Radiology Services including MRI, CT, PET, Ultrasound	~~$75~~[$0-$300] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	~~$150~~[$0-$400] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
X-Ray Services	~~$20~~[$0-$75] Copay per visit Copays/Coinsurance may change based on	~~$40~~[$0-$150] Copay per visit Copays/Coinsurance may change	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
	setting where the Covered Health Services are received.	based on setting where the Covered Health Services are received.	
Emergency Room Services Copay/Coinsurance is waived if You are admitted.	~~$100~~[$0-$750] Copay per visit	~~$100~~[$0-$750] Copay per visit	~~$100~~[$0-$750] Copay per visit
Home Care Services	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Annual Visit Limitation for Home Care	90 visits, combined Tier 1 and Tier 2 Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 90 visits
Annual Visit Limitation for Private-Duty Nursing	82 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 82 visits

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Lifetime Visit Limitation for Private-Duty Nursing	164 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 164 visits
Hospice Services	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Inpatient and Outpatient Professional Services	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Inpatient Facility Services	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Annual Limitation for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2 combined limitation of 60 days
Annual Limitation for Skilled Nursing Facility	90 days, combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any days approved apply toward Tier 1 and Tier 2

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			combined limitation of 90 days.
Mammograms (Outpatient – Diagnostic & Routine)	For Mammogram Health Services recommended by the United States Preventive Services Task Force (USPSTF) and subject to guidelines by the USPSTF, see the "Preventive Care Services" provision in this Schedule. For all other Mammogram Health Services, see the "Diagnostic Services" provision in this Schedule.		Not Covered without Prior Authorization
Maternity Services	Copays/Coinsurance may change based on setting where the Covered Health Services are received.		Not Covered without Prior Authorization
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Participating Pharmacy)	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
	Note – Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are Covered the same as any other Medically Necessary items and Health Services and will be subject to the same annual Deductible, Coinsurance, Copay provisions otherwise applicable under the Contract. **Note –** If durable medical equipment or appliances are obtained through Your Primary Care Physician or another Participating Physician's office, Urgent Care Center Services, Outpatient Services, Home Care Services the		

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
	Copay/Coinsurance listed above will apply in addition to the Copay/Coinsurance in the setting where Covered Services are received.		
Outpatient Services			
Other Outpatient Services	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
	Note – Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copay/Coinsurance regardless of setting where Covered Services are received.		
Outpatient Surgery Hospital/Alternative Care Facility	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~20%~~ Coinsurance	Not Covered without Prior Authorization
Physician Home Visits and Office Services			
Primary Medical Provider (PMP)	$~~5~~ 0 Copay per visit PMP visits are not subject to the Deductible	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any Provider that is not Your chosen (or	Not Covered in Tier 2 or by a Non-Participating Provider. You must select Your PMP upon selecting MDwise, if you do not select a PMP MDwise will assign you one. Any

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
		assigned) PMP is considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.	Provider that is not Your chosen (or assigned) PMP is considered a Specialist. Your PMP will ***always*** be in your Tier 1 network.
Specialty Care Physician (SCP)	~~$20~~[$0-$90] Copay per visit	~~$40~~[$0-$150] Copay per visit	Not Covered without Prior Authorization
	Note – Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations Covered under "Preventive Care Services" in the Contract) received in a Physician's office are subject to the Other Outpatient Services Copay / Coinsurance.		
Allergy Services ~~Injections~~	[$0-$90] ~~$50~~ Copay if visit~~per injection~~	[$0-$150] ~~$50 Copay per injection~~Copay if visit	Not Covered without Prior Authorization
	[0%-35%] Coinsurance for Serum	[0%-50%] Coinsurance for Serum	Not Covered without Prior Authorization
	~~**Note –** Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations Covered under "Preventive Care Services" in the Contract) received in a Physician's office are subject to the Other Outpatient Services Copay / Coinsurance.~~ ~~The allergy injection Copay/~~Coinsurance will be applied to allergy serum when the injection(s) is billed by itself. The office visit Copay~~/Coinsurance~~ will apply if an office visit is billed with an allergy injection. No Copay if injection administered by a nurse.		

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
Preventive Care Services	No Copay	No Copay	Not Covered without Prior Authorization
Surgical Services	[0%-35%] ~~5%~~ Coinsurance	[0%-50%] ~~10%~~ Coinsurance	Not Covered without Prior Authorization
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	~~$20~~[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] ~~$40~~ Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
Therapy Services	~~$20~~[$0-$90] Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	[$0-$150] ~~$40~~ Copay per visit Copays/Coinsurance may change based on setting where the Covered Health Services are received.	Not Covered without Prior Authorization
	Note – If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.		

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
Annual Visit Limitation ~~(Includes both Rehabilitative and Habilitative Services)~~			
Physical Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Occupational Therapy (Limits apply separately to Rehabilitative and Habilitative Services)	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Speech Therapy (Limits apply separately to Rehabilitative	20 visit combined Tier 1 and Tier 2		Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers
and Habilitative Services)			Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 20 visits
Manipulation Therapy	12 visits combined Tier 1 and Tier 2		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 12 visits
Cardiac Rehabilitation	36 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2 combined limitation of 36 visits
Pulmonary Rehabilitation	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Tier 1 and Tier 2. When rendered in the home, Home Care Service limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.		Not Covered without Prior Authorization Any visits approved apply toward Tier 1 and Tier 2

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	**Tier 2**	**Non-Participating Providers**
			combined limitation of 20 visits
Urgent Care Center Services	[$0-$100]~~$40~~ Copay per visit	~~$80~~[$0-$200] Copay per visit	Not Covered without Prior Authorization
Pediatric Vision			
Pediatric Eyewear	No Copay	Not Available	Not Covered without Prior Authorization
Lenses	Limit 1 pair per year.	Not Available	Not Covered without Prior Authorization
Frame	Limit 1 per year from Pediatric Exchange collection.	Not Available	Not Covered without Prior Authorization
Contact Lenses	• Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) • Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) • Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) • Dailies (one month supply) = 30 lenses per eye (total 60 lenses)	Not Available	Not Covered without Prior Authorization

COVERED HEALTH SERVICES	COPAYS/COINSURANCE/VISIT LIMITATIONS/MAXIMUMS		
	Tier 1	Tier 2	Non-Participating Providers

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following.

- **Cornea and kidney transplants, and**
- **Any Covered Health Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above Health Services are Covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Enrollee cost shares.

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW/STEM CELL) SERVICES		
	Participating Transplant Provider	**Non-Participating Transplant Provider**
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (the number of days will vary depending on the type of transplant received and the Participating Transplant Provider Agreement. Contact the Transplant Case Manager for specific Participating Transplant Provider information) for services received at or coordinated by a Participating Transplant Provider Facility.	Starts one day prior to Covered Transplant Procedure and continues to the date of discharge.
Deductible	Not applicable.	Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will not apply to Your Out-of-Pocket Limit.
Covered Transplant Procedure During The Transplant Benefit Period	During the Transplant Benefit Period, No Copay/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and	During the Transplant Benefit Period, You will pay 50% of the Allowed Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Participating Transplant Provider Facility will not apply to Your Out-of-Pocket Limit.

	Office Services depending where the service is performed.	If the Provider is Non-Participating Provider for this Contract, You will be responsible for the Covered Health Services which exceed Our Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Health Services will be paid as Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
	Participating Transplant Provider Professional and Ancillary (non-Hospital) Providers	**Non-Participating Transplant Provider Professional and Ancillary (non-Hospital) Providers**
Covered Transplant Procedure During the Transplant Benefit Period	No Copay/Coinsurance up to the Allowed Amount.	You are responsible for 50% of the Allowed Amount. These charges will not apply to Your Out-of-Pocket Limit.
Transportation and Lodging	[0%-35%] ~~5%~~ coinsurance Covered, as approved by the Contract, up to a $10,000 benefit limit	Not Covered for Transplants received at a Non-Participating Transplant Provider Facility
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	[0%-35%] ~~5%~~ Coinsurance Covered, as approved by the Contract, up to a $30,000 benefit limit	Covered, as approved by the Contract, up to a $30,000 benefit limit. You will be responsible for 50% of search charges. These charges will not apply to Your Out-of-Pocket Limit.
Live Donor Health Services	Covered as determined by the Contract.	Covered as determined by the Contract. These

		charges will not apply to Your Out-of-Pocket Limit.

PRESCRIPTION DRUGS	
Days Supply Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limitation and Utilization Guidelines	
Retail Pharmacy (Participating & Non-Participating)	30
Mail Service	90
~~Retail Specialty Pharmacy (Participating & Non-Participating) and Specialty Mail Service~~Tier 4 Drugs	30* *~~See additional information in Specialty Participating Retail/Specialty Mail Service Section below,~~Some Tier 4 drugs may be available in 90 day supply via mail service.
Participating Retail Pharmacy Prescription Drug Copay/Coinsurance	
~~Generic~~ Tier 1Prescription Drugs	~~$10~~[$0-$30] Copay per Prescription Order ~~*Generic~~ Tier 1 drugs are not subject to the Deductible
Tier 2~~Preferred Brand~~ Prescription Drugs	~~$25~~[$0-$85] Copay per Prescription Order Tier 2 drugs are not subject to the Deductible.
~~Non-Preferred Brand Prescription~~Tier 3 Prescription Drugs	~~$50 Copay~~ [0%-35%]~~ ___%~~ Coinsurance per Prescription Order
~~Specialty Prescription~~ Tier 4 Prescription Drugs	~~$50 Copay~~[0%-35%] ~~___%~~ Coinsurance per Prescription Order; See ~~Specialty~~ Participating Retail/Specialty Mail Service Information below.
~~**Specialty Participating Retail, Including Specialty Mail Service Program, Prescription Drug Copay/Coinsurance**~~	
~~Level 1 Specialty Prescription Drugs~~	~~$30 Copay per Prescription Order~~

	~~*Generic drugs are not subject to the Deductible~~
~~Level 2 Specialty Prescription Drugs~~	~~$75 Copay per Prescription Order~~
~~Level 3 Specialty Prescription Drugs~~	~~$150 Copay per Prescription Order~~
~~Level 4 Specialty Prescription Drugs~~	~~$150 Copay per Prescription Order; See Specialty Participating Retail/Specialty Mail Service Information below.~~
~~***Note** –Certain Specialty Drugs in Levels 1–3 (including but not limited to oral HIV drugs and immunosuppressant drugs) may be dispensed in up to a 90-day supply, subject to the Mail Service Copays listed above. When a 30-day supply is obtained, the Copays listed below will apply. Specialty Drugs in Level 4 are limited to a 30-day supply.~~	
Non-Participating Retail Pharmacy and Non-Participating ~~Specialty~~ Pharmacy Prescription Drug Copay	
Non-Participating Retail Pharmacy and Non-Participating ~~Specialty~~ Pharmacy Prescription Drug Copay	Not Covered without Prior Authorization
Orally Administered Cancer Chemotherapy	
Orally Administered Cancer Chemotherapy	[0%-35%] ~~$50 copay~~ Coinsurance for retail; [0%-35%] ~~$150~~ Coinsurance for mail order As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to Coverage for cancer chemotherapy that is administered intravenously or by injection.

Note – Prescription Drugs will always be dispensed as ordered by Your Physician. You may request, or Your Physician may order, the ~~Preferred Brand~~ Tier 2 or ~~Non-Preferred Brand~~ Tier 3 Drug. However, if a ~~Generic~~Tier 1 Drug is available, You will be responsible for the difference in the cost between the Tier 1~~Generic~~ Drug and ~~Preferred Brand~~ Tier 2 or ~~Non-Preferred~~Tier 3 Drug. If a ~~Generic~~ Tier 1 Drug is not available, or if Your Physician writes "Dispense as Written" or "Do not Substitute" on Your Prescription, You will ~~only~~ be required to pay the applicable ~~Preferred Brand~~Tier 2 or ~~Non-Preferred Brand~~Tier 3 Copay/Coinsurance. You will not be charged the difference in cost between the ~~Generic~~Tier 1 Drug and ~~Preferred Brand~~Tier 2 or ~~Non-Preferred Brand~~Tier 3 ~~Prescription~~ Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in Our sole discretion, to remove certain higher cost Generic Drugs from this policy.

Note – No Copay/Coinsurance applies to certain diabetic and asthmatic supplies, up to the Allowed Amount when obtained from a Participating Pharmacy. These supplies are Covered as medical supplies, durable

medical equipment, and appliances if obtained from a Non-Participating Pharmacy. Diabetic test strips are Covered subject to applicable Prescription Drug Copay/Coinsurance.]

Actuarial Memorandum

MDwise Issuer #62033

Individual Health Insurance Exchange Premium Rate Filing

May 11, 2014

Developed By:

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1. EXECUTIVE SUMMARY

This memorandum documents the development of individual rates for MDwise. These rates will be offered inside of the State of Indiana's health insurance exchange, which is being operated by the federal government.

MDwise is a not-for-profit corporation that purchased 100% of the stock in IU Health Plan, Inc., a fully licensed HMO, (IUHP) on December 29, 2006. IUHP was merged into MDwise, Inc. as of January 1, 2007. MDwise remains a fully licensed Indiana domestic HMO. MDwise is jointly controlled by Indiana University Health, Inc. and Health & Hospital Corporation of Marion County Indiana. The two parent companies are not-for-profit, are incorporated in the State of Indiana, and are provider delivery system companies.

Beginning January 1, 2011, MDwise was granted a four-year contract with the State of Indiana (the "State"), through the Family and Social Service Administration ("FSSA") and Office of Medicaid Policy and Planning ("OMPP"), to arrange for and administer two risk-based managed care programs ("Hoosier Healthwise" and "Healthy Indiana Plan") for certain Indiana Medicaid enrollees. MDwise contracts with various delivery networks. The delivery networks accept the medical service risk for enrollees who choose a primary care provider after selecting the MDwise network. There were approximately 280,000 members enrolled in the Hoosier Healthwise and Healthy Indiana Plan products at December 31, 2013.

Under an Accountable Care Organization model, MDwise contracts with several integrated delivery systems to provide medical services and claims administration under risk contracts for their current business. MDwise has operated under this model since its inception.

MDwise is offering two individual health insurance products in the Bronze and Silver metal tiers and one individual health insurance product in the Gold metal tier. Being a non-profit health plan focused on low income individuals, MDwise expects most enrollment to be in the Silver plan, for individuals eligible for premium tax credits and cost sharing reductions. MDwise's mission is to provide health care services to the lower income population. One of the primary reasons that MDwise is entering the individual market within the health insurance exchange is to provide its Medicaid members with an MDwise product offering if they lose Medicaid eligibility.

MDwise has applied for a new HMO license in the State of Indiana (MDwise Marketplace). Our filing is in the review process. MDwise anticipates it to be active in time for 2015 Open Enrollment season. MDwise has applied and received a new HIOS ID number of 62033.

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2. GENERAL INFORMATION

Company Legal Name: MDwise Marketplace, Inc.

State: Indiana

HIOS Issuer ID: 62033

Market: Individual Market

Effective Date: January 1, 2015

Company Contact Information

Primary Contact Name: Elizabeth Eichhorn

Primary Contact Telephone Number: 317-822-7232

Primary Contact Email Address: Eeichhorn@mdwise.org

3. PROPOSED RATE INCREASES

MDwise began selling individual policies with effective dates beginning January 2014. They did not previously participate in the individual market. The effective rate increase is 35% for 2015 for all proposed individual policies. This large increase is driven primarily by Indiana's transition from a 209(b) state to a 1634 state and the associated population expected to enroll in the individual market because of this change.

4. EXPERIENCE PERIOD PREMIUM AND CLAIMS, BENEFIT CATEGORIES AND PROJECTION FACTORS

MDwise began selling individual policies with effective dates beginning January 2014. The effective rate increase for 2015 is 35% for all proposed individual policies.

Because they did not participate in the individual or small group markets prior to 2014 and 2014 experience is not yet credible, the rate development is based entirely on a manual rate.

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5. MANUAL RATE DEVELOPMENT

The basic manual rate development methodology is unchanged from the 2014 premium rate development. Updated market experience was not available at a sufficient level of detail to justify redeveloping the manual rate. Instead, we reflected emerging demographic and risk adjustment information in our morbidity assumptions and updated other assumptions that were different from 2014 including trend, the impact of reinsurance, benefit changes, leveraging of fixed cost sharing items and the addition of individuals expected to enroll in the Individual market starting in 2014 because of Indiana's transition from a 209(b) state to a 1634 state.

The approach to premium rate development is as follows:

1. Paid and/or allowed PMPM medical costs were developed using market information including competitor rate filings, premium rates, and financial filings. If historic experience net of member cost sharing was used, paid to allowed ratios were estimated using the Wakely pricing model. Table C-1 in Appendix C shows the various sources used for the small group source development.

2. Allowed PMPMs were adjusted for trend and ACA changes and requirements including EHB, pent up demand, morbidity changes between pre and post ACA enrollment and others described below.

3. The Wakely pricing model was calibrated to the adjusted allowed PMPMs and used to estimate paid to allowed ratios. Within a benefit plan offering, a consumer may choose to use providers in a preferred network of providers and receive reduced cost sharing, represented by Tier 1. If a consumer chooses instead to use non-preferred providers, the cost sharing is greater, represented by Tier 2. They have been blended with a 90% weighting on Tier 1 and 10% on Tier 2, reflective of MDwise's expectations on actual utilization. The pricing by tier and blended result is shown in Appendix A.

4. Administrative costs and regulatory fees and taxes, along with contribution to surplus were added.

Appendix C, Table C-2 shows the components of the starting allowed PMPM shown in Appendix A. A comparison to the 2014 development is also provided.

Source and Appropriateness of Experience Data Used

The allowed PMPM target for post reform experience was developed using pre-reform small group market information.

Even though the goal is to price individual products post reform, the post reform individual market may look more like the pre-reform small group market than the pre-reform individual market. Therefore, we reviewed rate filings and financial reports for Indiana small group products. We made adjustments for trend, benefit design, and others to adjust the allowed PMPM to the midpoint of the rating period.

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Population Changes

The manual rate incorporates results from the SOA study[1] (performed by Optum/Lewin) to estimate changes in morbidity from the Indiana pre-ACA market to that enrolled in Indiana post ACA. Results from other states and analyses, including those performed by Wakely were also reviewed, but the Lewin model framework was used. Wakely has performed detailed studies on behalf of individual states with broad health plan participation and detailed data collection. We have found some of the values provided by the health plans, high risk pool, and the state differ (sometimes significantly) from the values presented in the SOA study, which is reasonable given the different data sources used and differences in judgment likely between actuaries performing this type of modeling. We made adjustments and applied judgment with input from the health plan in developing the final estimates of how the post reform market would compare to the pre-reform market. The primary changes were to decrease the number of previously uninsured entering the market and to increase their assumed health status since the SOA values are targeted once the ACA has been fully implemented.

Wakely also reviewed emerging results from the Wakely National Risk Adjustment Reporting study. This study included participation from Indiana issuers, including MDwise. The issuers reported claims and demographic based risk adjustment information through February 2014. The project will include updated information throughout 2014 which we will be reviewing as it becomes available. Emerging Indiana information caused us to increase our morbidity assumption by 3%. This is primarily driven by a higher age distribution than originally anticipated. This adjustment captures expected morbidity over and above allowable rating variation.

The components of the Morbidity Adjustment are shown in Appendix C, Table C-2.

Appendix F provides the detail behind the base SOA tables and our adjustments to the SOA tables to develop the final morbidity adjustment factor in Appendix C (1.0339).

Pent up demand and the 2014 strategic renewal impact adjustments are described in more detail below.

Cost Adjustments

We have made two adjustments to account for cost variances.

- Smoking Load – We adjusted the base period data by a factor of 0.9874 to create an index rate that is reflective of a non-smoking population.
- Bad Debt – To account for the likelihood that some policy holders will not pay premiums within the grace period, we have increased rates by a factor of 1.00275. This is calculated assuming a 15% rate of non-payment of one out of twelve months on about 22% of premium, after considering federal subsidies (.15 x .224 x 1/12 = .00275).

[1] Web link (as of 4-4-2013): http://www.soa.org/NewlyInsured/

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Trend Factors (cost / utilization)

We assumed PMPM medical costs would increase by 8% annually from 2012 to 2015 due to ongoing increases in utilization, unit costs and technology. This assumption is based on review of rate filings for Indiana and other states, national publicly available trend surveys, and judgment. These trends do not include the effect of demographics or benefits because those adjustments are included elsewhere.

Essential Health Benefits (EHB)

We adjusted the allowed claims sources in the manual rate development for expected changes in covered benefits due to EHB requirements, specific to individual and small group market starting cost sources. The following is not an all-inclusive list but it highlights the benefits expected to have the most significant impacts on allowed costs:

- Maternity and prescription drug coverage.
- State mandated benefits included in the EHB that previously only applied to group coverage.
- Mental health and substance abuse parity. Each health plan will need to understand what benefit changes, if any, are needed to bring their current benefits up to parity, especially if the selected EHB is not at parity.
- Habilitative services, if not defined by the state, need to be defined by the plan. The impact on claims can vary significantly depending on the definition of the benefit.
- Pediatric vision and dental must be offered under EHB although pediatric dental may be excluded if a stand-alone dental plan is offered on the Exchange. Each plan must determine the resulting costs of pediatric coverage.

Adjustments for changing demographics, changes in benefits, and others were separately addressed and included in the premium rate development.

To incorporate these adjustments we increased the small group market source by 2%.

Provider Reimbursement Adjustment

MDwise provided Wakely with provider contracting targets by plan (based on service area) for inpatient facility, outpatient facility and professional categories of service. Wakely analyzed these targets and compared them to market information regarding current commercial reimbursement rates. We assumed provider volume by provider system would be consistent with current MDwise Medicaid volume by provider system. The total adjustments to allowed cost varied by plan and are reflected in the geographic factors.

Strategic Renewal Impact

Many health plans were working to provide communication and incentive for individual policyholders to renew on 12/1/2013, 1/1/2014, or at their scheduled renewal. This type of strategic approach has been used in the past as states have implemented different state based reforms. This approach likely increased the average morbidity of individuals included in the risk adjustment pool in 2014. The healthy individuals

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will get a smaller rate increase under pre-ACA policies due to rating for health status while the sicker individuals would get a better rate on ACA policies since they do not rate for health status. For 2015, the impact of strategic renewal would have disappeared but the administration allowed states to continue renewing these policies on pre-ACA products and Indiana has allowed such policies (referred to as a transitional or "grandmothering").

We have included a 10% adjustment (1.10 factor) within our manual rate development for this (part of morbidity adjustment in Appendix C, Table C-2).

Pent Up Demand

In 2014, there were many new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems or receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated and utilize preventive services.

We expect very little remaining pent up demand in 2015. Therefore, we have removed the pent up demand effect and used a factor of 1.0 in Appendix C, Table C-2.

Inclusion of Capitation Payments

While MDwise will pay the Delivery Systems a global cap rate (percentage of premium), the State of Indiana has required MDwise to report the underlying provider payments as the true medical costs to provide coverage in MDwise's financial statements. This is because the Delivery Systems are delegated a portion of the administrative costs associated with their members. Therefore, the capitation paid to the delivery systems is meant to cover direct medical costs, and provider overhead. Based on discussions between MDwise, CCIIO and the state of Indiana, we understand that this treatment will continue in 2014 and beyond. This is important because of the risk corridor protection and minimum loss ratio treatment, which affect the relative level of risk inherent in the premium rate development and overall delivery system payment amounts.

6. CREDIBILITY OF EXPERIENCE

MDwise began operating in the individual market in 2014 and that experience is not yet credible. As a result, the "Experience Period" section of Worksheet 1 of the URRT has not been populated. Similarly, the projection factors (cells J24:M29 on Worksheet 1) have also been left blank. The service category PMPMs shown in the "Credibility Manual" section of Worksheet 1 were developed based on the approach described above and assigned 100% credibility.

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7. PAID TO ALLOWED RATIO

The Wakely pricing model uses a nationally-representative detailed medical and pharmacy claim and enrollment data (Truven MarketScan) for over 40 million lives to develop paid to allowed pricing estimates for final rate development (as opposed to metal tier categorization). The model uses actuarially sound pricing methods to value the impact of deductibles, copays, coinsurance and maximum out of pocket cost sharing parameters. We calibrated the utilization and unit cost assumptions by category of service in the model to the allowed cost estimates underlying the manual rate and/or experience rate, including adjustments for EHB, trend, provider reimbursement changes by service category, average expected demographics and other adjustments discussed elsewhere in this report.

8. RISK ADJUSTMENT AND REINSURANCE

Projected Risk Adjustments PMPM

We have developed manual rates for a 1.0 average statewide risk and assumed that MDwise would enroll average risk individuals. Therefore, no risk adjustment PMPM payment is assumed in 2015.

Reinsurance

The presence of the Federal reinsurance program will reduce costs for issuers in the individual market. This adjustment is intended to capture the portion of costs that will be reimbursed to health plans for reinsurance. The 2015 reinsurance program has an attachment point of $70,000 and a maximum coverage limit of $250,000 per member. HHS will reimburse health plans 50% of paid costs between the attachment point and maximum coverage limit.

To estimate the impact of reinsurance, we reviewed several claims probability distributions (CPDs) from different sources, adjusted to our estimated allowed PMPMs. To estimate the impact of moving from allowed to paid continuance, we increased the attachment and maximum values from the federal parameters by the MOOP for various plans, since the vast majority of individuals would have already reached their MOOP when costs reach the reinsurance attachment point. Our estimates are very sensitive to the shape of the CPD, the overall allowed cost PMPM that the CPD is calibrated to, as well as the MOOP and underlying Actuarial Value of the plan. Based on sensitivity testing, we have assumed that the average reinsurance impact will be a 7.9% reduction to net allowed claims costs. This adjustment was applied uniformly across all benefit plan packages. We have assumed that the allocated federal reinsurance dollars will be sufficient to fund the federal reinsurance program in 2015, which is not guaranteed.

9. NON-BENEFIT EXPENSES AND PROFIT & RISK

Administrative Expense Load

MDwise developed expected administrative costs based on current administrative costs for their Medicaid line of business, adjusted to reflect any differences in functions or level of effort for the

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commercial product. MDwise assumed a 50% of administrative expenses would increase by 3% from 2014 on a PMPM basis while 50% would increase with premium rates. For the small service areas, the PMPM component was increased to spread fixed costs across a small member cohort.

Contribution to Surplus & Risk Margin

Three percent (3%) of premiums has been allocated to contribution to surplus.

Taxes and Fees

Taxes and regulatory fees include the following:

1. PCORI Fee = $0.25 PMPM
2. Issuer Fee = It is not clear if MDwise will be exempt from the issuer fee in 2015. We have assumed they will be subject to the fee in this filing.
3. Health Insurance Exchange Fee = 3.5% of premium for products sold through the Exchange. MDwise expects the vast majority of their business to be sold through the exchange and we have included the full 3.5% load in premium rate development.

Please note that in the URRT taxes and fees section, the risk adjustment and reinsurance fees have been excluded.

Reinsurance and Risk Adjustment Fees

The following fees were netted out of the experience in the URRT.

1. Reinsurance Charge = $3.67 PMPM
2. Risk Adjustment User Fee = $1.00 PMPY ($0.08 PMPM)

10. PROJECTED LOSS RATIO

Wakely's estimates indicate projected MLRs for the individual line of business of 83.8% for 2015. Consistent with the MLR and Risk Corridor calculations, regulatory fees and taxes were excluded from premium in the calculation of this value.

11. SINGLE RISK POOL

MDwise has established a single risk pool for all of its individual business. Since MDwise did not participate in the individual market prior to 2014, all of its individual business is non-grandfathered, non-transitional, and ACA-compliant.

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12. INDEX RATE

Index Rate for Projection Period

The starting allowed claim index of $810.19 is developed from the historical claim index rate of the Indiana Small Group Market. Appendix C, Table C-2 illustrates this development. The bullet points below briefly describe specific line items in Table C-2. For comparative purposes, the adjustment for average percentage of smokers has been retained in the table. Per CCIIO instructions, the adjustment for the smoker load should not be included in the starting allowed claim cost, so to calculate the $810.19 the factor is excluded.

- Base Period Allowed PMPM – These historical claim index rates are developed from publicly available information.
- Cost Adjustment – This adjustment accounts for cost differences between the base period and projected period and include an adjustment for the embedded smoking load in the base period and expected bad debt that is introduced by the grace period.
- Benefit Adjustment – This adjustment accounts for differences between the base period benefits and those offered under the exchange as essential health benefits.
- Morbidity Adjustment – This adjustment accounts for differences in the morbidity of the population underlying the base period allowed PMPM and the population expected in the exchange market. Included in this adjustment are considerations for morbidity and demographic differences, pent-up demand, and the impact of transitional policies.
- Trend factor – We used an assumed trend of 8.0% over 30 months to trend the base period data to a midpoint of 7/1/2015.
- Allowed Claim Index Rate by Source – The allowed claim index rate is calculated as the product of the historical claim index rate and all the factors listed above in this section.

Market Adjusted Index Rate

We included the impact of reinsurance and risk adjustment and the exchange user fee to the index rate for the projection period to develop the market adjusted index rate.

The development of this index rate can be seen in Appendix A, item g.

Plan Adjusted Index Rate

To bring the experience used in the manual rating to a “non-tobacco” basis, a downward adjustment is applied using a factor of 0.9875. Among the items contemplated when setting this assumption were the rates of tobacco use in Indiana as well as the proportion of people who will self-report as “Smokers.”

We multiplied the market adjusted rate by provider contracting discounts, the actuarial value and the federal induced demand factors.

We then included the admin, commissions, ACA fees, tax, and profit margin.

The development of this index rate can be seen in Appendix A, item v.

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Calibration

To bring the experience to age 21 rate, we divided the plan adjusted index rate by the weighted average age factor. The age factor was calculated as the weighted average of ACA age factors and the 2015 expected individual enrollment by age. The average age is approximately 50 years.

The development of this index rate can be seen in Appendix A, item w.

Consumer Adjusted Index Rate

The consumer adjusted index rates are calculated by multiplying the calibrated plan adjusted index rates by the consumer's specific age factor, area, and tobacco status. As last year's restrictions on the smoker load (limiting smoker loaded rates to the same 3:1 limit as non-smoker rates) have been removed, the loads have been change and are shown in Appendix D.

Using the age factors and smoking load Area Factors in Appendix D, one can take the index rate from Appendix A and develop the rates for each product and age combination. Two examples are provided in Appendix E.

13. AV METAL LEVELS

The Federal AVC was used without modification to generate the AV metal tier (column b on Appendix A). The Federal AVCs were as follows:

Bronze A	61.8%
Silver A (base)	71.9%
Silver A (73% CSR)	73.9%
Silver A (87% CSR)	87.7%
Silver A (94% CSR)	94.8%
Gold A	80.5%
Bronze B	58.3%
Silver B (base)	68.1%
Silver B (73% CSR)	73.8%
Silver B (87% CSR)	86.1%
Silver B (94% CSR)	93.0%

14. AV PRICING VALUES

The reference plan underlying our pricing was a Silver plan. From this base PMPM, we applied benefit richness utilization adjustments to stratify this PMPM to levels suitable for each of the metal tiers. We used the following values which are equal to the Federal values published in the Federal Register payment notice, normalized to the silver benefit level:

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Bronze = 1.00 / 1.03 = 0.9709

Silver = 1.03 / 1.03 = 1.0000

Gold = 1.08 / 1.03 = 1.0485

MDwise is not offering Platinum or Catastrophic plans.

The adjustment factors above are shown in Appendix A, column o.

The same underlying cost distribution and cost level was used. The only adjustment before determining AV pricing values was benefit richness utilization differences using Federal adjustment factors. **Therefore, differences in expected morbidity across metal tiers were not included in the pricing development for each metal tier plan.**

These adjustments do not incorporate a selection bias due to health status. Rather, they represent an adjustment due to any particular individual utilizing services differently when they have a richer or less rich benefit design.

The pricing AVs are higher than the Federal AVCs primarily because the estimated allowed PMPMs are higher than those underlying the Federal AV calculator. This is due to a leveraging effect for fixed cost sharing elements like copays, deductibles and MOOPs. This effect is more pronounced in 2015 than it was in 2014 because of the morbidity increases assumed due to the addition of the high risk population (conversion from 209(b) to 1634) and the higher age distribution.

15. MEMBERSHIP PROJECTIONS

The membership projections for 2015 were developed by Wakely in consultation with MDwise based on emerging enrollment and expected new enrollment for 2015.

Appendix B shows estimates of the Cost Sharing Reduction by Silver base and Silver variant level. We used the Federal formula shown in the Advance Payment Notice, which is equal to the difference in AVC multiplied by the allowed cost PMPM for each base plan, increased by 1.12 for cost sharing utilization for the 87% and 94% variants.

16. TERMINATED PRODUCTS

MDwise began selling individual policies with effective dates beginning January 1, 2014. They have no prior products to terminate.

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17. PLAN TYPE

MDwise is filing HMO products.

18. URRT WARNINGS

There were no warnings in the URRT.

19. RELIANCE

Wakely Consulting Group, Inc., 9777 Pyramid Ct, Suite 260, Englewood, CO 80112 relied on information provided by MDwise to develop the 2014 individual premium rates. This information includes, but is not limited to the following:

- Provider contracting levels, including descriptions of the relationship between the Delivery systems and MDwise
- Administrative cost projections
- Projected enrollment figures by QHP
- Product design information
- Provider network information including discount data
- CCIIO and the State of Indiana regulatory and compliance interpretations and rulings
- Commercial rate filings and financial reports of carriers participating in the pre-ACA market.

20. ACTUARIAL CERTIFICATION

I, Ross Winkelman, am a Fellow in the Society of Actuaries (FSA) and a member of the American Academy of Actuaries (MAAA). I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

The submission is in compliance with all applicable laws, regulations, and guidance of the Federal government and the state of Indiana as of May 10, 2014. The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:

ASOP No. 5, Incurred Health and Disability Claims

ASOP No. 8, Regulatory Filings for Health Plan Entities

ASOP No. 12, Risk Classification

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ASOP No. 23, Data Quality

ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

ASOP No. 41, Actuarial Communication

In my opinion, the premiums are reasonable in relation to the benefits provided and the population anticipated to be covered. Further, the premiums are not excessive nor deficient although actual experience may vary from the estimates inherent in the premium rate development.

The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with ASOPs.

The Federal AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

Electronic Signature

Ross Winkelman, FSA, MAAA
Managing Director
(720) 226-9801
RossW@Wakely.com

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Appendix A

Wakely Mdwise Premium Rate Development

Individual Market Premium Rates (Non-Smoker, 1.0 HHS Age Factor, by Metal Tier and Plan ID)

Plan ID (a)	Metal Tier (b)	Starting Allowed (c)	Impact of Reinsurance (% allowed) (d)	Impact of Risk Adjustment (e)	Exchange User Fee Adjustment (f)	Market Adjusted Index Rate (g)	Provider Contracting Adjustment (h)	Tobacco Adjustment (non-tobacco rates) (i)	Cost Sharing Utilization (j)	Tier 1 AV (k)	Tier 2 AV (l)	Tier 1 PMPM (m)	Tier 2 PMPM (n)	AV (o)	Composite PMPM (p)*
62033IN0010001	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010002	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010003	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010004	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010005	Silver								1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
62033IN0010006	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010007	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010008	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010009	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010010	Silver	$810.19	0.8962	1.0000	$12.27	$738.33	0.8663	0.9874	1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
62033IN0010011	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010012	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010013	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010014	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010015	Silver								1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
62033IN0010016	Bronze								0.9710	68.8%	65.5%	$409.34	$390.02	68.4%	$407.40
62033IN0010017	Silver								1.0000	77.5%	73.6%	$482.18	$457.87	77.1%	$479.75
62033IN0010018	Gold								1.0490	87.4%	96.2%	$578.79	$636.98	88.3%	$584.61
62033IN0010019	Bronze								0.9710	65.5%	65.5%	$387.76	$387.76	65.5%	$387.76
62033IN0010020	Silver								1.0000	73.6%	73.6%	$455.38	$455.38	73.6%	$455.38
	Total/Average								1.0012	76.7%	74.7%	$476.82	$464.71	76.5%	$475.61

Plan ID (a)	Metal Tier (b)	Fixed Admin (q)	Variable Admin (r)	PMPM Regulatory Fees (s)	Other Regulatory Fees (t)	Contribution to Surplus (u)	Plan Adjusted Index Rates (v)	Average Age Factor (w)	Calibrated Plan Index Rate (1.0 HHS Factors) (x)	Target Loss Ratio (y)	Projected Member Months (z)
62033IN0010001	Bronze	$32.94	$35.73	$3.44	$28.82	$15.72	$524.05	**1.75**	$299.46	79.9%	3,289
62033IN0010002	Silver	$32.94	$41.47	$4.01	$33.55	$18.30	$610.01	1.75	$348.57	80.9%	235,181
62033IN0010003	Gold	$32.94	$49.81	$4.58	$40.39	$22.03	$734.35	1.75	$419.63	81.8%	28,008
62033IN0010004	Bronze	$32.94	$34.21	$3.44	$27.55	$15.03	$500.91	1.75	$286.23	79.6%	29,603
62033IN0010005	Silver	$32.94	$39.58	$4.01	$31.97	$17.44	$581.31	1.75	$332.17	80.6%	53,995
62033IN0010006	Bronze	$35.54	$35.73	$3.44	$28.98	$15.81	$526.90	1.75	$301.08	79.5%	1,328
62033IN0010007	Silver	$35.54	$41.47	$4.01	$33.71	$18.39	$612.85	1.75	$350.20	80.5%	82,805
62033IN0010008	Gold	$35.54	$49.81	$4.58	$40.55	$22.12	$737.20	1.75	$421.26	81.5%	9,456
62033IN0010009	Bronze	$35.54	$34.21	$3.44	$27.71	$15.11	$503.76	1.75	$287.86	79.2%	11,956
62033IN0010010	Silver	$35.54	$39.58	$4.01	$32.13	$17.52	$584.15	1.75	$333.80	80.2%	18,994
62033IN0010011	Bronze	$35.54	$35.73	$3.44	$28.98	$15.81	$526.90	1.75	$301.08	79.5%	1,074
62033IN0010012	Silver	$35.54	$41.47	$4.01	$33.71	$18.39	$612.85	1.75	$350.20	80.5%	85,906
62033IN0010013	Gold	$35.54	$49.81	$4.58	$40.55	$22.12	$737.20	1.75	$421.26	81.5%	9,912
62033IN0010014	Bronze	$35.54	$34.21	$3.44	$27.71	$15.11	$503.76	1.75	$287.86	79.2%	9,666
62033IN0010015	Silver	$35.54	$39.58	$4.01	$32.13	$17.52	$584.15	1.75	$333.80	80.2%	19,745
62033IN0010016	Bronze	$36.94	$35.73	$3.44	$29.06	$15.85	$528.43	1.75	$301.96	79.3%	797
62033IN0010017	Silver	$36.94	$41.47	$4.01	$33.79	$18.43	$614.38	1.75	$351.08	80.3%	64,417
62033IN0010018	Gold	$36.94	$49.81	$4.58	$40.63	$22.16	$738.73	1.75	$422.13	81.3%	5,928
62033IN0010019	Bronze	$36.94	$34.21	$3.44	$27.79	$15.16	$505.29	1.75	$288.74	78.9%	7,171
62033IN0010020	Silver	$36.94	$39.58	$4.01	$32.21	$17.57	$585.68	1.75	$334.68	80.0%	14,827
	Total/Average	$34.41	$41.15	$4.00	$33.37	$18.20	$606.74	1.75	$346.71	80.6%	694,058

* The exchange user fee was excluded in this column and re-included in column (t).

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Appendix B

Wakely Mdwise Cost Sharing Reduction Estimates and Justification

(based on a 1.0 Area Factor)

Base Silver Plan	No CSR Allowed PMPM	Federal AVCs for Base and CSR Silvers				87% and 94% Utilization	CSR Advance Payments by Level			Weighted Average PMPM*
		Base Silver	73% Silver	87% Silver	94% Silver		73% Silver	87% Silver	94% Silver	
62033IN0010002	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010005	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010007	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010010	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010012	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010015	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010017	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19
62033IN0010020	$693.00	68.15%	73.69%	87.56%	94.37%	1.12	$38.39	$150.65	$203.51	$90.19

* See Actuarial Memo, Assumes 23.3% No CSR, 34.9% at 73% Silver, 15.7% at 87% Silver, and 26.1% at 94% Silver.

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Appendix C

Table C-1

Small Group Source Starting Allowed PMPM Development

Source	Allowed PMPM	Weight
Anthem SG Financial	$352.41	25.0%
UHLC Rate Filing	$421.71	25.0%
AWLP SG Rate Filing	$405.76	25.0%
ADVA Rate Filing	$480.85	0.0%
Plan Finder 1) Anthem PPO	$412.45	4.2%
Plan Finder 2) Anthem Lumenos	$334.88	4.2%
Plan Finder 3) United ChoicePlus	$430.98	4.2%
Plan Finder 4) Humana IN Copay 10	$367.33	4.2%
Plan Finder 5) All Savers Group	$343.55	4.2%
Plan Finder 6) Aetna PPO	$422.90	4.2%
Total / Weighted Average	**$391.31**	**100.0%**

Table C-2

Average Allowed PMPM Development for Appendix A from Starting Allowed PMPM

Item	Description	2015 Rate Development
(a)	Base Period Allowed PMPM (Small Group)	$391.31
	Cost Adjustment	
(b)	Bad Debt	1.0028
(c)	Benefit Adjustment	1.0200
	Morbidity Adjustment	
(d)	Morbidity	1.1545
(e)	Demographic - Age Gender (Outside of allowable age rating)	1.0692
(f)	Pent Up Demand	1.0000
(g)	2014 Strategic Renewal Impact	1.1000
(h)	Trend Factor to 7/1/2015	1.2122
(i)	Market Demographic (Allowable age rating)	1.2298
(j)	Allowed Claim Index Rate (product of all figures above)	$810.19

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Appendix D
Age Factors, Smoker Loads, and Area Factors

Demographics		HHS Factor	Smoker Load	Non-Smoker Load
	Children 00-20	0.635	1.000	1.000
Ages	21	1.000	1.050	1.000
	22	1.000	1.061	1.000
	23	1.000	1.071	1.000
	24	1.000	1.082	1.000
	25	1.004	1.093	1.000
	26	1.024	1.104	1.000
	27	1.048	1.114	1.000
	28	1.087	1.125	1.000
	29	1.119	1.136	1.000
	30	1.135	1.146	1.000
	31	1.159	1.157	1.000
	32	1.183	1.168	1.000
	33	1.198	1.179	1.000
	34	1.214	1.189	1.000
	35	1.222	1.200	1.000
	36	1.230	1.211	1.000
	37	1.238	1.221	1.000
	38	1.246	1.232	1.000
	39	1.262	1.243	1.000
	40	1.278	1.254	1.000
	41	1.302	1.264	1.000
	42	1.325	1.275	1.000
	43	1.357	1.286	1.000
	44	1.397	1.296	1.000
	45	1.444	1.307	1.000
	46	1.500	1.318	1.000
	47	1.563	1.329	1.000
	48	1.635	1.339	1.000
	49	1.706	1.350	1.000
	50	1.786	1.361	1.000
	51	1.865	1.371	1.000
	52	1.952	1.382	1.000
	53	2.040	1.393	1.000
	54	2.135	1.404	1.000
	55	2.230	1.414	1.000
	56	2.333	1.425	1.000
	57	2.437	1.436	1.000
	58	2.548	1.446	1.000
	59	2.603	1.457	1.000
	60	2.714	1.468	1.000
	61	2.810	1.479	1.000
	62	2.873	1.489	1.000
	63	2.952	1.500	1.000
	64 and Older	3.000	1.500	1.000

Rating Area	Area Factor
1	1.0000
2	0.9713
3	1.0748
4	0.9814
5	1.0082
6	1.0243
7	1.0761
8	1.0748
9	1.0261
10	1.0785
11	1.0748
12	1.0691
13	1.0823
14	N/A
15	1.0823
16	0.8636
17	1.1179

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Appendix E
Sample Rate Calculations

Example 1

Sample Plan:	62033IN0010001	
Metal Level:	Bronze	
Effective Date:	1/1/2015	
Rating Area:	2	
Age:	42	
Smoker Status:	Non-Smoker	
Calculation of Monthly Premium:		
Base Rate:	$299.46	Appendix A
Area Factor:	0.971	Appendix D
Age Factor:	1.325	Appendix D
Smoker/Non-Smoker Load:	1.000	Appendix D
Monthly Premium:	$385.39	Product of numbers above

Example 2

Sample Plan:	62033IN0010002	
Metal Level:	Silver	
Effective Date:	1/1/2015	
Rating Area:	5	
Age:	35	
Smoker Status:	Smoker	
Calculation of Monthly Premium:		
Base Rate:	$348.57	Appendix A
Area Factor:	1.008	Appendix D
Age Factor:	1.222	Appendix D
Smoker/Non-Smoker Load:	1.200	Appendix D
Monthly Premium:	$515.36	Product of numbers above

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Appendix F - SOA Values, Including Adjustments to SOA Values and Final Morbidity Adjustment

	OPTUM VALUES								Adjusted Values							
Figure 1- Changes in Sources of Coverage under the ACA in Selected State in 2014																HOME
Baseline Coverage	Total	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	768,681	200,861	43,675	493,581	556	2	23,974	6,032	768,681	200,861	10,919	526,337	556	2	23,974	6,032
Employer 51-100	149,666	27,449	6,762	113,722	13	-	1,204	516	149,666	27,449	6,762	113,722	13	-	1,204	516
Employer 101+	2,358,762	-	55,065	2,253,680	1,217	157	39,491	9,152	2,358,762	-	13,766	2,294,979	1,217	157	39,491	9,152
High Risk Pool	10,969	185	8,662	526	-	-	1,595	-	10,969	185	8,662	526	-	-	1,595	-
Other Non-Group	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093	178,442	3,899	84,597	12,050	52,167	-	13,637	12,093
Retiree	81,477	-	-	68,081	-	-	13,395	-	81,477	-	-	68,081	-	-	13,395	-
TRICARE	84,044	-	-	-	-	84,044	-	-	84,044	-	-	-	-	84,044	-	-
Medicare	815,120	-	-	-	-	815,120	-	-	815,120	-	-	-	-	815,120	-	-
Dual Eligible	138,231	-	-	-	-	138,231	-	-	138,231	-	-	-	-	138,231	-	-
Medicaid/CHIP	945,008	5,410	6,128	16,018	38	62	917,352	-	945,008	5,410	6,128	16,018	38	62	917,352	-
Uninsured	922,141	32,591	202,697	93,143	1,816	-	291,966	299,929	922,141	32,591	50,674	93,143	1,816	-	291,966	451,952
% of Currently Uninsured	-	3.5%	22.0%	10.1%	0.2%	0.0%	31.7%	32.5%	-							
Total	**6,452,541**	**270,394**	**407,586**	**3,050,802**	**55,807**	**1,037,616**	**1,302,613**	**327,723**	**6,452,541**	**270,394**	**181,508**	**3,124,857**	**55,807**	**1,037,616**	**1,302,613**	**479,745**

Elasticity Model - Lewin Baseline ACA model

	OPTUM VALUES								Adjusted Values							
Figure 1A- Changes in Morbidity under the ACA in Selected State in 2014																
Baseline Coverage	Pre-ACA PMPM	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured	Total #	Employer Exchange	Individual Exchange	Private Employer	Private Non-Group	Medicare/ TRICARE	Medicaid/ CHIP	Uninsured
Employer 2-50	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15	$464.98	$502.27	$536.56	$435.57	$143.94	$29.00	$524.49	$172.15
Employer 51-100	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08	$525.57	$436.55	$653.23	$534.97	$600.00	$0.00	$191.69	$996.08
Employer 101+	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92	$549.15	$0.00	$775.00	$543.36	$1,055.11	$218.98	$407.52	$288.92
High Risk Pool	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00	$2,328.49	$1,506.34	$1,789.03	$2,535.76	$0.00	$0.00	$3,853.87	$0.00
Other Non-Group	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32	$331.56	$271.89	$225.04	$173.60	$367.18	$0.00	$234.86	$161.32
Retiree	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00	$203.31	$0.00	$0.00	$199.98	$0.00	$0.00	$2,046.24	$0.00
TRICARE	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00	$849.19	$0.00	$0.00	$0.00	$0.00	$849.14	$0.00	$0.00
Medicare	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00	$1,038.36	$0.00	$0.00	$0.00	$0.00	$1,038.36	$0.00	$0.00
Dual Eligible	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00	$1,588.31	$0.00	$0.00	$0.00	$0.00	$1,594.90	$0.00	$0.00
Medicaid/CHIP	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00	$443.81	$711.57	$713.39	$344.38	$98.72	$1,069.25	$450.76	$0.00
Uninsured	$222.21	$369.76	$362.84	$627.13	$4,084.72	$0.00	$555.17	$125.31	$222.21	$369.76	$453.55	$627.13	$4,084.72	$0.00	$555.17	$125.31
Total	**$555.38**	**$481.18**	**$448.93**	**$518.34**	**$500.79**	**$1,097.05**	**$492.28**	**$133.45**	$557.04	$481.18	$456.37	$517.80	$500.79	$1,097.05	$492.28	$130.87

	Pre-ACA		Post ACA W/out Changes		Post ACA W/ Changes		Post ACA Modified / Original	
	Members	PMPM	Members	PMPM	Members	PMPM	Members	PMPM
Individual	178,442	$331.56	463,393	$455.18	237,315	$466.81	0.5121	1.0256
Small Group	768,681	$464.98	694,442	$454.86	727,198	$453.99	1.0472	0.9981

Post ACA PMPM / Pre-ACA PMPM (This is Morbidity Change Only)

1.4079 Individual to Individual
1.0039 Small Group to Individual
0.9764 Small Group to Small Group

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