

## CELTIC INSURANCE COMPANY

Home Office: 233 South Wacker Drive, Chicago, Illinois 60606-6393  
Major Medical Expense Certificate

The *policy* is underwritten by *us*, Celtic Insurance Company. *We* will pay *benefits* to *you*, the *insured person*, for covered loss due to *sickness, bodily injury or complication of pregnancy* as outlined in this certificate. *Benefits* are subject to certificate definitions, provisions, limitations and exceptions. *We* reserve the full and exclusive right to interpret the terms of this certificate and to determine the *benefits* payable hereunder.

Renewability: This certificate is renewable at the option of the *insured person* except in the case of nonpayment of premium, fraud or termination of the coverage for all *insured persons* in your State.

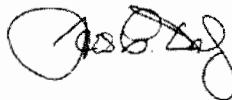
### TEN DAY RIGHT TO RETURN POLICY

Please read your certificate carefully. If you are not satisfied, return this certificate to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, less any *benefits* paid, and the certificate will be considered null and void from the effective date.

### CONSIDERATION

*We* issued this certificate in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the certificate.

Celtic Insurance Company



James P. Daly  
Chief Operating Officer and Executive Vice President

**Pre-existing Conditions Limitation.** A pre-existing condition is a *sickness or bodily injury* for which an *insured person* received a diagnosis, medical advice, consultation or treatment from a *physician* during the 12 months prior to the effective date of coverage, or which, in the opinion of a *physician*, caused symptoms during the 12 months prior to the effective date that were obvious enough to cause an ordinarily prudent person to seek diagnosis, medical care or treatment.

## SCHEDULE OF BENEFITS

### Plan Information

Plan Type:	Celtic Basic
Health Plan:	80/20
Primary Insured:	[REDACTED]
Certificate Number:	[REDACTED]
Date of Birth:	[REDACTED]
Original Effective Date:	[REDACTED]
Last Coverage Change Date:	[REDACTED]

### Dependent Information

<u>First Name</u>	<u>Relationship to You</u>	<u>Birth Date</u>	<u>Effective Date</u>
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

### Description of Benefits Per Insured Person

	<u>In-Network*</u>	<u>Out-of-Network</u>
Annual Deductible: (Per calendar year)	\$1500.00	\$1,500 in addition to the In-Network deductible
Hospital Confinement Deductible:	\$500 for each admission, in addition to the annual deductible	
Outpatient Deductible:	\$250 for each occurrence, in addition to the annual deductible	
Emergency Room Deductible:	\$250 for each emergency room visit, in addition to the annual deductible	
Lifetime Maximum Benefit:	\$5,000,000	
Preventive Care:	\$200 after coverage has been in force for 12 consecutive months	
Outpatient Prescription Drug Card Option:	No	

	<u>In-Network*</u>	<u>Out-of-Network</u>
Coinsurance:	20% of first \$10,000 of eligible expenses	40% of eligible expenses
Coinsurance Amount:	\$2,000 per Calendar Year	No limit
Out of Pocket Maximum:	\$3500 per Calendar Year	No limit
Physician's Office Visit Copayment: (Limited to 2 visits per calendar year)	\$30	Deductible and Out-of-Network Coinsurance apply

\*Celtic's primary PPO network is Private HealthCare Systems (PHCS)

### Outpatient Prescription Drug Card

Annual Deductible	\$1000
<b>Retail Copayment (30 day supply)</b>	
Generic:	\$25 copayment

**Outpatient Prescription Drug Card**

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Brand with a generic substitute:	\$25 copayment plus 100% of the cost difference between the brand name drug and the generic substitute.
Preferred Brand:	35% coinsurance
Non-Preferred Brand:	50% coinsurance
Specialty Drug:	50% coinsurance

**Mail Order Copayment (90 day supply)**

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Generic:	\$75 copayment
Brand with a generic substitute:	\$75 copayment plus 100% of the cost difference between the brand name drug and the generic substitute.
Preferred Brand:	35% coinsurance
Non-Preferred Brand:	50% coinsurance
Specialty Drug:	50% coinsurance

## SECTION I - DEFINITIONS

Note: Italicized words are defined in this certificate.

Masculine pronouns used in this certificate include the feminine.

*You, your* and *yours* refer to the *insured persons* named on the Schedule of Benefits. *We, us and ours* refer to Celtic Insurance Company.

**Ambulatory Care Facility** is a state licensed facility that is equipped to handle surgical and diagnostic procedures that require *hospital* facilities but do not require *hospital confinement*. An *ambulatory care facility* must:

- Be established, equipped and operated for the performance of surgical procedures by *physicians* who are part of an organized medical staff which includes full-time *nurses*;
- Have equipment and supplies not usually available to a *physician* outside a *hospital*, including operating rooms, a recovery room, diagnostic facilities, emergency equipment; and
- Have written agreement with a nearby *hospital* to accept patients who develop complications and require *hospital confinement*.

**Annual Deductible** is the amount of *incurred eligible expenses* that must be paid by or on behalf of the *insured person* per *calendar year* before *we* pay *benefits*. The maximum *annual deductible* for a family is three times an *insured person's annual deductible*. The *annual deductible* is shown on the Schedule of Benefits.

In the first *calendar year*, an *insured person* will receive a credit up to the amount of the *annual deductible* for any *deductible* paid under a prior group or individual health plan from January 1 of the current year until the effective date of this coverage. To receive this credit your prior plan must have terminated within 30 days of the effective date of this coverage.

**Asymptomatic Individual** is an individual who does not exhibit any evidence of disease or physical disorder.

**Beneficiary** is the person(s) named as the *beneficiary* on the application form or any other document accepted by Celtic.

**Benefit** is the amount or portion of *eligible expenses* that *we* pay under this certificate.

**Bodily Injury** is an accidental injury sustained by an *insured person* that directly results in a loss or an *eligible expense* under this certificate. The injury must occur while this coverage is in force.

**Calendar Year** is the period beginning on the initial effective date of this certificate and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

**Coinsurance** is the percentage of *eligible expenses* that must be paid by or on behalf of the *insured person* per *calendar year* after the *annual deductible*. This amount is shown on the Schedule of Benefits.

**Coinsurance Amount** is the actual dollar amount that must be paid by the *insured person*. This amount is shown on the Schedule of Benefits.

**Complication of Pregnancy** is a condition that is distinct from *pregnancy* but is adversely affected by *pregnancy*. Examples of such conditions include: acute nephritis, nephrosis, cardiac decompensation, and

conditions of comparable severity. It also includes conditions such as ectopic pregnancy and spontaneous abortion occurring when a viable birth is not possible.

It does **NOT** include: false labor, occasional spotting, threatened abortion, *physician*-prescribed rest during *pregnancy*, morning sickness, pre-eclampsia or other conditions related to a difficult pregnancy which cannot be classified as distinct from the pregnancy.

**Custodial Care** is treatment designed to assist an *insured person* with activities of daily living and not specifically aimed at curing or assisting in recovery from a *sickness, bodily injury* or *complication of pregnancy*.

*Custodial care* includes (but is not limited to) the following:

- Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
- Preparation of special diets;
- Supervision of medication which can be self-administered; and
- Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Such treatment is *custodial* regardless of who orders, prescribes or provides the treatment.

**Dependent** is a lawful spouse or unmarried child of the *primary insured person*. Unmarried *dependent* child includes step-child, legally adopted child and child in the custody of the *primary insured person* as a result of an interim court order of adoption.

**Donor** is a person or a cadaver donating an *organ* for the sole purpose of reinfusing, transfusing or transplanting into an *insured person*.

**Durable Medical Equipment** is equipment which:

- Is primarily and customarily used to serve a specific medical purpose;
- Can withstand repeated use;
- Is appropriate for use in the home;
- Is only useful to the *insured person* when he/she has a *sickness* or *bodily injury*; and
- Is not custom-fitted or made for or to the *insured person's* body.

**Elective Hospital Confinement** is a *medically necessary hospital confinement* prescribed by a *physician* that is not the result of a *medical emergency*.

**Eligible Expenses** are defined in the Eligible Expense provision of Section IV Benefits.

**Emergency Hospital Confinement** is a *medically necessary hospital confinement* resulting from a *medical emergency*.

**Emergency Room** is an organized *hospital* facility staffed 24 hours a day for treatment of a *medical emergency* and which provides outpatient services.

**Emergency Room Deductible** is the amount of *incurred eligible expenses* that must be paid by or on behalf of the *insured person* for emergency room charges before we pay *benefits*. The *emergency room deductible* is in addition to the *annual deductible* chosen and is shown on the Schedule of Benefits. If an *insured person*

is *hospital confined* immediately following an emergency room visit, the *emergency room deductible* will not apply. The *emergency room deductible* may not be used to satisfy the *out-of-pocket maximum*.

**Experimental / Investigational** is treatment or medication which includes, but is not limited to, a drug or procedure that is:

- Administered pursuant to a consent document which describes the drug, device or procedure as being a part of a research project that is *experimental or investigational*;
- Subject to the scrutiny of an Institutional Review Board, Peer Review Board or other body responsible for supervising biomedical research; and
- Has among its objectives the determination of the following: toxicity, maximum tolerance dosage, effectiveness and effectiveness in comparison to alternative treatment.

A treatment or procedure is **NOT** considered to be *experimental or investigational* if it is all of the following:

- Commonly performed on a widespread basis for treatment of the condition at issue;
- Generally accepted by the medical profession as the standard and most effective form of treatment;
- Proven safe and effective;
- *Medically necessary* for the patient;
- Recognized for reimbursement as a covered procedure or treatment by Medicare, Medicaid and other insurers;
- Used after other more conventional methods have been exhausted;
- Not deemed *experimental, investigational* or under investigation by the FDA and/or the AMA; and
- Legally obtainable.

**Extended Care Facility** is a licensed institution other than a *hospital* that provides inpatient medical care and treatment, or *psychiatric care*. The facility must be under full-time supervision by at least one *physician* or *nurse* and have 24 hour nursing service. Complete medical records must be kept and there must be a utilization review plan for all patients.

*Extended care facility* does **NOT** include institutions where care is not directed toward treatment of a specific medical condition. Such institutions are nursing homes or any other institution used mainly for convalescence, nursing, rest, housing the elderly or providing *custodial care* or educational care.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103) as then constituted or later amended.

**Home Health Care** is care provided in the home by a *home health care agency* that is prescribed by a *physician*. *Home health care* includes the following medical services and supplies:

- Services provided by a registered *nurse* or licensed practical *nurse*;
- Health services provided by physical, occupational, respiratory and speech therapists;
- Health services provided by a home health aide to the extent that such services would be covered if provided to the *insured person* on an inpatient basis;
- Medical supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided to the *insured person* on an inpatient basis; and
- Services provided by a licensed midwife or a licensed nurse midwife, as defined in West Virginia Code.

*Home health care* does **NOT** include treatment for alcoholism, drug or other substance abuse, neurosis, psychoneurosis, psychopathy, psychosis, or mental, nervous or emotional disease or disorder of any kind.

*Home health care* includes only treatment which is *medically necessary* and does not include *custodial care* or educational care.

*Home health care* also does **NOT** include services provided by someone who is related to an *insured person* by blood, marriage or adoption or who is normally a member of the *insured person's* household.

Each visit by a *home health care* agency staff of four hours or less is considered a single visit.

**Home Health Care Agency** is a public or private agency, licensed by the state in which the *home health care services* are provided or under Title XVIII of the Social Security Act, that provides nursing or therapeutic services in the home and operates within the scope of its license.

**Hospice Services** are services provided under a coordinated comprehensive program of palliative and supportive rather than curative care on a 24 hour, seven days per week basis for persons who have been diagnosed as terminally ill. Palliative care includes: pain and symptom management by a medical team; psychosocial, spiritual and practical support for the patient and family; and bereavement care.

**Hospital** is a legally operated institution that provides medical care and treatment through medical, diagnostic and surgical facilities either on its premises or available on a pre-arranged basis. It must be under the supervision of a staff of *physicians* and have 24 hour a day nursing service and maintain adequate medical records.

*Hospital* does **NOT** include institutions where care is not directed toward treatment of the condition for which the patient is *hospital confined*, such as nursing homes, *extended care facilities*, *skilled nursing facilities* or psychiatric or substance abuse facilities or any other institution used mainly for convalescence, nursing, rest, housing the elderly or providing *custodial care* or educational care.

**Hospital Confined or Hospital Confinement** means a stay as a registered bed patient in a *hospital* for 24 hours or longer. A registered bed patient is one assigned a bed in any department of a *hospital*, except the outpatient department, and who is charged for *room and board*. The stay must be recommended by a *physician* for a *medically necessary* purpose. The patient cannot leave the *hospital* during the stay.

**Hospital Confinement Deductible** is the amount of *incurred eligible expenses* that must be paid by or on behalf of the *insured person* for each *hospital confinement*. The *hospital confinement deductible* is in addition to the *annual deductible* chosen and is shown on the Schedule of Benefits. The *hospital confinement deductible* may not be used to satisfy the *out-of-pocket maximum*.

**Incurs, Incurred** refers to the date services or supplies are rendered to an *insured person*.

**Insured Person** means the *primary insured person* and includes any *dependents* listed on the Schedule of Benefits.

**Intensive Care Unit** is an area in the *hospital* that is appropriately equipped and used solely to provide intensive care for critically and seriously ill patients who require constant supervision as prescribed by a *physician*.

**Lifetime Maximum Benefit** is the total amount of *benefits* payable during an *insured person's* lifetime. This amount is shown on the Schedule of Benefits.

**Major Diagnostic Tests** are *medically necessary* procedures and tests performed in a *hospital*, outpatient facility, free-standing ambulatory surgical center, single-day surgery unit or a *physician's* office.

**Medical Emergency** is a sudden or unexpected onset of a *sickness, bodily injury, or complication of pregnancy* that requires immediate (no later than 24 hours after onset) medical or surgical care. Without immediate treatment these severe, often life-threatening conditions would result in death or permanent impairment to bodily functions.

**Medically Appropriate** means any medical service, supply or treatment that is *medically necessary* and which utilizes the most cost-effective, quality method and site of treatment, as determined by Celtic and its *physician* advisors.

**Medically Necessary** means any medical service, supply, or treatment authorized by a *physician* to diagnose and treat an *insured person's sickness, bodily injury or complication of pregnancy* which:

- Is consistent with the symptoms or diagnosis;
- Is provided according to generally accepted medical practice standards;
- Is not *custodial care*;
- Is not solely for the convenience of the *physician* or the *insured person*;
- Is not *experimental or investigational*;
- Is provided in the most cost effective care facility or setting;
- Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- Could not have been omitted without affecting *your* condition or quality of care; and
- When specifically applied to a *hospital confinement*, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges *incurred* for treatment not *medically necessary* are not *eligible expenses*.

**Non-PPO Hospital** is a *hospital* which is not a *PPO hospital*.

**Non-PPO Provider** is a medical care *provider* who is not a *PPO provider*.

**Non-Transplant Network Provider** is a medical *provider* who is not a *transplant network provider*.

**Nurse** is a graduate Registered nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.), midwife or licensed nurse midwife who is providing care prescribed by a *physician*. This definition does not include someone who is related to an *insured person* by blood, marriage, adoption, or who is normally a member of the *insured person's* household.

**Observation Unit** is an area in a *hospital* or outpatient facility providing outpatient observation of less than 24 hours for the purpose of monitoring a patient prior to or following an emergency treatment, *outpatient surgery* or *major diagnostic test(s)*.

**Organ** is a distinct part of the human body that serves a specific function such as respiration, secretion or digestion. The term includes the heart, lungs, kidneys, liver, bone marrow, stem cells (whether derived from the bone marrow or the peripheral blood), umbilical cord cells and any other variety of blood cells.

**Other Care Provider** is a Community Integrated Living Arrangement, group home, supervised apartment, or other residential service licensed or certified by the Department of Mental Health and Developmental Disabilities, the Department of Public Health, the Department of Public Aid, or a comparable state agency.

**Out-of-Pocket Maximum** is the sum of the *annual deductible* and the *coinsurance amounts*. This amount is shown on the Schedule of Benefits. After the *annual deductible* and *coinsurance amounts* are paid for

each *insured person* per *calendar year*, Celtic pays 100% of *eligible expenses* up to the *lifetime maximum benefit* listed on the Schedule of Benefits.

The *total out-of-pocket maximum* for a family is three times the *per insured person out-of-pocket maximum* per *calendar year*.

**Outpatient Deductible** is the amount of *incurred eligible expenses* that must be paid by or on behalf of the *insured person* for *outpatient surgery* or *major diagnostic procedures* performed in a *hospital*, outpatient facility or *ambulatory care facility*. The *outpatient deductible* is in addition to the *annual deductible* chosen and is shown on the Schedule of Benefits. The *outpatient deductible* may not be used to satisfy the *out-of-pocket maximum*.

**Outpatient Surgery** is *medically necessary* surgery performed in a *hospital* or outpatient treatment facility but not during a *hospital confinement*.

**Physician** means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a *bodily injury* or *sickness*.

A *physician* does **NOT** include someone who is related to an *insured person* by blood, marriage or adoption or who is normally a member of the *insured person's* household.

**Physician's Office Visit** means an evaluation and management service for which the *insured person* incurs a *physician office visit* charge.

**Physician's Office Visit Co-payment** is the amount that must be paid by or on behalf of the *insured person* and applies only to charges for an office visit. *Eligible expenses* received during or in conjunction with a *physician's office visit* are subject to the *annual deductible* and *coinsurance*. The co-payment does not apply toward the *annual deductible* or *out-of-pocket maximum* and continues to apply after the *out-of-pocket maximum* has been satisfied.

**Policy** is the contract between Celtic and the *policyholder*.

**Policyholder** is the trustee of the trust to which the *policy* is issued.

**Preferred Provider Organization (PPO)** is an organization of medical care *providers* that contracts to provide medical services or supplies at pre-determined rates. *Benefits* for *PPO eligible expenses* are payable during the term of *our* contract with the *PPO*. If the contract is terminated for any reason, no *incurred* charges are considered *eligible expenses* under the *PPO* plan.

**PPO Eligible Expense** is the amount of *eligible expense* charged by a *PPO provider*.

**PPO Hospital** is a *PPO provider* that is a *hospital*.

**PPO Provider** is a medical care *provider* under contract to the *PPO* to provide cost-effective medical services and supplies.

**Pregnancy** means a normal *pregnancy*, normal childbirth or elective cesarean section.

**Prescription Drug** is any drug, under applicable law, that is dispensed only with a written prescription from a physician and has a label reading, in effect, "Caution: Federal law prohibits the dispensing without a prescription". It may also include any mixed medicine with at least one ingredient containing this required wording. *Prescription Drug* does **NOT** include:

- Drugs or medicines that can be legally obtained without a prescription;
- Therapeutic devices or applicances, including hypodermic needles, support garments and other non-medical substances, no matter what the intended use;
- Immunization agents, biological serum, blood or blood plasma;
- Charges for the administration of a drug, including insulin;
- Drugs consumed at the place where sold or dispensed;
- Refills dispensed more than 12 months from the prescription or that exceed the number of refills authorized;
- Drugs administered while hospital confined or while a patient is at an extended care facility; skilled nursing facility; rest home, nursing home or other similar facility; or
- Drugs with an over-the-counter equivalent.

**Preventive Care** means immunizations, examinations and diagnostic tests recommended and administered for the purpose of early detection of illness in an *asymptomatic individual*.

**Primary Insured Person** is the person named as the *primary insured person* on the Schedule of Benefits.

**Provider** is a *physician, hospital* or any other entity providing services or supplies that result in *eligible expenses*.

**Psychiatric Care** is treatment by a *physician* for psychiatric or psychological conditions. These conditions include: neurosis, psychoneurosis, psychopathy, psychosis, treatment of eating disorders, or, except as noted below, mental, nervous, or emotional disease or disorder of any kind listed in the most current edition of the DSM, the medical code reference book for psychiatric disorders.

*Psychiatric care* does **NOT** include treatment for drug or other substance abuse, codependency treatment or marital counseling.

**Reasonable and Customary Charges** are charges made for services or supplies that do not exceed the usual charges made for such services in the geographical area where services are performed. A statistical geographic profile of medical fees is used to determine the usual charges for the same or similar services. However, any charge which is agreed upon in advance between Celtic and the health care *provider* for a treatment or surgery will be considered the *reasonable and customary charge*, regardless of what may be normally charged in that geographical region.

**Rehabilitation Facility** is any of the following West Virginia licensed facilities that provide rehabilitative services:

- a facility that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration (HCFA);
- (2) a distinct part rehabilitation unit meeting the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1, as published by the HCFA; or (3) a hospital which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August 1989, as promulgated by the HCFA.

A *rehabilitation facility* provides the following rehabilitative services which are designed to remediate the patient's condition or restore patients to their optimal physical, medical, psychological, social, emotional vocational, and economic status. These services include, but are not limited to the following: stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma, fracture of femur; brain injury;

polyarthritis, including rheumatoid arthritis; neurological, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease; cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease; and burns.

Services provided by a *rehabilitation facility* do NOT include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

**Rehabilitation Therapy** means services provided to restore a bodily function after an *insured person's* sickness or *bodily injury*. It includes occupational therapy, physical therapy and speech therapy.

**Room and Board** are all charges to inpatients by a *hospital, hospice* or *extended care facility* for the following:

- A bed;
- Meals;
- Nursing services; and
- The general services essential to daily medical care.

**Sickness** means a disease or illness manifested after the effective date of the certificate and while the certificate is in force. *Complications of pregnancy* will be covered as a *sickness*.

**Skilled Nursing Facility** is a licensed facility approved for payment of Medicare benefits and which provides skilled nursing care under the supervision of a duly licensed *physician* and continuous 24 hour a day nursing service under the supervision of a registered graduate professional *nurse*. It must also maintain a daily medical record for each patient.

**Specialty Drugs** - include drug therapies that are:

- Indicated for the treatment of chronic or life threatening diseases;
- Require administration by injection;
- Require surveillance, counseling or monitoring in conjunction with their use;
- Require special handling in their distribution;
- Are commonly administered by a physician; rather than patients;
- Have limited availability or distribution;
- Are considered an orphan drug; or
- Require the use of non-standard billing and reimbursement practices.

Celtic determines which drugs are *specialty drugs*.

**Total Disability or Totally Disabled** means a condition caused by an *insured person's* sickness, *bodily injury* or *complication of pregnancy* which:

- Prevents an *insured person* from being able to perform substantially all of the material duties of his regular occupation;
- Prevents an *insured person* from engaging in all normal activities of a person of like age and sex who is in good health.

**Transplant** means a *medically necessary, non-experimental organ transplant*.

**Transplant Related Expenses** are costs associated with pre-*transplant* phase testing, chemotherapy or radiation therapy when supported by *transplant* procedures, harvest and reinfusion of stem cells or bone

marrow, drugs and medications (including those administered to mobilize stem cells for *transplants*), inpatient hospitalization and outpatient services.

***Transplant Network Provider*** is a medical *provider* who is under contract with Celtic to provide *medically necessary, non-experimental transplants* in a quality, cost-effective manner.

## SECTION II - ELIGIBILITY

To be eligible for coverage under this certificate, all *insured persons* must be United States citizens living in the United States or foreign residents who have lived in the United States for at least 24 months under a permanent resident visa, and, except for newborn or newly adopted children, must complete a written application for coverage, and, to the extent permitted by law, be deemed acceptable by Celtic in accordance with our regular underwriting guidelines. Any required premium must also be paid.

To be eligible as a *primary insured person* or spouse, *you* and *your* spouse must be over age 18 and under age 65 and cannot be covered under Medicare or Medicaid. A child must be at least six months of age to be eligible for coverage as a *primary insured person*.

To be eligible as a *dependent* the child(ren) must meet the definition of *dependent*, be under 25 years of age and be principally dependent on the *primary insured person* for the majority of their support and maintenance. *Your dependents* who are incapable of earning their own living due to a handicapped condition are eligible for coverage regardless of age. *We* reserve the right to request reasonable proof of their continuing condition while coverage is in force.

Any individual in full-time military service is not eligible for coverage under this certificate.

### **Newborn Children**

Children born to an *insured person* while this certificate is in force will be insured without evidence of insurability from the moment of birth for an initial 31 day period. Coverage will include the necessary care and treatment of medically diagnosed congenital birth defects and birth abnormalities. For eligibility to continue after the initial 31 day period, children born to an *insured person* must meet the definition of *dependent*. *You* must notify *us* of the birth within 31 days after the birth and pay any additional required premium. If *you* do not notify *us* of the birth of such children or fail to pay the additional required premium, their coverage will end 31 days after the birth. If *you* later wish to add such children, their coverage will be subject to *our* eligibility requirements, regular underwriting guidelines, and the payment of any required premium.

### **Adopted Children**

Children adopted by an *insured person* while this certificate is in force will be insured without evidence of insurability from the moment of placement with the *insured person* for the purpose of adoption, for an initial 31 day period. For eligibility to continue after the initial 31 day period, children adopted by an *insured person* must meet the definition of *dependent*. *You* must notify *us* within 31 days of the placement and pay any additional required premium. If *you* do not notify *us* of the placement with an *insured person*, or fail to pay the additional required premium, their coverage will end 31 days after their placement with the *insured person*. If *you* later wish to add such children, their coverage will be subject to *our* eligibility requirements, regular underwriting guidelines, and the payment of any required premium.

### **Effective Date**

Coverage is effective at 12:01 a.m. standard time on the date shown on the Schedule of Benefits.

## SECTION III - THE HEALTH CARE CERTIFICATION PROGRAM

### Cost Containment Features

To help control rapidly rising health care costs, a Health Care Certification Program is included as a part of this certificate. This program does not interfere with needed medical treatment and is designed to help protect the *insured person's benefits* as well as reduce health care costs. The Health Care Certification Program assures Celtic and the *insured person* that any hospitalization or *hospital* outpatient procedure is *medically necessary* and *medically appropriate*. Notification to the Health Care Certification Program must be made according to the time periods described in the Notification provision or a penalty will apply. If it is determined that treatment is not *medically necessary* and *medically appropriate*, you will receive a Notice of Non-Certification and no *benefits* will be paid as described in the Non-Certification provision. For information regarding the appeal process, refer to the Appeal Process provision at the end of this section.

### Certified Treatments

The Health Care Certification Program requires Certification for the following:

- *Elective hospital confinements*;
- *Hospital confinement* as the result of a *medical emergency*;
- *Outpatient surgeries* and *major diagnostic tests*;
- *Home health care agency* visits;
- *Extended care facility* confinements;
- *Rehabilitation facility* confinements;
- *Skilled nursing facility* confinements; and
- *Transplants*.

Except for *medical emergencies*, Certification must be obtained before services are rendered or expenses are *incurred*.

### Certification

Certification means that treatment is considered to be *medically appropriate* and *medically necessary* by Celtic's team of *physician* advisors and a Notice of Certification is sent to the *insured person* and the *physician*. Certification is not a guarantee that *benefits* are payable. *Benefit* payment is subject to all certificate provisions and limitations, including premium payment and eligibility.

Certification is complete when a written Notice of Certification is received by the *insured person* and the *physician*. In some instances, a preliminary Certification may be obtained over the telephone. A Notice of Certification includes:

- The number of certified days of *hospital confinement*;
- The medical diagnosis, and if applicable, the surgical procedure that was certified;
- Instructions for a *physician* to request additional days of *hospital confinement* (if necessary); and
- Instructions regarding questions about the Certification process.

### Non-Certification

If treatment is not *medically appropriate* and *medically necessary*, a Notice of Non-Certification is issued to the *insured person* and the *physician*.

The *physician* is informed of a non-certification by telephone and the *insured person* and the *physician* will also receive a Notice of Non-Certification. If an *insured person* decides to receive non-certified medical treatment, then no benefits are paid. The *insured person* may elect to file an appeal with Celtic. **At all times, the final decision for actual medical treatment to be provided is the right and responsibility of the insured person and the physician.**

### **Notification**

To receive Certification, *you* must notify the Health Care Certification Program by using the toll-free number shown on *your* Identification Card.

It is *your* responsibility to notify the Health Care Certification Program and arrange for the release of necessary medical information from *your physician* to the Health Care Certification Program. *You* may also arrange for the *hospital* or *your physician* to notify the Health Care Certification Program; however, if for any reason *your physician* or *hospital* fails to cooperate, the penalty applies as described in the Penalty provision of this section.

Notification is required for all *elective hospital confinements, outpatient surgeries, major diagnostic tests, home health care, extended care facility confinements, and rehabilitation facility confinements*. Notification MUST take place at least two weeks prior to the scheduled confinement.

### **Notification of an Emergency Hospital Confinement**

Notification is required for all continued *hospital confinements* as the result of a *medical emergency*. Notification must take place in the next business day following the first day of *hospital confinement*.

If the *physician* or other representative has no knowledge of the Notification requirement and:

- The *insured person* is unconscious, in a coma or otherwise physically unable to request that notification be made; or
- In the case of a *dependent*, if the *insured person* is not informed of the *hospital confinement*.

The requirement for Notification is met provided that Notification is made as soon as reasonably possible.

### **Notification of Additional Days**

Notification is required for all additional days of *hospital confinement* beyond those originally certified. To notify the Health Care Certification Program of additional days, the standard Notification procedure should be followed and Notification should take place as soon as reasonably possible. A separate Notice of Certification is issued for all additional days determined to be *medically necessary* and *medically appropriate*.

### **Penalty**

There is a penalty if treatment is not certified due to the lack of notification to the Health Care Certification Program. The penalty is an exclusion from *eligible expenses* of 20% of all charges related to the treatment.

The penalty applies to all otherwise *eligible expenses* that are:

- *Incurred* for treatment not certified;
- *Incurred* during additional inpatient *hospital* days that are not certified; or
- Determined to be inappropriately certified following a retrospective review, or inappropriately certified due to misrepresentation of facts or false statements.

Penalties cannot be applied toward the required *annual deductible*, *coinsurance* or *out-of-pocket maximum*. Remaining *eligible expenses* are subject to all certificate provisions, including the *annual deductible* and *coinsurance*.

If you are *hospital confined* without obtaining Certification, Notification may be made during the *hospital confinement*. Reasons for the *hospital confinement* are reviewed for *medical necessity* and *medical appropriateness* and any remaining days may be certified. The penalty applies to all days that are not certified.

### **Pregnancy**

Only *complications of pregnancy* are covered under this certificate. However, even if you believe that the *pregnancy* will be normal and therefore not covered, Celtic strongly encourages Notification of the *pregnancy* in order to properly certify treatment if a complication arises later. Notification of all *pregnancies* is encouraged to be made prior to delivery and within 24 hours following delivery.

### **Second Surgical Opinion**

Any second surgical opinions required by the Health Care Certification Program are paid at 100%.

### **Medical Case Management**

For catastrophic injury/illness, Medical Case Management is automatically provided. We provide this service at no additional charge.

### **Other Requirements**

The following may also occur before the Certification process is complete:

- A request may be made for additional medical information from a *physician* or related information from the *insured person*;
- The treatment plan may be referred to a consulting *physician* specialist for *medical appropriateness* and *medical necessity* review. The *insured person* may be asked to be examined by the specialist. Charges for these second opinions are paid at 100% by Celtic;
- Select medical procedures may be directed to an *ambulatory care facility* or other appropriate, quality medical setting such as a *physician's* office.

These requirements do not apply to a *hospital confinement* as the result of a *medical emergency*.

### **Appeal Process**

There is an appeal process to resolve differences of medical opinion regarding determination of what is *medically necessary* and *medically appropriate*. All appeals must be submitted in writing within 60 days of the date we send notice to you.

To the extent that the Health Care Certification Program affects *benefits* paid, the claimant may submit a written appeal as described in the Claim Appeal Process provision of Section VIII Claim Payment Provisions.

## SECTION IV - BENEFITS

### Your Benefits

The following apply to all *benefits*:

- *Benefits* are only paid for *eligible expenses* that are *incurred* as a result of a *sickness, bodily injury* or *complication of pregnancy*;
- *Benefits* are not paid for those expenses that are excluded from coverage (refer to Section V Exclusions and Limitations);
- *Benefits* are only paid after the *annual deductibles* have been satisfied (refer to the Schedule of Benefits);
- *Benefit* payment is subject to a 20% *coinsurance* payment (refer to the Schedule of Benefits);
- The sum of the *annual deductible* and *coinsurance amount* is equal to the *out-of-pocket maximum*;
- A *physician's office visit co-payment* applies to a *physician's office visit* charge when services are received from a *PPO provider* contracted with the primary *PPO*. The *physician's office visit co-payment* is limited to two (2) visits per calendar year. Please see your Schedule of Benefits for the amount of the *physician's office visit co-payment* and primary *PPO*. If you receive services from a *Non PPO provider*, the *physician's office visit co-payment* does not apply and *eligible expenses* will be subject to the *annual deductible* and out-of-network *coinsurance*. Please refer to *your* Schedule of Benefits.
- Any *coinsurance* percentage that you must pay increases by 20% for all cumulative *eligible expenses* that you incur for services received from a *Non-PPO provider*. This increased *coinsurance amount* does not apply toward the *out-of-pocket maximum*. Please see your Schedule of Benefits for *your coinsurance* percentage.
- If charges by a *Non-PPO provider* are *incurred* by an *insured person* due to a *medical emergency*, the *deductible* and *coinsurance* will be the same as if provided by a *PPO provider*.
- *Benefits* for *eligible expenses* are only paid up to the *lifetime maximum benefit* of \$5,000,000 for each *insured person*;
- Under the Health Care Certification Program, an *elective hospital confinement, hospital confinement* as the result of a *medical emergency, outpatient surgery, major diagnostic tests, home health care, extended care facility confinements, rehabilitation or skilled nursing facility confinements* and transplants must be certified, or else a penalty applies which reduces *benefit* payments in accordance with the Health Care Certification Program (refer to Section III The Health Care Certification Program).

### Eligible Expenses

*Eligible expenses* are *reasonable and customary* charges for medical services, supplies and treatment needed to diagnose and treat a *bodily injury, sickness or complication of pregnancy* of an *insured person*. *Eligible expenses* must be for charges authorized by a *physician* for *medically necessary* and *medically appropriate* treatment. *Eligible expenses* do not include any charges listed in Section V Exclusions and Limitations. Not all procedures are *eligible expenses*.

For an *eligible expense* to be payable, it must be *incurred* while coverage is in force. No *benefits* are paid on losses or *eligible expenses incurred* prior to the effective date, after the coverage termination date, or after the Extension of Benefits termination date. To the extent that the following charges are *eligible expenses* we will pay:

- **HOSPITAL CHARGES** for medical services and supplies *incurred* by an *insured person* while *hospital confined* up to the maximum of the average semi-private *room and board* charge in that *hospital*. For *intensive care*, the maximum *eligible expense* is four times the average semi-private room charge. The following *hospital charges* are examples of *eligible expenses*:

- Pre-admission testing;
  - Up to 12 days of confinement per *calendar year* in an *extended care* or *skilled nursing facility*, but only if a *hospital confinement* would otherwise be needed; and
  - Up to 30 days of confinement per *calendar year* in a *rehabilitation facility*.
- **SURGICAL CHARGES** made by a *physician* for surgical services.
    - Assistant Surgeon - The *eligible expense* for required services of an assistant surgeon, when medically appropriate, are paid at 20% of the *eligible expense* allowed for the primary surgeon's charges. If there are two or more co-surgeons, the combined coverage for all surgeon and assistant surgeon charges will be limited to 120% of the *reasonable and customary* charge for a single surgeon.
    - Multiple Surgeries - When two or more surgical procedures are performed in the same operative session, 50% of the *reasonable and customary* allowance is considered eligible for the subsequent surgeries.
- **OBSERVATION UNIT CHARGES** for outpatient observation charges by an *observation unit*. The maximum *eligible expense* for observation in a *hospital* facility is half the average semi-private *room and board* charge, or up to \$250 per occurrence in an outpatient facility.
- **MEDICAL SERVICE CHARGES** for the following medical services:
    - Nonsurgical professional services by a *physician* or *nurse*;
    - Radiologist or laboratory for x-ray or radiation therapy; diagnosis or treatment;
    - Charges by a *hospital* while an *insured person* is not *hospital confined*;
    - Tubal ligations and vasectomies performed as *outpatient surgery* are *eligible expenses* after 12 months of continuous coverage;
    - Up to 20 visits of *home health care* per *calendar year*, by a *home health care agency*, but only if a *hospital* or *extended care facility* confinement would otherwise be needed;
    - Emergency ground or air transportation in an ambulance to the nearest *hospital* up to \$3,000 per *calendar year*;
    - Coverage for screening by low-dose mammography as follows:
      - one baseline mammogram for an *insured person* age 35 through 39; and
      - one mammogram per *calendar year* for an *insured person* age 40 and over or more often as recommended by a *physician*.
    - One cytologic screening per *calendar year* for women age 18 and older and for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening;
    - Coverage for prostate cancer screening, including a prostate-specific antigen (PSA) blood test and a digital rectal examination. Coverage will be provided according to the following guidelines:
      - one screening per *calendar year* for an *insured person* age 40 to 50 years of age who is at an increased risk of developing prostate cancer as determined by a *physician*; and
      - one screening per *calendar year* for an *insured person* age 50 and over.
    - Benefits are paid for the cost of child immunization services from birth through age sixteen, including the cost of the vaccine, if *incurred* by the health care provider, as well as all costs of vaccine administration. These services are exempt from *deductible*, per-visit charge and/or copayment.
    - Eligible expenses for Temporomandibular and craniomandibular disorders. Medically necessary charges for:

- Health history (medical and/or dental) pertinent to symptoms;
  - Clinical examination related to the presenting symptoms;
  - Imaging procedures; provided radiographs must be diagnostic for temporomandibular disorders (TMD) and/or craniomandibular disorders (CMD);
  - Conventional diagnostic and therapeutic injections;
  - Temporary orthotics limited to one every three years. All adjustments to the appliance performed during the first six months of its installation are considered part of the total appliance fee. Appliances designed for orthodontic purposes such as bionators, functional regulators, Frankel devices, and similar devices are not covered;
  - Physical medicine and physiotherapy, including:
    1. Ultrasound
    2. Diathermy
    3. High Voltage Galvanic Stimulation
    4. Transcutaneous Nerve Stimulation;
  - Surgery on the Temporomandibular Joint which includes, but is not limited to arthotomy and diagnostic arthroscopy.
- **MEDICAL SUPPLY CHARGES** for the following medical supplies:
    - Blood, blood plasma, oxygen and anesthesia and their administration;
    - Initial artificial limbs or eyes needed to replace natural limbs or eyes that are lost while an *insured person's* coverage is in force;
    - Casts, splints, braces or surgical dressings;
    - Diabetic charges for equipment and supplies for the treatment and management of diabetes for both an insulin-dependent and non insulin-dependent *insured person* with diabetes or gestational diabetes, when *medically necessary* and prescribed by a *physician*. Coverage includes the following: blood glucose monitors, monitor supplies, insulin, injections aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics and any additional items required by the state of West Virginia. Coverage for self-management education and education relating to diet when prescribed by a *physician* is limited to:
      - visits medically necessary upon the diagnosis of diabetes;
      - visits under circumstances where a physician identifies or diagnoses a significant change in the insured person's symptoms or condition that necessitates a change in the insured person's self-management;
      - new medications or therapeutic processes relating to the *insured person's medically necessary treatment* or management of diabetes, limited to \$100 per *calendar year*.

The education may be provided by any of the following: a *physician* as part of an office visit for diabetes diagnosis or treatment; a certified diabetes educator certified by a national diabetes educator certification program; or a registered dietitian who is registered by a nationally recognized professional association of dietitians which has been certified to the West Virginia commissioner of insurance by the commissioner of the bureau of public health, upon the referral of a *physician*.

- Medications that are medically necessary, FDA approved, are not considered experimental/investigational and administered parenterally in an outpatient office setting by a physician, are paid at 75% of *eligible expenses*. *Eligible expenses* for these medications will not

exceed the charge for these medications had they been purchased through Celtic's contracted Prescription Benefit Manager.

- **RECONSTRUCTIVE BREAST SURGERY** charges for reconstructive breast surgery as a result of a partial or total mastectomy. Coverage is provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed. Coverage includes prosthetic devices necessary to restore symmetry.
- **HUMAN ORGAN AND TRANSPLANT CHARGES** for *medically necessary, non-experimental human organ transplants*. *Eligible expenses for transplants* include all *transplant-related expenses* such as pre-transplant testing; chemotherapy or radiation therapy when supported by *transplant* procedures; drugs and medications, including those administered to mobilize stem cells for *transplants*; and inpatient hospitalization and outpatient services. *Eligible expenses* do not include storage charges *incurred* beyond 60 days of the removal of an *organ*. *Benefits* are available for a maximum of two *transplant* procedures per lifetime.

Certified non-experimental transplant procedures can be performed by either a *transplant network provider* or by a *non-transplant-network provider*. If a *transplant network provider* is used, *benefits* are payable up to the amount of negotiated charges within the network. In addition to the negotiated amount, travel and lodging expenses related to the covered *transplant* will be reimbursed to a maximum of \$2500. Travel and lodging includes round trip coach airfare and accommodations for the *insured person* and up to two companions.

If a *non-transplant network provider* is used, *benefits* for certified, non-experimental transplant procedures will be reimbursed up to \$100,000 per procedure. No charges for travel, lodging, *donor search* or *organ* procurement made outside of the *transplant network* will be considered *eligible expenses*.

- **ALCOHOLISM TREATMENT CHARGES** for *eligible expenses* for up to 30 days per *calendar year* for inpatient confinement in a *hospital* for the treatment of alcoholism. *Eligible expenses* for outpatient services are covered at 50% up to \$750 per *calendar year*. Alcoholism treatment charges are covered to \$10,000 per lifetime for inpatient and outpatient services combined.
- **PREVENTIVE CARE BENEFIT:** After coverage has been in force for twelve months, *eligible expenses* for medical services and supplies *incurred* for *preventive care* in an *asymptomatic individual* are covered up to \$200 per *insured person* per *calendar year*. The annual deductible does not apply.

Preventive Care Benefits include, but are not limited to, charges for the following:

- Annual physical examinations, including office visits;
- Routine x-rays, labs and diagnostic tests;
- Screening services such as colorectal cancer tests, bone mass measurement and cardiovascular and diabetes tests; and
- Immunizations.

*Preventive Care* charges in excess of the *calendar year* maximum are not *eligible expenses*.

- **OUTPATIENT PRESCRIPTION DRUG BENEFIT:** The outpatient prescription drug benefit has a separate *annual deductible* that must be paid before we pay benefits (refer to the Schedule of Benefits). Once the *annual deductible* for prescription drugs has been satisfied, we will pay the following *eligible expenses* for prescription drugs received from a participating network pharmacy:

- Purchases for retail and mail order prescription drugs are subject to a co-payment or *coinsurance* percentage that must be met each time a prescription is filled or refilled.
- The generic *prescription drug* will always be used when available. If a brand name prescription drug is prescribed when a generic version is available, you will be responsible for 100% of the additional cost in addition to the applicable co-payment or *coinsurance*. If a generic version is not available, you will receive the brand name prescription drug for the applicable co-payment or *coinsurance*. The co-payment and *coinsurance* are shown in the Schedule of Benefits.
- For *specialty drugs* not purchased through the Celtic Prescription Drug program, reimbursement will be based on Celtic's contracted price for that drug.
- Celtic determines which drugs are generic, brand, preferred brand or *specialty drugs*.

Celtic's generic, brand, preferred brand or *specialty drug* list is available to an insured person by contacting Customer Service at (800) 477-7870 and also available on the Internet at [www.celtic-net.com](http://www.celtic-net.com).

## SECTION V - EXCLUSIONS AND LIMITATIONS

Definitions, other plan provisions, or plan *benefits* may further limit payments; therefore, this section cannot be solely relied upon to determine when *benefits* are **NOT** payable.

### Exclusions

*Benefits* will **NOT** be paid for *incurred* charges for the following:

- Normal *pregnancy* and delivery, elective or repeat cesarean section or elective abortion;
- *Sickness or bodily injury* as a result of:
  - Participation in a riot, felony or other illegal act;
  - Suicide or attempted suicide or self-inflicted *bodily injury* while sane or insane;
  - *Bodily injury, total disability* or death sustained while being intoxicated by and/or under the influence of alcohol, drugs or narcotics unless used as prescribed by a *physician*. Intoxication is defined and determined by the laws of the jurisdiction where the loss or the cause of the loss occurred. The alcohol intoxication exclusion applies only to the expenses resulting from an accident occurring while the *insured person* is operating a motorized vehicle; or
  - Any act of war, declared or undeclared, or service in the military forces of any country, including non-military units supporting such forces;
- Outpatient *prescription drugs*, unless purchased at a participating pharmacy;
- Treatment of psychiatric or psychological disorders or mental and nervous disorders of any kind;
- Any treatment for drug addiction, substance abuse or chemical dependency;
- Routine physical examinations within twelve months of the effective date, immunizations, newborn nursery charges and routine well-baby care, of a *dependent* child, unless required by state law. Well-baby care is defined as charges not related to a *sickness or bodily injury*.
- Allergy tests and injections;
- Diagnosis, treatment or surgical procedure relating to fertility or infertility;
- Tubal ligations or vasectomies if performed within 12 months of the effective date or if performed while *hospital confined*. If a tubal ligation is performed during a *pregnancy* or *complication of pregnancy*, then those charges will be considered as *eligible expenses*. The reversal of a tubal ligation or vasectomy is not covered at any time;
- Treatment or surgery for exogenous, endogenous or morbid obesity;
- Smoking cessation or weight loss programs;
- Treatment of chronic pain disorders, acupuncture or biofeedback, non surgical treatment of the spinal column, or treatment, including manipulation, for dislocations and subluxation of the vertebrae or spinal column;
- Outpatient *rehabilitation therapy* not related to a *home health care* visit;

- Cosmetic surgery or reconstructive surgery unless surgery is needed as a result of a *bodily injury* sustained while coverage is in force. Complications of non covered cosmetic or reconstructive surgery or drugs prescribed for cosmetic purposes are not *eligible expenses*;
- Gender re-assignment (sex change);
- Repair or replacement of artificial limbs, artificial eyes or other prosthetic devices;
- Durable medical equipment not specifically listed under the medical supply charges;
- Eye refractions, vision therapy, glasses or fitting of glasses, contact lenses, or surgical or non surgical treatment to correct refractive eye disorders or any treatment or procedure to correct vision loss;
- Speech exams, hearing aids, exams or fittings, or surgical or non surgical treatment or procedure to correct hearing loss;
- Orthognathic surgery; dental implants; prevention or correction of teeth irregularities and malocclusion of jaws; removal, replacement, or treatment of or to teeth (including removal of impacted or unerupted teeth) or surrounding tissues; except:
  - Treatment of sound, natural teeth due to *bodily injury* that occurs while the *insured person's* coverage is in force and the *bodily injury* must not have been caused directly or indirectly by biting or chewing. All treatment must be completed within six (6) months of the date of *bodily injury*.
- Surgical treatment of tonsils, adenoids, hernia, myringotomy, or dilation and curettage if performed within 6 months of the effective date;
- Treatment or medication that is *experimental/investigational*;
- Any treatment, service or supply connected with hospice care;
- *Custodial care*, including maintenance care, which consists of services or supplies furnished mainly to maintain rather than improve a level of physical or mental function;
- *Room and board* unless the *insured person* has an overnight stay. In the case where an *insured person* leaves a *hospital, psychiatric care* or *extended care facility* for visitation privileges, the *insured person* must return to sleep in the facility before midnight the same night;
- *Sickness* or *bodily injury* that arises out of, or as a result of, any work if the *insured person* is required to be covered under Worker's Compensation or similar legislation;
- Any otherwise *eligible expense* for which *you* are not financially responsible in the absence of this insurance;
- Any otherwise *eligible expense* for treatment provided by a *hospital* operated by a government body unless *you* are required to pay;
- Treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days;
- *Sickness* caused by a congenital defect, which affects a bodily function, unless the *sickness* begins while the *insured person's* coverage is in force;

- Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services;
- Complications of any treatment or surgery for an excluded service or procedure;
- Any charge in excess of the *reasonable and customary* charge;

### **Pre-existing Conditions Limitation**

A pre-existing condition is a *sickness or bodily injury* for which an *insured person* received a diagnosis, medical advice, consultation or treatment from a *physician* during the 12 months prior to the effective date of coverage, or which, in the opinion of a *physician*, caused symptoms during the 12 months prior to the effective date that were obvious enough to cause an ordinarily prudent person to seek diagnosis, medical care or treatment.

No *benefits* are paid for otherwise *eligible expenses* for pre-existing conditions unless those conditions were fully disclosed on the application form and not specifically excluded from coverage under this certificate.

*Benefits* are paid for an *insured person's* pre-existing condition once coverage is in force for 12 continuous months after the effective date, unless specifically excluded from coverage under this certificate.

Any medical conditions not disclosed on the application form may result in rescission of coverage. Rescission means that coverage is void from the effective date.

### **Weekend Admissions Limitations**

There is a restriction for non-emergency weekend admissions. If an *insured person* is *hospital confined* on a Friday, Saturday, or Sunday, *room and board* expenses will only be covered if the treatment or surgery is certified, as required, and is performed within 24 hours from the time *hospital confinement* begins.

## SECTION VI - TERMINATION OF COVERAGE

### Coverage Terminates

All coverage terminates for an *insured person* at 12:01 a.m. on the day following the date through which your premium has been paid if any of these circumstances occurs:

- The *insured person* gives prior written notice of termination;
- The *insured person* begins living outside the United States;
- The *insured person* fails to make any required premium payments, subject to the grace period provision;
- The *dependent* ceases to be eligible under the plan;
- Coverage is terminated for a line of business or class of eligible *insured person*; or
- The *policy* is terminated.

If there are losses for charges *incurred* in connection with a disability or medical condition that began while coverage was in force, this certificate does not provide *benefits* after the *insured person's* coverage terminates and any Continuation or Extension ends.

### The Policy Is Terminated

The *policy* provides continuous coverage subject to the payment of monthly premiums and all other *policy* provisions. Celtic or the *policyholder* can terminate the *policy* at any time. If this occurs, coverage terminates for all *insured persons*.

Celtic can terminate the *policy* on the first day of any month by giving 60 days prior written notice to the *policyholder*. The *policyholder* can terminate the *policy* on the first day of any month by giving prior written notice to Celtic and 30 days written notice to each *primary insured person*. Celtic can modify any provision and can terminate any line of business, any class of eligible *insured persons*, or any plan or option by giving 30 days written notice to all affected *primary insured persons*.

### Rights at Termination of Coverage

A limited Continuation of Coverage or Extension of Medical Benefits may begin when coverage terminates.

#### • Continuation of Coverage

Continuation is available to *dependents* if coverage terminates as a result of the death or dissolution of marriage of the *primary insured person* or attainment of the limiting age by a *dependent*. Any Continuation will be as a *primary insured person* and requires payment of premiums.

Continuation is not available when coverage ends due to any of these circumstances:

- The *policy* is terminated;
- The *insured person* fails to make any required premium payments;
- The *insured person* obtains other coverage; or
- We have paid the *lifetime maximum benefit*.

Continuation under this provision ends at the earliest of the date:

- The former spouse remarries;
- After the first 120 consecutive days, if the *policy* terminates;
- A *dependent* becomes covered by Medicare or Medicaid or enters the military service; or

- The *lifetime maximum benefit* has been paid.
- **Handicapped Child**

Medical expense plan coverage can be continued for a child who is unable to earn his own living because of a handicapped condition and is principally dependent on the *primary insured person* or *other care providers* for total care and supervision. Celtic may request proof of such a handicap no earlier than two months prior to the date the child reaches the limiting age, or as reasonably required thereafter. Proof acceptable to Celtic must be furnished within 60 days.

Celtic may, from time to time, at its own expense require proof that the handicap continues. It may also have the *dependent* examined by *physicians* chosen by Celtic.

- **Notification Requirements**

The *dependent* must notify Celtic in writing within 60 days of the date of the *primary insured person's* death, entry of a judgment of divorce or attainment of the limiting age by a *dependent*. Failure to provide such notice will result in the loss of the right to continue coverage.

Within 30 days of receiving notice from the *dependent* requesting continued coverage, Celtic must notify the *dependent* of his right to continue coverage and provide the election form, if any, and instruction for premium payment.

To receive Continuation, the *dependent* must submit the election form and the first premium payment by certified mail, return receipt requested, within 30 days of receiving the notice form. Failure to submit the election form and the first premium payment by certified mail will result in the loss of the right to continue coverage. Subsequent premiums are payable each month.

This certificate meets any obligation Celtic has to inform the *insured person* about notification, premium collection and eligibility.

- **Continuation Ends**

Once begun, a Continuation ends as described in each provision above, or earlier than that date if:

- The *policy* is terminated;
- Coverage terminates for any class of eligible *insured person's* or line of business;
- The *insured person* fails to make any required premium payments; or
- A *dependent* ceases to be eligible for any reason other than attainment of the limiting age, death or divorce. In the case of a handicapped child, continuation ends when the handicapped child is no longer dependent on the *primary insured person* or *other care provider*.

### **Extension of Medical Benefits**

If an *insured person* becomes *totally disabled* while coverage is in force, we will extend limited *benefits* for a limited period of time after termination of coverage.

Extension covers only the *totally disabled insured person* for *eligible expenses* resulting from the cause of the *total disability*. Coverage can be obtained for the disabled person's other medical conditions and for other *dependents* by taking Conversion coverage at the same time that Extension begins.

If the *policy* is terminated, Extension ends at the earliest of the date:

- The *insured person* is no longer *totally disabled*;
- 12 months after coverage terminates; or
- The *lifetime maximum benefit* has been paid.

After Extension terminates, individual Conversion coverage may be available as described in the Conversion Privilege provision in this section.

*Benefits* are not paid for *eligible expenses incurred* after Extension terminates even though expenses are from a *total disability* that began while coverage was in force.

A *primary insured person* who has converted any life insurance coverage to individual coverage in accordance with the terms of the Conversion of Life Insurance Privilege provision is not entitled to this Extension.

### **Conversion Privilege**

When coverage terminates, or a Continuation or Extension of coverage ends, the *insured person* may be eligible for a Conversion privilege as set forth in this provision.

### **Conversion of Medical Expense Plans**

If health coverage terminates or a Continuation or Extension of coverage ends, the *insured person* may be eligible to convert to an individual health Conversion certificate. This Conversion requires no evidence of insurability and no suicide/contestable periods will start over. The medical expense *benefits* of Conversion are not as complete as those provided under this certificate. However, a new suicide or contestable period can apply to new benefits not contained in the original certificate or to any increase in benefits. Coverage is available until the *insured person* attains age 65.

### **Eligibility for Conversion of Medical Expense Plans**

If an *insured person* has been covered under this certificate for at least three consecutive months prior to the date coverage terminates or a Continuation or Extension ends, that *insured person* may apply for individual Conversion coverage.

*Insured persons* are not eligible for health Conversion if:

- Coverage terminates because the *policy* is terminated;
- Coverage terminates for any class of *insured persons* or line of business;
- The *primary insured person* fails to pay any required premiums; or
- The *insured person* is covered by or eligible for Medicare or other medical expense *benefits* offered by any group plan, individual policy, prepayment plan, governmental program or other plan or program whether insured or self-insured if, according to *our* guidelines, overinsurance would result.

### **Application for Conversion**

Individual Conversion coverage begins on the date coverage terminates or a Continuation or Extension ends. Application must be made and the first premium must be paid no later than:

- Thirty-one days after the Conversion coverage begins; or
- Fifteen days after the *insured person* has been given written notice of the Conversion privilege, but not more than 60 days after coverage ends.

## SECTION VII - CLAIM PAYMENT PROVISIONS

### Filing a Claim

Written notice of a loss must be sent to *us* within 20 days after the loss is *incurred* or as soon as reasonably possible. Written notice consists of the original bills of the *provider* of the medical services or supplies. If *we* determine that a claim form is necessary, *we* will send *you* a form within 15 days of *our* receiving written notice.

### Proof of Loss

Proof of loss consists of the original bills of the *provider* or such other documentation of *incurred eligible expenses* that *we* deem acceptable. Proof of loss may also include a completed and signed claim form and any investigation *we* deem necessary to validate *your* right to receive *benefits*.

Proof of loss must be submitted to *us*, in writing, within 90 days of the date of loss or as soon as reasonably possible. *Benefits* are not paid if proof of loss is received more than 12 months after it is required, unless *you* were legally unable to act.

### Payment of Claims

*Benefits* are paid to the applicable *insured person* or *beneficiary* upon receipt of proof of loss. An *insured person* may authorize payment of *benefits* directly to the person or *provider* upon whose charges the loss is based. Any payment made in good faith will fully discharge *us* to the extent of the payment.

### Claims Investigation

*We* have established guidelines to investigate the eligibility, pre-existing conditions, and other questions affecting *benefits*. *We* may also investigate to verify the accuracy of answers to questions on the individual application form and any other documents requested and accepted by *us*, to ensure that valid application has taken place.

An investigation may require submission of *physician* office records, pharmacist drug statements, *hospital* medical records or other relevant information. When legally permitted and at *our* expense, *we* can also require an autopsy or medical examination as a condition of paying *benefits*.

*We* will notify *you* of any investigation. *Benefits* are not processed for any *insured person* until the investigation is completed. As a result, delays may occur in processing if a claim investigation is necessary.

### Beneficiary

*We* will pay *benefits* to the *beneficiary* of record. *You* may change the *beneficiary* by submitting written notice to *us*. Once it is recorded, the change takes effect on the date written notice is signed by *you*. If the change has not been recorded, the *benefit* is payable to the *beneficiary* of record.

### Facility of Payment

A *benefit* may be payable to an *insured person* who dies, or to an *insured person* who is a minor or legally incapable of giving valid receipt and discharge of payment. If so, Celtic may pay *benefits*:

- Directly to the *provider* making a charge; or
- To a spouse or blood relative of the claimant.

If a *benefit* is payable to a *beneficiary* who is a minor, the *benefit* may be paid to the legally appointed guardian. If there is no such guardian, the *benefit* may be paid to any adult or institution that, in the opinion of Celtic, has assumed custody and support of the minor.

A *beneficiary* may be incapable of giving a valid release for *benefit* payment due. If so, the *benefit* due may be paid out in installments to any person or institution who appears to have assumed custody and support of the *beneficiary*. Payments cannot exceed \$50.00 per month. They stop when a legal guardian is found or the total due is paid.

Any payment under the Facility of Payment provision is considered a *benefit* payment. That payment will fully discharge *us* to the extent of the payment. Celtic is not required to see the proper application of payments, and has no further obligations.

### **Claim Appeal Process**

Though claim submissions are treated fairly based on the facts surrounding the loss, some claim decisions need further review. A claimant may have additional information which could change the decision or may want a review of the decision. There is an appeal process to provide a full and fair review of the proof of loss. All appeals must be submitted in writing within 60 days of the date *we* send notice to *you*.

### **Arbitration**

Controversies or disputes arising out of, in connection with, or relating to this certificate which cannot be resolved to the satisfaction of both parties, may be resolved by arbitration, only as herein provided. Except that, judicial injunctive relief may be sought, if, such action is necessary to avoid irreparable harm or to preserve the status quo. Arbitration may not be initiated more than one year after the date written notice of the controversy or dispute was given. Arbitration shall be by a panel of three neutral arbitrators. Each arbitrator shall meet the requirements of, and agree to act in accordance with, the procedures established by, the American Arbitration Association. Within thirty days after receipt of a demand for arbitration, each party shall designate its arbitrator. The designated arbitrators shall, within thirty days, select the third arbitrator. If the arbitrators cannot agree on a third arbitrator within thirty days, they shall each nominate three individuals. The American Arbitration Association shall choose the third arbitrator from the list of nominated individuals. Unless agreement is otherwise reached, the proceedings will be conducted in the county seat of the county nearest the *insured person's* residence which has a population of at least 100,000 persons.

Each party shall bear the cost of its own arbitrator. The costs of the arbitration proceeding, including the fees of the third arbitrator, shall be borne equally by the parties. Attorney fees and expenses for witnesses will not be deemed to be expenses of arbitration, but will be borne by the party incurring them.

Each party hereby irrevocably waives any right to recover punitive damages. The arbitrators shall have no power to award any punitive damages or to ignore or vary the terms of this certificate.

In any arbitration dispute or controversy that conflicts with this certificate this certificate shall govern. The parties agree that the arbitration award and any decision by the arbitration panel shall be confidential. It is understood and agreed that the arbitration shall be binding upon the parties, unless prohibited in *your* state, that the parties are waiving their right to seek remedies in court (except for judicial injunctive relief, as stated above), including the right to a jury trial; and that an arbitration award may not be set aside in later litigation except upon the limited circumstances set forth in the Federal Arbitration Act. Judgment upon the award rendered by the arbitration panel may be entered in any court having jurisdiction thereof.

### **Legal Action**

No legal action may be brought to recover on this certificate within 60 days after written proof of loss has been given as required by this certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

## SECTION VIII - GENERAL PROVISIONS

### Entire Contract and Changes

This entire contract consists of the *policy*, *the certificate*, any endorsements, the application of the *policyholder*, *your* application, and any other documents requested and accepted by *us*. No change in the *policy* or the certificate is valid unless approved by an executive officer of Celtic. The approval must be endorsed by the officer and attached to the *policy* or certificate. No producer or agent can change or waive any part of the contract provisions.

Statements made by *you* on the application or on other documents requested and accepted by *us* are representations, not warranties in the absence of fraud. No such statements will be used to void the insurance, reduce *benefits*, or defend against claims under the certificate unless a copy of the application is provided to *you* with *your* certificate.

### Conformity with State and Federal Law

Any provision of this certificate which, on its effective date, conflicts with the laws of the state in which the *primary insured person* resides, is amended to conform to the minimum requirements of such laws. Any provision which conflicts with Federal Law, is amended to conform to the minimum requirements of such law on the next anniversary of *your* effective date.

### Grace Period

After the first premium is paid, unless at least 30 days prior to a premium due date, *we* have mailed to *you* written notice of *our* intention not to renew this coverage, a grace period of 31 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If payment of premium is not received within the grace period, coverage will be terminated as of the premium due date.

### Reinstatement

If any premium is not paid by the end of the grace period *your* coverage will terminate. Later acceptance of premium by *us*, within four calendar days of the end of the grace period, will reinstate *your* certificate with no break in *your* coverage. We will refund any premium that we receive after this four day period.

Reinstatement shall not change any provisions of the certificate.

### Premium Calculation and Adjustment

The premium for each *insured person* is determined by *us*. *We* may change premiums on any premium due date by giving *you* 31 days advance written notice of the change. Premiums are determined by, but not limited to, such factors as the table of premiums then in effect, the attained age of the *insured person*, place of residence, class of insured and the experience of the class. Premiums may change during the initial rate guarantee period if there is a change in coverage from what was originally applied for or if there is a change in the primary residence of the *primary insured person*.

Premiums are payable in advance on the premium due date at *our* home office or at the office of *our* authorized administrator. Failure to pay premium by the premium due date will cause your coverage to lapse at the end of the period for which premium has been paid.

## Right of Reimbursement

If an *insured person* incurs expenses for *sickness* or *bodily injury* that occurred due to the acts or negligence of a third party, Celtic has the right to reimbursement for all benefits *we* paid from any and all damages collected for those same expenses whether by action at law, settlement, or compromise, by the *insured person*, *insured person's* parents, if the *insured person* is a minor, or *insured person's* legal representative as a result of that *sickness* or *bodily injury* and *we* are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits Celtic paid for that *sickness* or *bodily injury*.

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

The *insured person* is required to furnish any information or assistance or provide any documents that Celtic may reasonably require in order to obtain *our* rights under this provision. This provision applies whether or not the third party admits liability.

## Misstatement of Age

If the age of an *insured person* has been misstated then all *benefits* payable under this coverage will be such as the premium paid would have purchased at the correct age.

## Time Limit on Certain Defenses

*We* rely on the application of the *policyholder* to issue the *policy* and on the individual applications to issue certificates to *primary insured persons*. No statement of the *policyholder*, except a fraudulent misstatement, shall be used to void the *policy* after it has been in force for 24 months from the date of issue. No statement of any applicant, except a fraudulent misstatement or omission, shall be used to void coverage, reduce *benefits*, or defend against a claim for loss *incurred* after 24 months from the effective date of the applicant's insurance.

## Alternative Treatment

All medical expense claims are reviewed to assess the cost-effectiveness of medical treatment to ensure that only those charges that are *medically necessary* and *medically appropriate* to provide quality care are paid.

If *our physician* advisor determines that a more cost-effective treatment is appropriate, only charges for the least costly alternative treatment are considered *eligible expenses*. *We* will advise *you* of those charges that are considered *eligible expenses* under this provision. This treatment shall be agreed upon by all parties involved including the *insured person*, the attending physician and Celtic.

*We* consider all alternative treatment required by the Health Care Certification Program to be an *eligible expense*, subject to the *annual deductible*, *coinsurance* and *lifetime maximum benefit*.

## Coordination of Benefits

To avoid duplicate payments by other medical expense plans, coordination of benefits applies to this certificate and ensures that no more is paid than the full cost of the medical care among medical expense plans.

The benefits under this certificate are coordinated with the benefits of "another plan" using the first of the following rules:

- The plan that covers the person as other than a *dependent* will determine its benefits before the plan that covers the person as a *dependent*.
- For a *dependent* child, when this plan and “another plan” both cover the *dependent* child, the benefits of the plan of the parent whose birthday falls earlier in the year are determined first. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before the one which covered the parent for a shorter period of time.
- For a *dependent* child whose parents are separated or divorced, when this plan and “another plan” both cover the *dependent* child, the benefits are determined in the following order:
  - The plan of the parent with custody of the child;
  - The plan of the spouse of the parent with custody of the child;
  - The plan of the parent not having custody of the child.

If the terms of a court decree state that one of the parents is responsible for the health care expenses of the child. The benefits of the plan of that parent will be determined first.

If the terms of a divorce decree state that there is to be joint custody of the *dependent*, without stating which parent is responsible for the *dependent's* health care expenses, the rule to determine benefits will follow as explained in number 2 above.

- The benefits of the plan that covers a person as an employee who is neither laid off nor retired (or as that employee's *dependent*) are determined before the plan that covers that person as a laid off or retired employee (or that employee's *dependent*).
- If bullets 1 through 4 above do not decide which plan's benefits are determined first, then the plan that has covered the person for a longer length of time will determine its benefits before the plan which covered the person for the shorter length of time.

For the purposes of this provision, “another plan” means:

- group insurance and subscriber contracts;
- uninsured arrangements of group or group-type coverage;
- group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;
- group-type contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group;
- the amount by which group or group-type hospital indemnity contracts exceed \$100 per day;
- the medical benefits coverage in group, group-type and individual automobile “no fault” and traditional automobile “fault” type contracts; and
- Medicare or other governmental benefits, except as described below.

For the purposes of this provision, “another plan” does not include:

- Individual or family insurance contracts;
- Individual or family subscriber contracts;
- Individual or family coverage through HMOs or under other prepayment, group practice and individual practice plans;
- Group or group-type hospital indemnity benefits of \$100 per day or less;
- School accident-type coverages covering grammar, high school and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a “to and from school” basis; and

- A state plan under Medicaid including a law, or a plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

### **Receiving and Releasing Necessary Information**

To carry out the terms of this subsection, Celtic may, without consent or notice, give information about an *insured person* to any organization. An *insured person* must give any necessary information to Celtic.

### **Right of Recovery**

If we pay a *benefit* greater than that required by this subsection, *we* have the right to recover the excess payment from *you* and/or the organization or *provider* to whom the excess payment is made.

### **Right to Make Administrative Determinations**

*We* have the sole right to determine eligibility for coverage, to make administrative decisions related to the *policy*, and to interpret the terms of the *policy* accordingly.

### **Worker's Compensation**

The *policy* and certificate do not satisfy any requirement for coverage by any Worker's Compensation Act, or other similar legislation.

## **BENEFIT NOTICE**

Under the Women's Health and Cancer Rights Act of 1998, health insurers that provide medical and surgical benefits with respect to a mastectomy shall provide, to an insured person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the following services:

1. Coverage for all stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of a mastectomy, including lymphedemas.

These services are elective and may be chosen by the insured person in consultation with the attending physician. Benefits for reconstructive breast surgery are subject to all other plan provisions including annual deductibles and coinsurance amounts.