Important Disclaimer–Please Read:

This Evidence of Coverage becomes effective as PersonalCare health insurance policies renew beginning July 1, 2004, and thereafter. You may have received this Evidence of Coverage even though your policy was new or already renewed prior to July 1, 2004. If your health insurance policy was new or already renewed prior to July 1, 2004, you will not be covered under this Evidence of Coverage until your policy again renews after that date. Should you require a copy of your current Evidence of Coverage until your plan again renews, please contact our Customer Service Department by calling the phone number located on the back of your ID card.

Large Group HMO
Evidence of Coverage

PERSONALCARE
A Coventry Health Care Plan

Welcome to PersonalCare, a Coventry Health Care Plan!

We are extremely pleased to have you enrolling in our health plan and look forward to serving you. We have built a strong network of area physicians, hospitals, and other providers to offer a broad range of services for your medical needs.

As a Coventry Health Care member, it is important that you understand the way your health plan operates. This Evidence of Coverage (Certificate) contains the information you need to know about your coverage with us.

Please take a few minutes to read these materials and to make your covered family members aware of the provisions of your coverage. Our Customer Service Department is available to answer any questions you may have about your coverage. You can reach them at (800) 431-1211 or (217) 366-1226, Monday through Thursday, 8:00 a.m. to 6:00 p.m. and Friday, 8:00 a.m. to 5:00 p.m.

We look forward to serving you and your family.

Sincerely,

Todd A. Petersen
Chief Executive Officer

Important Phone Numbers

Customer Service Toll-Free Phone Number: (800) 431-1211

Dial this number to reach PersonalCare from anywhere in the USA.

TDD and Voice Line: (217) 366-5551

Operator-assisted and direct calls for hearing impaired members accepted.

Language Line: (800) 431-1211

Non-English speaking members may call this number to request translation services. We will connect you with a translator and a Customer Service representative to answer your questions.

Customer Service Hours:

Telephone Hours	8:00 a.m. till 6:00 p.m.; Monday–Thursday
	8:00 a.m. till 5:00 p.m.; Friday
Walk-In Hours	8:00 a.m. till 5:00 p.m.; Monday–Friday

Web Site: www.PersonalCare.org

LGGRP HMO0403

Large Group HMO Table of Contents

PERSONALCARE
A Coventry Health Care Plan

Evidence of Coverage (Certificate)

The Agreement between PersonalCare Insurance of Illinois, Inc. (hereafter called the "Health Plan", "PersonalCare", "We", "Us", or "Our") and You and between Health Plan and Your Dependents as Members of the Health Plan is made up of:

- This Evidence of Coverage (Certificate), endorsements, amendments, and riders;
- The Group application and enrollment forms; and
- The Group Enrollment Agreement

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to this Agreement unless approved in writing by an officer of the Health Plan, and the resulting waiver, change, or amendment is attached to the Agreement. This Agreement begins on the date defined in the Group Contract. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the Health Plan. By paying premiums or having premiums paid on Your behalf, You accept the provisions of this Agreement.

THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY.
Many of the provisions of this Agreement are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement have special meanings. These words will appear capitalized and are defined for You. By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, the Agreement may be amended. When that occurs, We will provide an Amendment or new Evidence of Coverage (Certificate) to You for this Agreement. You should keep this document in a safe place for Your future reference.

I. Using Your Benefits

1.1 Membership Identification (ID) Card
Every Health Plan Member receives a membership ID card. Carry Your Health Plan ID card with You at all times, and present it whenever You receive health care services. If Your Health Plan ID card is missing, lost, or stolen, contact the Health Plan Customer Service Department at 800-431-1211 or 217-366-1226 to obtain a replacement.

1.2 Your Primary Care Physician (PCP)
The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. You and Your PCP will work together to maintain Your health, and Your PCP will provide or work with you to coordinate most of Your health care needs. This may include preventive health services, consultation with Specialists and other Providers, Emergency Services, and Urgent Care.

1.3 Selecting and Changing Your Primary Care Physician (PCP)
Health Plan members must choose a PCP from the PersonalCare Provider Directory, a list of Participating Family and General Practitioners, Internists, and Pediatricians.

Female members may select a Woman's Principal Health Care Provider (WPHCP) in addition to their PCP. This physician specializes in woman's health care needs (Family Practice or Obstetrics and Gynecology) and is specially identified in the Provider Directory.

When selecting a PCP, You may wish to contact the individual Provider office for additional information, such as specifics of a physician's training and experience or office hours and policies. Physician profiles for many PCPs can also be obtained by calling PersonalCare's Customer

Service Department or by visiting Our website. One PCP may be selected for the entire family, or each Dependent may select a different PCP, but the PCP should be located within 30 miles of Your residence or work. If You do not choose a PCP upon enrollment or after notification that Your PCP is no longer participating with Health Plan, one will be assigned to You.

If You wish to change Your PCP or WPHCP, You should contact Our Customer Service Department or visit our website.

1.4 Referrals and Authorization
In the event You require Hospitalization, Your PCP or the Participating Physician who admits You to an inpatient facility or schedules services at an outpatient facility is responsible for obtaining Authorization from Us. For all other care, You may make an appointment directly with a Participating Provider without a referral to obtain Covered Services, unless Prior Authorization is otherwise required in the Schedule of Covered Services. Your PCP can assist you in coordinating Your care. All care must be obtained from a PersonalCare Participating Provider, unless: specifically authorized in advance by Us in accordance with PersonalCare policies and procedures; services are not available from a Participating Provider; and the exception is approved in advance by Our Medical Director. If Your PCP or WPHCP believes that You need to see a Physician or other medical provider who is not in the PersonalCare Provider Network, then Your physician must call or submit medical information to Us in writing. Our medical management staff will review the information and notify Your physician and You of Our decision. Except in an Emergency, if Prior Authorization is not obtained before you see a Non-Participating Provider, the costs associated with Your visit will be Your responsibility.

1.5 Continuing Care Coverage

1.5.1 Continuing Care Coverage for New Members
When You enroll in Our Plan, if You have an ongoing course of treatment with a Non-Participating Provider who is in Our Service Area, You may be eligible to continue an ongoing course of treatment with that provider during a transitional period of up to ninety (90) days in certain circumstances. If You are in the last trimester of pregnancy at the effective date of enrollment, you may be eligible for an ongoing course of treatment that includes coverage through delivery and post-partum care directly related to the delivery, even if it exceeds ninety (90) days in certain circumstances. Such continuation of care shall be authorized by Us for the transitional period only if Your Non-Participating Provider agrees to: accept reimbursement rates similar to other Participating Providers in the Service Area, comply with Our quality assurance requirements, provide Us necessary medical information relating to Your care, and otherwise agree to adhere to Our policies and procedures. In order to be eligible for coverage for continuing care with Your Non-Participating Provider, You must contact Us with your request for continuing care prior to receiving treatment and within fifteen (15) days of Your effective date of coverage. Within fifteen (15) days after receipt of your request, PersonalCare will notify You in writing whether Your request has been approved or denied, and, if denied, the specific reason for such denial.

1.5.2 Continuing Care Coverage Following Provider Termination
If You have an ongoing course of treatment with a Participating Provider and the Provider leaves

PersonalCare network of providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the Provider remains within the Service Area, You may be eligible in certain circumstances to continue an ongoing course of treatment with that Provider during a transitional period of ninety (90) days from the date We notify You of the Provider's termination from the Health Plan.

If You have entered the third trimester of pregnancy at the time of the Provider's disaffiliation, You may be covered in certain circumstances through delivery and post-partum care directly related to the delivery, even if it exceeds ninety (90) days. Such continuation of care shall be authorized by Us for the transitional period only if the Provider agrees to: accept reimbursement from Us at the rates applicable prior to the start of the transitional period, comply with Our quality assurance requirements, provide Us necessary medical information relating to Your care, and otherwise agree to adhere to Our policies and procedures. In order to be eligible for coverage for continuing care with Your Provider who is leaving Our network, You must contact us within thirty (30) days after you receive notification of the provider termination. Within fifteen (15) days after receipt of your request, PersonalCare will notify You in writing whether Your request has been approved or denied, and, if denied, the specific reason for such denial.

1.6 Co-payments and Coinsurance

You are responsible for paying Co-payments to Participating Providers at the time of service. Coinsurance amounts, based on the Health Plan's reimbursement to the Provider, will be billed to You at a later time by the Provider. Specific Co-payments and Coinsurance amounts are listed in Your Description of Coverage.

1.7 Out-of-Pocket Maximum

The individual Out-of-Pocket Maximum is the maximum amount You are required to pay out of Your pocket in Co-Payments and Coinsurance for Basic Health Care Services during Your Contract Year. The family Out-of-Pocket Maximum is the maximum on the total amount Members of the same family covered under this Agreement must pay out-of-pocket for Basic Health Care Services during the Contract Year. Once the Out-of-Pocket Maximum is met, Basic Health Care Services are paid at 100% without any Co-payment or Coinsurance for the remainder of the Contract Year. Any Co-payment or Coinsurance for Covered Services that are not Basic Health Care Services do not apply to Your Out-of-Pocket Maximum.

1.8 How to Contact the Health Plan

Throughout this Agreement You will find that We encourage You to contact Us for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact Us at the telephone number on the back of Your identification card.

Telephone numbers and addresses to request review of denied claims, register complaints, place requests for prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers included in this Agreement.

II. Enrollment and Eligibility

2.1 Eligibility

2.1.1 Subscriber Eligibility - To be eligible to be enrolled You must:

- Live or work in the Service Area at least nine (9) months out of the calendar year unless on temporary work assignment of six (6) months or less; and
- Be an employee or Retiree of the Group; and
- Be eligible to participate equally in any alternate health benefits plan offered by the Group by virtue of his/her own status with the Group and not by virtue of dependency; and
- Meet any eligibility criteria specified by the Group and approved by PersonalCare, including, without limitation, the criteria set forth in Section 2.2 below (retiree); and
- Complete and submit to PersonalCare such applications or forms that We may reasonably request.

2.1.2 Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Live in the Service Area at least nine (9) months out of the year, except as permitted herein, and
- Be the lawful spouse of the Subscriber or be an unmarried child of the Subscriber or the Subscriber's spouse, including:
- Children under age nineteen (19) who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's spouse;
- Children under age nineteen (19) for whom the Subscriber or the Subscriber's spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order;
- Children under age nineteen (19) for whom the Subscriber or the Subscriber's

spouse is the court-appointed legal guardian; (Proof of guardianship is required at the time of enrollment)

- Children nineteen (19) or older who are either the birth or adopted children of the Subscriber or the Subscriber's spouse and are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber for support and maintenance, provided that: the onset of such incapacity occurred before age nineteen (19), proof of such incapacity is furnished to Us by the Subscriber upon enrollment of the person as a Dependent child or at the onset of the Dependent child's incapacity prior to age nineteen (19) and annually thereafter;
- Children between the ages of nineteen (19) and under twenty-three (23) or the age set forth in the Group Contract who are either the birth or adopted children of the Subscriber or the Subscriber's spouse and are attending on a full-time basis an accredited educational institution, defined as an educational institution which is eligible for payment of benefits under the Veterans Administration program on a full-time basis, provided that the Subscriber provides documentation of such attendance to PersonalCare upon request. Coverage ends the last day of the month in which the dependent attains the age of 23 or is no longer enrolled in school on a full-time basis.

Notwithstanding the above, coverage is not provided for foster children, grandchildren (unless the Subscriber is the legal guardian and documentation has been submitted to PersonalCare), parents or relatives. In addition, a common law spouse qualifies as a spouse under this Agreement only if his/her spousal status is affirmed by a court of competent jurisdiction. In all cases, PersonalCare's determination of eligibility shall be conclusive.

2.2 Retirees

A Retiree or Retiree spouse who is eligible to be covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B coverage on the later of the date he/she is first eligible for Medicare or the effective date of this Agreement in order to be eligible or continue coverage under this Agreement. If a Retiree or a Retiree spouse does not enroll within thirty (30) days of the later of the date he/she is first eligible for Medicare or the effective date of this Agreement, his/her coverage under this Agreement shall terminate.

2.3 Change of Group's Eligibility Rules

In order to be eligible for Coverage under this health benefit plan, individuals must meet specific Group eligibility requirements. So long as this Agreement is in effect, any change in the Group's eligibility requirements must be approved in advance by PersonalCare.

2.4 Persons Not Eligible to Enroll

2.4.1 A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with PersonalCare for coverage under this Agreement.

2.4.2 A person whose coverage under this Agreement was terminated due to a violation of a material provision of this Agreement shall not be eligible to enroll with PersonalCare for coverage under this Agreement.

2.4.3 Late Enrollees are not eligible to enroll except during the next Group Enrollment Period.

2.5 Enrollment

2.5.1 Group Enrollment Period: All eligible employees or Retirees of a Group and their eligible Dependents may enroll with PersonalCare for Coverage under this Agreement during the Group Open Enrollment Period or during a Special Enrollment Period.

2.5.2 Any new employee or employee who transfers into a PersonalCare Service Area may enroll with PersonalCare for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit a PersonalCare Enrollment Application for purposes of enrolling with PersonalCare for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he/she is not eligible to enroll until the next Group Open Enrollment Period unless there is a special enrollment under Section 2.6.

2.5.3 A special enrollee may enroll with PersonalCare for Coverage under this Agreement as provided below.

2.5.4 Eligible employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Agreement, are not eligible to enroll until the next Open Enrollment Period, unless they are eligible to enroll as a special enrollee, as described in Section 2.6 below.

2.6 Special Enrollment

2.6.1 Special Enrollment Due to Loss of Other Coverage.

Subject to the conditions set forth below, an

employee and his or her dependents may enroll in this Health Plan if the employee waived initial coverage under this Health Plan at the time coverage was first offered because the employee or dependent had other coverage at the time coverage under this Health Plan was offered and the employee's or dependent's other coverage was:

- COBRA continuation coverage that has since been exhausted; or,
- If not COBRA continuation coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term "loss of eligibility for such coverage" includes a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. This term does not include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation).

Required Length of Special Enrollment. An employee and his or her dependents must request special enrollment in writing no later than thirty (30) days from the date that the other coverage was lost.

Effective Date of Coverage. If the employee or dependent enrolls within the thirty-day period, coverage under the Health Plan will become effective no later than the first (1st) day of the first calendar month after the date the completed request for special enrollment is received.

2.6.2 Enrollment Due to New Dependent Eligibility. Subject to the conditions set forth below, an employee and his or her Dependents may enroll in this Health Plan if the employee has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- **Non-participating Employee.** An employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).
- **Non-participating Spouse.** Your spouse may enroll at the time of marriage to You, or upon the birth, adoption or placement for adoption of his or her child (even if the new child does not enroll).
- **New Dependents of Covered Employee.** A child who becomes a Dependent of a covered employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time.
- **New Dependents of Non-enrolled Employee.** A child who becomes a Dependent of a non-enrolled employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time but only if the non-enrolled employee is eligible for enrollment and enrolls at the same time.

Required Length of Special Enrollment. An employee and his or her Dependents must request special enrollment in writing no later than thirty (30) days from the date of marriage, birth, adoption or placement for adoption.

Effective Date of Coverage. Coverage shall become effective:

- In the case of marriage, the first (1st) day of the first (1st) calendar month beginning after the date a completed enrollment request is received by the Health Plan; and,
- In the case of a Dependent's birth, the date of such birth; and,
- In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

2.7 Notification of Change in Status. A covered employee must notify the Health Plan of any changes in Your status or the status of any Dependent within thirty (30) days after the date of the qualifying event. This notification must be submitted on a written Change of Status Form to the Health Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or coverage by another payer. The Health Plan should be notified within a reasonable time of the death of any Member.

III. Effective Dates

3.1 Effective Date

3.1.1 During Group Enrollment Period: An employee or Retiree who is eligible for coverage under this Agreement and enrolls or such coverage during a Group Enrollment Period shall be covered under this Agreement as of the Member Effective Date, a date mutually agreed to by PersonalCare and the Group.

3.1.2 Newly Hired Employees: A newly hired employee who is eligible for coverage shall be covered under this Agreement as of the date that he/she first becomes eligible for coverage so long as PersonalCare receives the employee's completed Enrollment Application within thirty-one (31) days of the date that the employee first became eligible for coverage.

3.1.3 Newly Eligible Employees: An employee of the Group who transfers into the Service Area and had been otherwise eligible for coverage under this

Agreement shall be covered as of the first (1st) day of the month following the date that he/she first transfers into the Service Area so long as PersonalCare receives the employee's Enrollment Application within thirty-one (31) days of the date that the employee first become eligible for coverage.

3.1.4 Special Enrollees: Special enrollees shall be covered under this Agreement as provided in Section 2.6 above.

3.2 Member Effective Date for Dependents

3.2.1 Dependents may be enrolled during a Group Enrollment Period, upon the valid enrollment of a newly hired or newly eligible employees (as provided in Section 3.1 above). In the case of Dependents who are enrolled during the Group Enrollment Period or upon the valid enrollment of a newly hired or eligible employee, the Dependent Effective Date shall be the same as the Member Effective Date.

3.2.2 Dependents who are Special Enrollees shall be covered under this Agreement when stated in Section 2.6 above; provided, that a child born under circumstances where there is two-Member or family coverage is automatically covered for the treatment of injury or sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first thirty-one (31) days from the date of birth. For coverage to continue beyond the first thirty-one (31) days, application to add the child as a Dependent must be received within thirty-one (31) days from the date of birth, and payment of the required premium must be received within thirty (30) days following receipt of the application. In the event that no other members of the Subscriber's immediate family are covered, immediate coverage for the first newborn infant shall be provided only if the Subscriber applies for Dependent's coverage and pays the applicable additional premium within thirty-one (31) days of the newborn's birth. Any newborn that is covered for the first thirty-one (31) days from the date of birth but is not eligible to enroll as a Dependent under this Agreement may convert to an individual contract under the terms and conditions set forth in Section 9 of this Agreement. Dependents eligible for coverage as a result of a Qualified Medical Child Support Order shall be covered as of the date specified in the order. If no date is specified in the order, coverage shall be effective as of the date the order is issued by the court.

IV. Termination of Coverage

4.1 Termination of Coverage For Members

Your coverage shall terminate upon the occurrence of any one of the following events:

- At least thirty (30) days' notice of termination of Your Coverage if You no longer meet the eligibility requirements set forth in this Agreement, including, without limitation, living outside the Service Area for a period longer than permitted under this Agreement.
- At least fifteen (15) days' notice of the termination of Your Coverage due to the nonpayment of premiums or supplemental charges (Co-payments) required for Hospital or medical services;
- Upon written request by the Subscriber or covered Dependent to voluntarily terminate coverage; (coverage will terminate as of the date requested, unless notice is received by PersonalCare after the date of the requested termination. In that event, coverage will terminate retroactively no more than sixty (60) days prior to the receipt of written notice by PersonalCare.)
- Upon the termination of all Certificates of Coverage by PersonalCare in accordance with the terms of the Group Enrollment Agreement.
- Upon the termination or non-renewal of the Group Contract by the Group;
- At least thirty (30) days' notice of termination to You if You and Your PCP fail to establish a satis factory patient-physician relationship and:
    - PersonalCare has, in good faith, provided You with the opportunity to select an alternative PCP;
    - You have repeatedly refused to follow the plan of treatment ordered by your PCP;
    - We have in good faith provided You with the opportunity to select an alter native Primary Care Physician;
    - You have been notified by PersonalCare in writing at least thirty (30) days in advance that the patient-physician relationship is unsatisfactory, and specific changes are necessary in order to avoid termination; and
    - You have failed to make a good faith effort to make the specific changes outlined in PersonalCare's notice detailed in the subsection immediately above.

If a Dependent fails to establish a satisfactory patient-physician relationship, only the coverage of the Dependent shall be terminated. If the Subscriber fails to establish a satisfactory patient-physician relationship, the coverage of the Subscriber and his/her Dependents will be terminated.

- At least fifteen (15) days' written notice if You materially violate the terms of the Agreement or Evidence of Coverage.
- At least fifteen (15) days' written notice if You participate in fraudulent or criminal behavior, including but not limited to:
    - Performing an act or practice that constitutes fraud or intentionally mis representing material facts including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, coverage for the Subscriber and all Dependents will be terminated.
    - Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the coverage of the Subscriber and his/her Dependents will be terminated.
    - Threatening or perpetrating violent acts against the Health Plan, a Provider, or an employee of the Health Plan or a Provider. In this instance, coverage for the Subscriber and all Dependents will be terminated.
    - Knowingly misrepresenting or giving false information on any enrollment application form which is material to PersonalCare's acceptance of such application.

4.2 Effect of Termination.

- If Your coverage under this Agreement is terminated under Section 4.1, all rights to receive Covered Services shall cease as of the date of termination.
- Identification cards are the property of PersonalCare and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.
- Your coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under PersonalCare's Grievance and Complaint procedures. PersonalCare may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

4.3 Certificates of Coverage.

At the time coverage terminates, You are entitled to receive a certificate verifying the type of coverage, the date of any waiting periods, and the date any creditable coverage began and ended.

4.4 Extension of Benefits for Total Disability.

In accordance with Title 50, Part 2013.60 of the Illinois Administrative Code, in the event a Member who became eligible for coverage under the terms of a Group Enrollment Agreement has a Total Disability on the date of discontinuance of the Group contract, coverage for such Member shall be extended until the earliest of the following:

1) the end of twelve (12) months; or
2) the date the maximum benefit is reached; or
3) the end of the total disability.

Any benefits payable during any period of extension of benefits shall be subject to the Group contract's regular benefit limits. Extension of benefits for a totally disabling illness, injury or condition shall be limited to services provided by or through PersonalCare's Participating Providers, unless those services are provided on an Emergency basis.

4.5 Reinstatement.

If a Member is terminated for any of the foregoing reasons but wishes to be reinstated, reinstatement will not be automatic; re-application will be required, and a reinstatement fee may be charged.

V. Continuation of Coverage

5.1 Federally Mandated Continuation Of Coverage for Certain Subscribers and Dependents

5.1.1 In the event a qualifying event occurs which results in the loss of Your coverage under this Agreement, You may be entitled to elect continuation of coverage under COBRA, provided the premiums for such coverage continue to be paid by the Group and You pursuant to the terms of the Group Contract and COBRA, and You are eligible for COBRA coverage.

5.1.2 If You are eligible for COBRA coverage, it shall be available to You only if election of such coverage is made within the election period set by the Group.

5.1.3 COBRA coverage shall automatically terminate at the end of the minimum period of time required by COBRA or other applicable federal or state law or regulation. COBRA coverage shall terminate prior to the expiration of the

minimum period upon the earliest of: a) the date the Group ceases to provide any group health plan coverage to any employee; b) the date on which coverage ceases by reason of a failure to make timely premium payments; c) the date after the date of election on which you become covered under any other group health plan or entitled to benefits under Medicare; or d) termination under the terms and conditions of the termination and disenrollment section of this Agreement.

5.1.4 Your Group, not PersonalCare, is the plan administrator for purposes of COBRA. Consequently, You should contact Your Group for answers to any questions You have with respect to continuation of coverage. PersonalCare does not administer COBRA coverage.

5.1.5 You should also refer to Section 9 for any conversion privilege You may have at the end of any period of continuation coverage.

5.2 State Mandated Continuation Of Coverage for Certain Subscribers and Dependents

5.2.1 Eligibility. If You are a Member whose coverage under the Agreement would otherwise terminate because of termination of employment or membership, You may be entitled to continue coverage under the Agreement, for Yourself and Your eligible Dependents, subject to all of the terms and conditions of the Group Contract and conditions applicable to Your Coverage and the following conditions:

- You have been continuously covered under the Agreement during the entire three (3) month period ending with the termination of employment or membership;
- You are not, upon termination of employment or membership, covered by Medicare or any other insured or uninsured plan which provides hospital, surgical, or medical coverage for individuals in a group and under which You were not covered immediately prior to such termination; and
- You have not exercised Your conversion privilege under this Evidence of Coverage (Certificate).

Notwithstanding anything herein to the contrary, continuation of coverage under this section shall not be available for any employee who was discharged because of the commission of a felony in connection with his or her work, or because of theft in connection with his or her work, for which the employer was in no way responsible if the employee (i) admitted to committing the felony or theft or (ii) was convicted or placed under supervision by a court of competent jurisdiction.

5.2.2 Election. If You wish to elect continuation of coverage, You must request continuation in writing within the ten (10) day period following the later of (i) the date of termination or (ii) the date You are given written notice of the right of continuation. In no event, however, may You elect continuation of coverage more than sixty (60) days after the date of such termination. PersonalCare reserves the right not to offer or provide continuation of dental, vision care, prescription drug or other similar supplementary benefits, if any, that are provided under the Group Enrollment Agreement in addition to its basic health care services.

5.2.3 Premium for Continuation Coverage. In order to continue benefits under this provision, You and/or your eligible Dependents must pay to the Group, on a monthly basis, in advance, the total amount of premium specified under the Group Enrollment Agreement, including that portion of the premium contributed to by the Subscriber or Group, if any) which shall in no event exceed the Group rate for the insurance being continued.

5.2.4 Termination of Continuation Coverage. Your continuation benefits under this section shall terminate upon the earlier of the following:

- The date You become eligible for Medicare;
- The date You become covered by any other insured and uninsured plan which provides hospital, surgical or medical coverage for individuals in a group and under which You were not covered immediately prior to termination of employment or membership;
- The expiration of nine (9) months after the date coverage under this Evidence of Coverage (Certificate) would otherwise have terminated because of termination of employment or membership;
- If You fail to make timely payment of a required premium, termination to be effective at the end of the period for which the required premium payments were made;
- The date on which the Group Enrollment Agreement is terminated or, if the Subscriber is an employee, the date his/her employer's participation under the Group Enrollment Agreement terminates even if the Group Enrollment Agreement itself has not terminated. However, if this section applies, and the coverage ceasing by reason of termination of the Group's Enrollment Agreement, or termination of the Group's participation in it, is replaced by similar coverage, continuation coverage may be available under such replacement policy.

5.2.5 You should also refer to Section 9 for any conversion privilege You may have at the end of any

period of continuation coverage.

VI. Covered Services

The Health Plan covers only those health services and supplies that are

(1) deemed Medically Necessary,
(2) provided by a Participating Provider,
(3) contained in the Schedule of Covered Services, and
(4) not excluded under the exclusions and limitations set forth in Section 7.

The following Schedule of Covered Services provides a list of the health care services and supplies covered under this Agreement. The schedule is provided to assist You with determining the level of coverage and Authorization procedures, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations set forth in Section 7. All Prior Authorizations and determinations referenced in the Schedule of Covered Services are made by Us.

SCHEDULE OF COVERAGE FOR SERVICES OR SUPPLIES WHEN DETERMINED BY PERSONALCARE TO BE MEDICALLY NECESSARY AND PROVIDED BY PARTICIPATING PROVIDERS

Allergy
Covered Service for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.

Ambulance
Covered Service for the following ambulance services:
Emergency transportation by ambulance under the following circumstances:

a) An Emergency Medical Condition exists, as defined by Illinois state law, and
b) The ambulance is licensed in its state as an emergency vehicle and has the necessary patient care equipment, supplies, and personnel to provide emergency care, and
c) Your medical condition is such that any other form of transportation would be medically unsafe, and
d) Transportation is to the nearest hospital with the appropriate facilities to treat your Emergency Medical Condition, or after appropriate stabilization, to a PersonalCare Participating Hospital.

Non-emergency transportation by ambulance under the following circumstances:

a) Transportation is to another hospital, inpatient rehabilitation facility, or skilled nursing facility, where additional treatment is intended to be delivered and has been Prior Authorized by PersonalCare, and
b) Your medical condition makes other forms of transportation medically unsafe, and
c) PersonalCare has Prior Authorized the ambulance transportation, and
d) PersonalCare will determine the most cost effective and medically appropriate mode of transportation.

Prior Authorization required unless emergent in nature. If it is determined that a transport by ambulance was not due to an Emergency, and Prior Authorization has not been obtained, the transportation by ambulance may not be covered by PersonalCare, and the resulting costs will be your responsibility.

You are not covered for the following ambulance services:

1. Non-emergent transportation that has not been Prior Authorized by PersonalCare.
2. Routine transportation.
3. Transportation for outpatient care.

Blood and Blood Products
Covered Service for Medically Necessary blood and blood products, including procurement and administrative charges, in connection with services covered under the Evidence of Coverage.

Authorization Requirement: Except in an Emergency, plasma fractions which include, but are not limited to, antihemophilic factor (factor VIII), prothrombin complex (factor VII, IX, X) and gamma globulin, require Prior Authorization by PersonalCare.

You are not covered for administration costs related to the procurement, processing and storage of blood from a person you designate as a donor.

Breast Implant Removal
Covered Service if the implants were inserted because of a Medically Necessary mastectomy, and the implants are causing illness or injury.
Limited benefit. ***Prior Authorization*** required.

You are not covered for the following breast implant removal services:

Removal of breast implants if implanted solely for cosmetic or other non-covered reasons, even if removal is determined to be Medically Necessary.

Breast Reconstruction
Covered Service. Consistent with the Women's Health and

Cancer Rights Act, if You have a mastectomy and elect reconstructive surgery in connection with the mastectomy, coverage will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas and other physical complications.

Coverage will be provided in a manner determined in consultation between You and Your attending Physician.

Covered Service for standard prosthetic breast devices, including surgical implants, external breast prostheses, and post-mastectomy surgical bras.

Prior Authorization required.

You are not covered for all other reconstructive or cosmetic surgeries of the breast or for breast enhancement or augmentation surgery, with or without implants.

Coverage for external prosthetic devices is limited. Contact Our Customer Service Department for current applicable benefit limits.

1. You may elect to purchase a more expensive external breast prosthesis by paying the excess cost.
2. Coverage is limited to one of each external breast prostheses (right and/or left).
3. Coverage for replacement of each external breast prostheses is limited to once every two (2) years.
4. Post-mastectomy surgical bras are limited to the standard model and limited to three (3) bras every six (6) months.

Cardiac Rehabilitation Therapy

Covered Service for cardiac rehabilitation therapy delivered in an approved, hospital-based cardiac rehabilitation program under the supervision of a cardiologist.

1. The cardiac rehabilitation therapy must be required and Medically Necessary due to a documented cardiac (heart) condition;
2. You must have a loss of function as a result of the cardiac condition;
3. The cardiac rehabilitation therapy must be significantly likely to substantially improve your functional status and result in either improved pain (angina) control or quality of life within a period of two (2) months; and
4. The cardiac rehabilitation therapy must not be able to be effectively and/or safely provided in a lesser setting (including, but not limited to, a non-monitored exercise program).

Limited benefit. ***Prior Authorization*** required. Please refer to Your Description of Coverage for benefit maximums.

You are not covered for:

1. Rehabilitative services provided for long-term, chronic medical conditions.
2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status.
3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs.
4. Educational or vocational therapy, schools or services designed to retrain You for employment.
5. Rehabilitative services (physical, occupational, and speech therapy) whose purpose is to treat or improve a develop-mental/learning disability or delay or congenital anomalies.
6. Stages III or IV of a cardiac rehabilitation program.
7. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated.
8. Alternative rehabilitation ser-vices (e.g., massage therapy).
9. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.

Chemotherapy and Radiation Therapy

Covered Service for chemotherapy and radiation therapy under the following conditions:

1. The treatment must be Medically Necessary; and
2. Chemotherapeutic drugs used in the treatment of cancer are limited to those drugs (a) which have been approved by the Federal Food and Drug Administration (FDA) and (b) recognized by the medical community for the specific type of cancer or which the drug has been prescribed in one of the following compendia: (i) the American Medical Association Drug Evaluations; (ii) the American Hospital Formulary Service Drug Information; or (iii) the United States Pharmacopoeia Drug Information or (c) if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer-reviewed professional journals pub lished in the United States or Great Britain; and
3. The treatment, including treatment combinations and treatment intervals, is considered to be the standard treatment for that particular cancer as recognized by a majority of

the national medical community and as published in peer-reviewed medical journals. The published results must clearly demonstrate either a survival or quality of life enhancement advantage in clinical trials; and

4. The treatment is currently not considered to be experimental or in clinical trials.

Chiropractic Care

You are ***covered*** for the chiropractic treatment of pain for those musculoskeletal conditions which can be expected to improve with chiropractic therapy through the manipulation of the spinal column and/or other skeletal structures under the following circumstances:

1. The chiropractic care must be Medically Necessary, and
2. The medical condition must reasonably be expected to improve with short-term (up to six weeks of) chiropractic treatment.
   * Note: Requests for laboratory testing, x-rays and physical therapy services must be referred back to Your PCP for coordination with Participating Providers.

Prior Authorization required.

You are not covered for chiropractic care related to the following:

1. Chiropractic therapy that is preventive in nature.
2. Chiropractic therapy that is long-term in nature or designed to provide for long-term maintenance and/or periodic adjustment of musculoskeletal alignment.
3. Massage therapy.
4. Holistic, homeopathic or naturopathic care.
5. Chiropractic therapy for musculoskeletal conditions that are typically not improved with chiropractic care. Examples include, but are not limited to, any benign or malignant neoplasms; fractures or dislocations; and organic/genetic musculoskeletal diseases and illness, such as multiple sclerosis, muscular dystrophy and osteomyelitis.
6. Chiropractic therapy for all non-musculoskeletal diseases and injuries. Examples include, but are not limited to, diabetes, asthma, obesity, hypertension, allergies, and infections.

Dental & Oral Surgical Services

This is a health insurance policy, not a dental insurance policy. Consequently, coverage for dental services is significantly limited. Covered Service for the following types of dental and oral surgical services:

1. Emergent and restorative services due to acci dental injury to sound, natural teeth within thirty (30) days of the injury.
   * Note: Accidental injury is defined as an injury related to an external trauma to the teeth, gums, or jaw. It does not include injuries resulting from natural function, such as biting or chewing. Additionally, accidental injury is that type of injury which, if left untreated, would result in the loss of the tooth or severe dysfunction.
   * Note: Sound, natural tooth is defined as a tooth with a normal root structure and no previous restoration.
   * Note: The emergent evaluation and treatment related to the accidental injury can be provided by Your dentist. Any further treatment to sound natural teeth must be coordinated by a Participating Provider and approved in advance by PersonalCare.
   * Note: Coverage ends if You leave PersonalCare, even if the thirty (30) days has not yet elapsed.
2. Medically Necessary, non-dental treatment for severe medical (non-dental) illness or accidental injury to Your jaw bones or surrounding tissues. Examples include:
   a) Treatment and correction of a pathological condition, such as a cyst, tumor, or infection involving the jaw or surrounding tissues, which is not dental in origin.
   b) Treatment and correction of cleft lip or cleft palate.
   c) Treatment and correction of illness or injury to the temporomandibular joint (TMJ) resulting from acute dislocation of the mandible from direct and external trauma, fractures, neoplasms, or other inflammatory rheumatologic or infectious conditions, such as rheumatoid arthritis, ankylosing spondylitis, disseminated lupus erythematosus, or osteomyelitis.
   d) Severe medical, but not dental, complications of dental work.
3. Hospital/ambulatory surgical charges incurred and anesthetics provided in conjunction with dental care provided to You to correct a dental condition if a non-dental concurrent medical condition or disability or age (6 and under) makes this setting necessary to safeguard Your health. Actual dental services provided are not covered.

Limited benefit. ***Prior Authorization*** required.

You are not covered for the following types of dental and oral surgical services:

- General dental care.
  1. General and preventive dental services,

including, but not limited to, crowns, bridges, dentures, orthodontic work, dental x-rays and other routine dental care.
2. Dental splints, dental prostheses or any on or to the teeth, gums or jaws and other services customarily provided by a dentist, unless related to trauma treatment.
3. Treatment of pain or infection known or thought to be due to a dental cause or in close proximity to the teeth or jaw, including, but not limited to, gum disease such as peridontitis and gingivitis.
4. Surgical or non-surgical removal of wisdom teeth or impacted teeth.
5. Prescription medications written by a dentist or physician for the purpose of treating a dental condition.

- Dental care delivered during the treatment of accidental injury to sound, natural teeth that is not related to the accidental injury.
- Other dental and oral surgery procedures:
  1. Surgical correction of malocclusion of the teeth and/or jaw, including, but not limited to, maxillofacial orthognathic and prognathic surgery.
  2. Orthodontic correction of tooth alignment or malocclusion.
  3. Treatment of the temporomandibular joint, or of temporomandibular joint syndrome (TMJ), resulting from dislocation of the cartilage with out dislocation of the mandible or from other dental causes or anomalies, including osteoarthritis.
- Hospital costs or related costs resulting from services that are excluded.
- Emergent and restorative services due to accidental injury to sound, natural teeth rendered thirty (30) days or more after the date of injury or after Your coverage with PersonalCare has ended.

Dermatological Services
Covered Service when necessary to remove a skin lesion that interferes with normal body functions or is suspected to be malignant.

Limited benefit. ***Prior Authorization*** required.

You are not covered for the removal of benign skin lesions, growths (such as warts), or skin tags primarily for cosmetic purposes.

Diabetic Self- Management Training and Education
Covered Service for outpatient self-management training and education programs for the treatment of Type 1 diabetes, Type II diabetes and gestational diabetes mellitus, as part of an office visit, group setting, or home visit.

You are covered for up to three (3) Medically Necessary visits to a qualified Participating Provider, including medical nutrition education, upon Your initial diagnosis of diabetes by Your Physician and up to two (2) Medically Necessary visits to a qualified Participating Provider upon a determination by Your physician that a significant change in Your symptoms or medical condition has occurred.

- Note: A significant change in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in Your medical condition that requires a significantly different treatment regimen.

Coverage for the following equipment when Medically Necessary and prescribed by a physician:
1. blood glucose monitors;
2. blood glucose monitors for the legally blind;
3. cartridges for the legally blind; and
4. lancets and lancing devices.

(Not applicable to a group policy that does not provide a durable medical equipment benefit.)

Coverage for the following pharmaceuticals and supplies when Medically Necessary and prescribed by a physician:
1. insulin;
2. syringes and needles;
3. test strips for glucose monitors;
4. FDA approved oral agents used to control blood sugar; and
5. glucagons emergency kits.

(Not applicable to a group policy that does not provide a drug benefit.)

Prior Authorization may be required. Contact PersonalCare's Customer Service Department for further information.

Dialysis
Covered Service for hemodialysis and peritoneal services provided by Participating outpatient or inpatient facilities or at home. Covered Service for home dialysis, including equipment and supplies.

Disposable Medical Supplies (DMS)
Covered Service for disposable medical supplies (DMS) under Your durable medical equipment (DME) benefit in limited quantities as follows:
1. DMS such as dressings, casts, splints, and other supplies when applied in the physician's office by a Participating Provider.
2. DMS such as dressings, casts, splints, and other supplies when applied in Your home by a Home Health Provider.
3. DMS that are essential for the correct and

effective operation of DME and have a direct medical function. The DME for which the DMS will be utilized must have been Prior Authorized by PersonalCare.
* Note: DMS must be prescribed by a Participating Provider.
* Note: PersonalCare maintains a list of covered DMS. You may contact PersonalCare's Customer Service Department for coverage information.

Limited benefit. ***Prior Authorization*** required.

You are not covered for the following:
1. Self-administered dressings, splints, and supplies.
2. Supplies that are typically purchased over-the-counter.
3. Products that provide for nutritional needs, including, but not limited to, formula, feeding solutions, and supplements.
4. Disposable supplies that do not perform a medical function or purpose.
5. Other DMS, such as catheters, electrodes, and filters.
6. Clothing or garments, including, but not limited to, elastic stockings, support hose, foot coverings, corsets, or any elastic joint supports (which are not considered orthopedic appliances).

Durable Medical Equipment (DME)
Durable medical equipment (DME) is defined as equipment that meets all four of the following criteria:
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury;
- Is designed to withstand repeated use; and
- Is appropriate for use in the home.

(Examples of DME include, but are not limited to, wheelchairs, hospital beds, oxygen equipment, home ventilators, suctions devices, and crutches.)

Covered Service for DME as follows:
1. Your coverage for DME is limited to the standard model equipment that meets Your needs, as determined by PersonalCare. You may decide to purchase a more advanced model of equipment, but You are responsible for any amount in excess of the charge for the standard model, in addition to applicable co-payments, co-insurance, and deductibles.
2. You are covered for the professional services for delivery, set-up, fitting, and adjusting of Your DME.
3. You are covered for the repair, refitting, and/or replacement of Your DME so long as it has been properly maintained and not subjected to abuse or misuse and when not covered by product warranty. PersonalCare will determine if the DME should be repaired or replaced.
4. Oxygen when Medically Necessary.

* Note: The DME, or the repair of the DME, must be prescribed by a Participating Provider.
* Note: PersonalCare will make the decision whether the DME will be rented or purchased.
* Note: PersonalCare maintains a list of covered DME. You may contact PersonalCare's Customer Service Department for coverage information.

Prior Authorization required.

You are not covered for the following DME:
1. Eyeglasses, contact lenses, and other equipment intended to improve vision.
2. Hearing aids, ear molds, and other equipment intended to improve hearing.
3. Equipment for environmental control, such as air conditioners, furnaces or heaters, air filters or purifiers, humidifiers or dehumidifiers.
4. Improvements or modifications to Your home or place of business.
5. Whirlpool baths.
6. Fitness or exercise equipment.
7. Educational materials, books, videotapes.
8. Repair or replacement of DME due to misuse, neglect or loss.
9. DME which may be used by multiple individuals.
10. Electrical continence aids, either anal or urethral.
11. Wheelchairs and lift-chairs, unless You would be bed- or chair-confined without such equipment.
12. Convenience or comfort items, including, but not limited to, tub grab bars, raised toilet seats, and seat lifts.
13. Items necessary for the operation of DME that are not directly related to the medical function of the equipment.
14. Replacement items, including, but not limited to, replacement batteries, tires, and light bulbs.
15. Replacements of DME when the device being replaced is one that would continue to meet Your basic medical needs as determined by PersonalCare.

Glucometers will be obtained from PersonalCare's National Vendor, when available.

Coverage limited to the standard model equipment that meets Your needs, as determined by PersonalCare.

Upgrades to the equipment are Your financial responsibility.

Elective Sterilization
Covered Service, unless Your Group has a specific restriction on file with Us.

Prior Authorization required, unless performed in a Participating Physician's office.

Emergency Services
Covered Service as set forth in Section 6.1 below.
The definitions of "Emergency Services," "Emergency Medical Condition," and "Emergency Out of Area" can be found in the Definitions Section of this Evidence of Coverage (Certificate).

While Emergency Room visits do not require ***Prior Authorization*** from or initial notification to Us, You should notify Your PCP and PersonalCare within 48 hours of admission, the next business day or as soon as reasonably possible after care begins.

Eyeglasses and Corrective Lenses (Vision Services)
Covered Service for Medically Necessary vision services required for the diagnosis and treatment of diseases of, or injuries to, the eye.

Limited benefit. ***Prior Authorization*** required.

You are not covered for the following vision services:

1. Routine eye examinations to check visual acuity, except as provided by Your Primary Care Physician in his or her office.
2. The measurement, fitting or adjustment, or polishing of eyeglasses or contact lenses.
3. Contact lenses, eyeglass frames, corrective lenses, tints, or other lenses, services, or treatments, except when necessary for the first pair of eye glasses or corrective lenses following cataract surgery performed while You are enrolled with Us.
4. Vision therapy or orthoptics treatment (eye exercises).
5. Surgery for the correction of a refractive disorder, including, but not limited to: radial keratotomy (RK), astigmatic keratotomy (AK), automated lamellar keratoplasty (ALK), (excimer laser) photorefractive keratectomy (PKR), photothera-peutic keratectomy (PTK) and laser assisted in situ keratomieusis (LASIK).

Genetic Counseling
Covered Service for genetic counseling and studies that are needed for diagnosis or treatment of genetic abnormalities.

Prior Authorization required.

You are not covered for diagnostic tests and procedures done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for the genetic disease in question.

Growth Hormone
Covered Service when specific criteria are met. Contact PersonalCare's Customer Service Department for further information.

Prior Authorization required.

Health Education
Covered Service includes instructions on achieving and maintaining physical and mental health and preventing illness and injury.

Health education does not require ***Prior Authorization*** by Us when provided in Your Primary Care Physician's office. Any other Participating Provider setting must be Prior Authorized.

Home Health Care
Covered Service for Medically Necessary home health care and/or home infusion services provided in Your home under the following circumstances:

1. The services are provided in lieu of hospitalization or placement in a skilled nursing facility or receiving outpatient services outside the home.
2. You must be homebound because of illness or injury and unable to be reasonably transported for necessary medical care, as determined by PersonalCare.
3. The services have been ordered by a Participating Provider and are directly related to an active treatment plan of care established by Your physician.
4. The services provided must be considered by PersonalCare to be specific, effective, and reasonable for the treatment of Your diagnosis and physical condition and the most cost-effective approach to care.
5. The services are provided on a part-time, intermittent basis.
6. The services must be delivered by or under the supervision of a registered nurse, licensed health care professional, or therapist and provided by a licensed and certified agency.
7. Covered services include nursing care, therapy services, medical and surgical supplies, and FDA-approved prescription drugs furnished by the Home Health Care agency or infusion program that are specific to the delivery of the Home Health Care services.
8. Services consist primarily of caring for the patient.
9. Prior to beginning home health care services, a treatment plan was both reviewed and approved by PersonalCare.

* Note: Rehabilitation services provided in the home will be covered under the applicable rehabilitative services sections of this Evidence of

Coverage (Certificate) and will be subject to the applicable co-payments and co-insurance as described in Your Description of Coverage.

Prior Authorization required.

You are not covered for the following home health care services:

1. Services that are otherwise not a covered benefit of this Evidence of Coverage (Certificate).
2. Housekeeping services.
3. Health aid services.
4. Private duty nursing or home care that is full-time, continuous or long-term.
5. Services provided by a person who ordinarily resides in Your home or is in Your immediate family.
6. Custodial care.

Hospice

Covered Service when each of the following five criteria has been met:

1. Services are ordered by a Participating Provider;
2. Your physician certifies that Your life expectancy is six (6) months or less;
3. The care is palliative in nature;
4. The care is provided through a licensed hospice care provider approved by PersonalCare; and
5. Prior to receiving coverage for hospice services, a treatment plan has been reviewed and approved by PersonalCare.

Prior Authorization required.

You are not covered for any treatment or services rendered by or at the direction of: a person residing in Your household; a family member (such as Your spouse, child, parent, grandparent, sibling, or any person related in the same way to Your covered dependent); or any person or agency not licensed to provide the services rendered.

Immunizations

Covered Service for childhood and adult immunizations according to Our recommended immunization schedule guidelines.

Immunizations for routine childhood immunizations and flu shots do not require ***Prior Authorization*** by Us.

Prior Authorization may be required for immunizations other than routine childhood immunizations.

You are not covered for immunizations for travel or employment or for unexpected mass immunizations directed or ordered by public health officials for general population groups.

Infertility

Covered Service for the diagnosis and treatment of infertility, including, but not limited to: diagnostic testing, treatments to enhance ovulation (injectable medications only unless pharmaceutical rider has been purchased by Your Group), surgical procedures to correct tubal defects not caused by elective sterilization, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination (AI), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and low tubal ovum transfer (LTOT), when diagnosed by a Participating Physician and applicable criteria have been met.

* Note: Infertility means the inability to conceive after one (1) year of unprotected sexual inter course or the inability to sustain a successful pregnancy.

You have coverage for procedures for in vitro fertilization, GIFT and ZIFT only if:

1. You have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under this Evidence of Coverage (Certificate);
2. You have not undergone four (4) completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two (2) more completed oocyte retrievals shall be covered; and
3. The procedures are performed at Participating medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Prior Authorization required.

You are not covered for:

1. Reversal of voluntary steriliza-tion;
2. Payment for medical services rendered to a surrogate for purposes of child birth, including, but not limited to, prenatal care and delivery of the baby;
3. Costs associated with cryo preservation and storage of sperm, eggs and embryos;
4. Selected termination of an embryo, except where the life of the mother is in danger;
5. Non-medical costs of an egg or sperm donor;
6. Travel costs for travel within 100 miles of the members' home address, and travel costs which are not medically necessary, not mandated or required by Us;
7. Infertility treatments deemed experimental in nature; and
8. Infertility treatments rendered to minor dependents.

Certain services may have specific restrictions or may not be covered for a religious institution or organization or to an entity sponsored by a religious institution or organization that finds the procedure in violation of the religious and moral teachings or beliefs.

Injectables

You are covered for injectable pharmaceuticals (including those medications intended to be self-administered) but only if each of the following criteria is met:

1. The injectable pharmaceutical must be Medically Necessary and appropriate for Your diagnosis or condition;
2. The injectable pharmaceutical must be FDA-approved and non-experimental;
3. Because of Your medical condition, the pharmaceutical can only be administered, or most effectively and appropriately be administered, by an injection, and an appropriate oral alternative drug does not exist; and
4. A Participating Provider arranges for, and/or provides, the injectable pharmaceutical.

* Note: To be consistent with changes in medical technology, PersonalCare maintains a list of covered and non-covered injectable pharmaceuticals and the medical conditions for which they are approved for coverage. Coverage can be verified by calling the Customer Service Department at PersonalCare.

* Note: Insulin is covered only if a pharmaceutical benefit rider has been purchased by You or Your employer as part of this Evidence of Coverage (Certificate).

* Note: Immunizations are covered as part of your Preventive Services benefit.

Prior Authorization required.

You are not covered for the following injectables:

1. Drugs related to the treatment of non-covered services.
2. Experimental or investigational drugs or drugs that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA.
3. Certain classes of injectable medications, such as anabolic steroids when used for performance enhancement, immunizations required for travel and injectable contraceptives.

Inpatient Hospital Care

Covered Service. You are covered for Medically Necessary inpatient hospital services, including, but not limited to, the following:

1. Semi-private room and board or specialty units, such as intensive care and coronary care.
2. General nursing care.
3. Hospital services, including lab, x-ray, other diagnostic tests, medical treatment, and the administration and processing of whole blood and blood plasma.
4. Use of an operating room and related facilities, including anesthesia.
5. Medical supplies used by You during Your inpatient stay.
6. Non-experimental, FDA-approved drugs administered to You during Your inpatient stay.
7. Therapy services, including rehabilitative therapy, radiation therapy, and inhalation therapy.
8. Inpatient hospital services are covered only when they are:
   a) Medically Necessary;
   b) Can be safely and/or effectively delivered only within a hospital inpatient setting;
   c) A Participating Provider arranges for, and manages, Your care within the hospital; and
   d) You are admitted to a Participating Hospital.

* Note: Inpatient hospital services arranged for, and managed by, Out-of-Network physicians and/or provided at an Out-of-Network hospital are covered only if:
   a) You meet the criteria of an Emergency Medical Condition as defined under the Emergency Services section of this Certificate of Insurance, or
   b) The inpatient services are Prior Authorized by PersonalCare.

Coverage is also provided for inpatient hospitalization following a mastectomy for a length of time determined to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient and the coverage for and availability of a post-discharge physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Prior Authorization required unless emergency admission. Consistent with Our utilization management policy, all acute care Hospital admissions and continued stays are reviewed for Medical Necessity during the inpatient stay. Coverage is dependent on the establishment of Medical Necessity for the care. If the Hospital stay or any portion thereof is determined not to be Medically Necessary, Your Provider and You will be notified that coverage will cease. In addition, You are not covered for the following inpatient hospital care services:

1. Take-home drugs dispensed prior to Your release, whether billed directly or separately by the hospital. You may have benefits as outlined in a prescription drug rider, if applicable.
2. If You are hospitalized prior to your Effective Date, coverage begins on your Effective Date.

You are not covered for expenses incurred prior to Your Effective Date or after Your Termination Date.

3. Private duty nursing.
4. Services provided in connection with otherwise non-covered admissions or non-covered services.
5. Personal comfort or convenience items, such as, but not limited to, in-hospital television, tele phone, guest trays and housekeeping.
6. Private rooms, unless one is determined to be Medically Necessary. (You shall be responsible for the payment of the difference between the private room rate and the semi-private room rate if a private room is requested, and it is not Medically Necessary.)

Inpatient Skilled Nursing Facility Services

Covered Service, including room and board in a semi-private accommodation, but only if the following conditions have been met:

1. The services must be provided at a facility licensed by the State of Illinois and approved as a Participating Provider or Skilled Nursing Facility under the Medicare Program and PersonalCare; and
2. The medical services delivered must be required to be provided by a licensed professional health personnel (i.e., registered nurse or licensed physical therapist); and
3. The required medical services cannot be consistently and safely provided in a less intense setting (i.e., at home or in a custodial nursing home); and
4. The medical care is required on a daily basis (at least five (5) days per week); and
5. The medical care is actually received by You; and
6. At least one of the following is a goal of the skilled nursing care:
   a) Your medical condition requires services to be provided or supervised by a professional to meet Your needs, promote recovery, and ensure Your medical safety following debilitation as a result of a prolonged acute or chronic illness. The services must be:
      i. temporary in nature; and
      ii. lead to rehabilitation and increased ability to function; and
      iii. not intended only to maintain Your current level of functioning; and
      iv. You must continue to have documented improvement in Your function during the course of Your stay.
   b) Your medical condition requires teaching and training from skilled nursing or rehabilitation personnel on how to manage a treatment regimen.
   c) Even if the prognosis for Your medical condition is such that partial recovery is not possible, a skilled service or nursing assessment and intervention is needed to alleviate pain or treat acute symptoms.

Prior Authorization required.
Limitations may apply. See Your Description of Coverage for Your applicable limits per Contract Year.

You are not covered for the following:

1. Custodial, convalescent, or domiciliary care in a hospital, skilled nursing facility, or any other facility.
2. Charges for services or supplies which are for the primary purpose of controlling or changing Your environment or providing You with a rest cure.
3. Take-home drugs dispensed prior to Your release from the skilled nursing facility.
4. Services and supplies which are otherwise not a Covered Benefit under this Evidence of Coverage (Certificate).

Laboratory Services

Covered Service.No ***Prior Authorization*** required if Participating laboratory is used.

Maternity Services

Covered Service for the following maternity services:

1. Prenatal, natal and postnatal care provided by a licensed physician, certified nurse mid-wife acting under the direction of a licensed physician and/or his or her staff.
2. Clinical preventative services for prenatal care as set forth in Our preventive care guidelines.
3. X-rays, laboratory, and other diagnostic tests.
4. Inpatient care, including covered, Medically Necessary operations and special procedures for the mother and the eligible newborn child, up to forty-eight (48) hours following a normal vaginal delivery and up to ninety-six (96) hours following a Caesarean section. Your physician may determine after consultation with You that a shorter length of stay is appropriate. This decision must be made in accordance with the protocols and guidelines developed by the American College of Obstetrics/Gynecology or the American College of Pediatrics. In the event of a shorter length of stay as described above, coverage shall be provided for a post-discharge visit at a Participating Provider's office or an in-home nurse visit to verify the condition of the infant in the first forty-eight (48) hours after discharge.

* Note: A Participating Provider must arrange for, and provide, Your maternity care.

* Note: Your newborn infant is covered for routine care and Medically Necessary treatment of illness or injury, subject to eligibility requirements and other policy limitations. (See the Eligibility section of this Evidence of Coverage (Certificate) for further information).
* Note: During Your prenatal care, if You are admitted for complications or any medical condition other than Your delivery, Your inpatient co-payment will apply for each admission.

Prior Authorization required. Notification and authorization required if You stay beyond 48 hours after a vaginal delivery or 96 hours after a delivery by Caesarian section. Maternity-related services, including global obstetrical care, perinatologist visits and more than 3 ultrasounds, also require Prior Authorization.

You are not covered for the following:

1. Abortions that are directly intended to terminate pregnancy before viability or directly intended to destroy a viable fetus, unless otherwise covered by this Evidence of Coverage (Certificate).
2. X-rays, laboratory tests, diagnostic tests, or other procedures that are not Medically Necessary. (Examples include, but are not limited to, testing to determine the sex or paternity of your unborn child, excessive testing for unlikely illness or disease or testing that does not add value to the management of the case).
3. Planned home deliveries.
4. Maternity care delivered by non-physicians, such as doulas.
5. Personal comfort or convenience items.
6. Routine prenatal care or delivery when You are outside the Service Area against medical advice, except when You are outside the Service Area due to circumstances beyond Your control.

Medical Complications
Covered Service for complications arising from Medically Necessary surgery regardless of Health Plan membership status at the time of surgery.

Prior Authorization required.

You are not covered if the medical complications occurred because You did not follow the course of treatment prescribed by a Participating Provider.
You are also not covered if the medical complications arose from non-covered services, even if the requested service may be Medically Necessary.

Mental Health Services
See Section 6.3.

Nutritional Counseling
Covered Service when provided (1) by a Registered Dietician associated with a Participating Provider or Hospital or by a Participating Physician and (2) in connection with morbid obesity, diabetes, coronary artery disease and hyperlipidemia.

Limited benefit. ***Prior Authorization*** required. Contact PersonalCare for applicable limitations and exclusions.

Occupational Therapy
Covered Service when delivered by, or under the direct supervision of, a licensed occupational therapist, and each of the following conditions has been met:

1. The therapy must be required and Medically Necessary due to a documented medical condition;
2. You must have a loss of function as a result of the medical condition;
3. The therapy must be significantly likely to substantially improve Your functional status and result in either improved pain control or quality of life within a period of two (2) months; and
4. The therapy must not be able to be effectively and/or safely provided in a lesser setting (including, but not limited to, a home exercise program).

Limited benefit. ***Prior Authorization*** required. Please refer to Your Description of Coverage for benefit maximums.

You are not covered for:

1. Rehabilitative services provided for long-term, chronic medical conditions.
2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status.
3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs.
4. Educational or vocational therapy, schools or services designed to retrain You for employment.
5. Rehabilitative services whose purpose is to treat or improve a develop-mental/learning disability or delay or congenital anomalies.
6. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated.
7. Alternative rehabilitation ser-vices (e.g., massage therapy).
8. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.

Physical Therapy

Covered Service when delivered by, or under the direct supervision of, a licensed physical therapist, and each of the following conditions has been met:

1. The therapy must be required and Medically Necessary due to a documented medical condition;
2. You must have a loss of function as a result of the medical condition;
3. The therapy must be significantly likely to substantially improve your functional status and result in either improved pain control or quality of life within a period of two (2) months; and
4. The therapy must not be able to be effectively and/or safely provided in a lesser setting (including, but not limited to, a home exercise program).

Limited benefit. ***Prior Authorization*** required. Please refer to Your Description of Coverage for benefit maximums.

You are not covered for:

1. Rehabilitative services provided for long-term, chronic medical conditions.
2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status.
3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs.
4. Educational or vocational therapy, schools or services designed to retrain You for employment.
5. Rehabilitative services whose purpose is to treat or improve a develop-mental/learning disability or delay or congenital anomalies.
6. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated.
7. Alternative rehabilitation ser-vices (e.g., massage therapy).
8. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.

Podiatry

Covered Service. Prior Authorization required.

You are not covered for the care or treatment of corns and/or calluses, the clipping of toenails, or the non-surgical care or treatment of flat feet, fallen arches, weak feet or chronic foot strain.

Preventive Services and Diagnostic Tests and Procedures

Covered service for office visits to Participating Providers for covered preventive, diagnostic and treatment services as follows:

Preventive Services:

PersonalCare has developed a comprehensive list of covered preventive services. That list is published annually and distributed to all of our Members. You may obtain a copy of that list by contacting the Customer Service Department at PersonalCare. Examples of types of covered preventive services include the following:

1. Well-baby care from birth to one and routine pediatric health evaluations, including school physicals and applicable recommended immunizations.
2. Annual health evaluations and physical examinations for adults, including applicable immunizations.
3. Annual pelvic exam and Pap smear test or c ervical smear for women.
4. Baseline mammogram for women 35 to 39 years of age and annual mammogram for women 40 years of age or older by low-dose mammography and breast exam for the presence of occult breast cancer.
5. Annual digital rectal examination and prostate-specific antigen test for men upon the recommendation of a physician for
   (a) asymptomatic men age 50 and over;
   (b) African-American men age 40 and over; and
   (c) men age 40 and over with a family history of prostate cancer.
6. Colorectal cancer screening by means of sigmoidoscopy or fecal occult blood testing once every 3 years for persons who are at least 50 years old.
7. Treatment of allergies and serum for allergy injections.

Diagnostic Tests and Procedures:

You are covered for diagnostic tests and procedures (including, but not limited to, laboratory tests, radiographic tests, and other diagnostic procedures) under the following circumstances:

1. The diagnostic test and/or procedure must be Medically Necessary, and
2. The diagnostic test and/or procedure must provide useful information that affects diagnostic and treatment decisions by Your physician, and
3. The diagnostic test and/or procedure must be done because of currently recognized health problems or symptoms, and
4. The diagnostic test and/or procedure must be ordered by a Participating Provider, and
5. The diagnostic test and/or procedure must be performed within the PersonalCare Provider

Network unless a Prior Authorization from PersonalCare is obtained.

* Note: Some diagnostic tests and procedures may require Prior Authorization from PersonalCare before they are performed. Failure to obtain Prior Authorization may result in the benefit being reduced or eliminated.

Certain preventive services/diagnostic tests and procedures require ***Prior Authorization***. Contact PersonalCare's Customer Service Department for additional information.

You are not covered for the following preventive services:

1. Unexpected mass immunizations directed or ordered by federal, state or local public health officials for general population groups.
2. Preventive chiropractic services, including, but not limited to, long-term or periodic manipulation of bones or joints, massage therapy, or holistic or alternative medicine.
3. Membership or service fees associated with health clubs, weight loss clinics and fitness programs.
4. Charges and fees for health education classes, smoking cessation programs, stress management and childbirth education.
5. Equipment and supplies to promote health or exercise, including, but not limited to, exercise equipment, videos, software, whirlpools, Jacuzzis, air conditioners, air purifiers, humidifiers, and dehumidifiers.
6. Hearing examinations, except for the treatment and diagnosis of diseases of, or injury to, the ear.
7. Vision examinations, except for the treatment and diagnosis of diseases of, or injury to, the eye.
8. Certain services or diagnostic or screening procedures determined by Us to be inappropriate for the delivery to, or screening of, an entire population or subpopula-tion. Typically, these services or procedures would not have been proven to be of value when applied to a large population or subpopulation.
9. Comprehensive preventive clinics or spas.

You are not covered for the following diagnostic tests and procedures:

1. Diagnostic tests and procedures that are considered to be experimental or investigational.
2. Diagnostic tests and procedures that have not demonstrated significant usefulness as recognized by a majority of the national medical community and as published in the peer-reviewed medical journals.
3. Diagnostic tests and procedures that are not done to evaluate current health problems or symptoms. Examples include, but are not limited to, premarital blood testing, paternity testing, and screening for various conditions in the absence of symptoms or significant risk factors.
4. Diagnostic tests and procedures done to detect genetic abnormalities in the absence of either significant symptoms of, or risks for, the genetic disease in question.

Primary Care Services

At PersonalCare, We believe that healthcare works best when it is coordinated by Your personal physician. Each member of Our health plan has a designated Primary Care Physician. You are covered for the following primary care services provided by your Primary Care Physician (PCP) or under your PCP's supervision:

1. Office visits for covered illness or injury.
2. Inpatient and outpatient hospital visits for Covered Services and approved stays.
3. Preventive care services and immunizations (provided in accordance with the Preventive Services section of this Evidence of Coverage (Certificate).
4. Covered office diagnostic testing.
5. Surgical procedures for Covered Services.
6. Covered injections and medications administered during an office visit.
7. Hearing and vision screening or testing by your PCP.

* Note: Your PCP has designated to PersonalCare other PCP(s) that cover for him or her in his or her absence. In the event Your PCP is unavailable, You may obtain primary care services from one of Your PCP's designated covering physicians. You can obtain the name of the designated covering physician by contacting Your PCP's office or the Customer Service Department at PersonalCare.

* Note: Co-payments or Coinsurance will apply to office visits when You are seen by Your PCP, or a covering physician, physician assistant, nurse practitioner or nurse. Some procedures performed in a Physician's office (i.e., lesion removal) and certain injectable medications require Prior Authorization. Contact PersonalCare's Customer Service Department for further information.

You are not covered for the following primary care services:

1. Physical examinations, immunizations, evaluations, or preparation of reports required by third parties and/or not required for health reasons. Examples may include, but are not limited to, services to secure insurance, meet employment requirements, obtain licenses, for foreign travel, to allow participation in recreational activities, or to comply with a court order.
2. Services or charges for which workers compensation is the primary payor.

3. Services, treatments or supplies that are not Medically Necessary for the treatment of an injury or illness or are outside generally accepted health care practice as determined by PersonalCare.
4. Services, treatments or supplies that are other wise not a covered benefit under this Evidence of Coverage (Certificate).

Prostheses, Prosthetic Appliances and Implants (PA)
Covered Service.

Prosthesis, Prosthetic Appliances and Implant (PA) is defined as an appliance or device that replaces all or part of a body organ, or all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The device may be external to, or implanted surgically into, the body. (Examples include, but are not limited to, artificial limbs, eyes, post-mastectomy prostheses and bras, hips, knees, pacemakers, surgical implants, and lens implants required as a replacement for natural lenses.)

You are covered for Prostheses, Prosthetic Appliances, and Implants (PA) as follows:

1. Your coverage for PA is limited to the standard model that meets Your needs as determined by PersonalCare. You may decide to purchase a more advanced model, but You will be responsible for any amount in excess of the charge for the standard model, in addition to applicable Co-payments, Coinsurance, and deductibles.
2. You are covered for the professional services for fitting and adjusting Your PA.
3. Ostomy supplies in limited quantities for patients that are colostomy or illiostomy status. You may contact PersonalCare's Customer Service Department for coverage information.
4. You are covered for the repair, refitting, and/or replacement of Your PA so long as it has been properly maintained and not subjected to abuse or misuse and when not covered by product warranty. PersonalCare will determine if the PA should be repaired or replaced.
5. You are covered for wigs, hair-pieces, and toupees for hair loss as a direct result of chemotherapy or radiation therapy. A lifetime maximum of $250 is applied for use at a provider of Your choice.

* Note: The PA, or the repair of the PA, must be prescribed by a Participating Provider.
* Note: PersonalCare maintains a list of covered PA. You may contact PersonalCare's Customer Service Department for coverage information.
* Note: For Your applicable Co-payment or Coinsurance for PA, please refer to the Durable Medical Equipment benefit listed on Your Description of Coverage or listing for PA, if indicated.

Prior Authorization required. If You require refitting and a replacement of your PA due to structural change in anatomy, the replacement must be Prior Authorized. Coverage for prosthetic devices will be through the DME benefit.

You are not covered for the following:

1. Eyeglasses, contact lenses, and other equipment intended to improve vision.
2. Hearing aids, ear molds, and other equipment intended to improve hearing.
3. Dentures.
4. Implants for cosmetic purposes.
5. Wigs, hair-pieces or prostheses, toupees, hair transplants and/or other equipment or supplies for the treatment of the loss of hair (except as provided).
6. Repair or replacement of PA due to misuse, neglect or loss.
7. Replacement of PA when the device being replaced is one that would continue to meet Your basic medical needs as determined by PersonalCare.

Pulmonary Rehabilitation Therapy

Covered Service when delivered in an approved, hospital-based pulmonary rehabilitation program under the direct supervision of a licensed therapist or pulmonologist, and each of the following conditions has been met:

1. The pulmonary rehabilitation must be required and Medically Necessary due to a documented pulmonary (lung) condition;
2. You must have a loss of function as a result of the pulmonary condition;
3. The pulmonary rehabilitation must be significantly likely to substantially improve your functional status and result in either improved symptom control or quality of life within a period of two (2) months; and
4. The pulmonary rehabilitation must not be able to be effectively and/or safely provided in a lesser setting.

Limited benefit. ***Prior Authorization*** required. Please refer to Your Description of Coverage for benefit maximums.

You are not covered for:

1. Rehabilitative services provided for long-term, chronic medical conditions.
2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status.
3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs.

4. Educational or vocational therapy, schools or services designed to retrain You for employment.
5. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated.
6. Alternative rehabilitation ser-vices (e.g., massage therapy).
7. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics, or home exercise equipment.

Radiology

Covered Service. Prior Authorization may be required for radiology services. Contact PersonalCare's Customer Service Department for further information.

Reconstructive Surgery

Covered Service for the following types of reconstructive surgery:

1. Reconstructive surgery performed to correct a seriously disfiguring condition resulting from accidental injury:
   a) A functional defect must also exist, and the disfiguring condition must have a major effect on Your appearance.
   b) The reconstructive surgery must be started within one (1) year of the accidental injury and must be completed within two (2) additional years, unless delay is directly related to Medically Necessity.
   c) The condition must reasonably be able to be corrected by surgery.
2. Reconstructive surgery performed to correct a seriously disfiguring condition resulting from surgery:
   a) The injury must occur as a result of a surgical procedure that is otherwise a covered benefit under this Evidence of Coverage (Certificate).
   b) A functional defect must also exist and the disfiguring condition must have a major effect on Your appearance.
   c) The reconstructive surgery must be started within one (1) year of the surgery which results in a seriously disfiguring condition and must be completed within two (2) additional years, unless delay is directly related to Medical Necessity.
   d) The condition must reasonably be able to be corrected by surgery.
3. Reconstructive surgery performed on a covered child to correct a seriously disfiguring condition resulting from a congenital disease or anomaly.
   a) The disfiguring condition must have a major effect on Your child's appearance.
   b) The reconstructive surgery must be started within one (1) year of birth or delayed for medical reasons documented in the first year of life, until a later age. Reconstruction must be completed within five (5) additional years.
   c) The condition must reasonably be able to be corrected by surgery.

Prior Authorization required.

You are not covered for the following:

1. Any surgical treatment or hospitalization for plastic or cosmetic surgery and/or which is undertaken to improve Your appearance and is not Medically Necessary for the correction of a functional defect caused by a bodily injury or illness. Functional defect does not include any consideration of the psychological impact caused by bodily injury or illness.
2. Any medical treatment, hospitalization, or drug which is undertaken to improve Your appearance and is not Medically Necessary for the correction of a functional defect caused by a bodily injury or illness. Functional defect does not include any consideration of the psychological impact caused by bodily injury or illness.
3. Procedures, services and supplies related to sex change operations.
4. Reconstructive surgery that occurs after You no longer have insurance coverage with PersonalCare, whether or not Prior Authorized.
5. The removal of benign skin lesions, growths, or skin tags primarily for cosmetic purposes.

Sexual Assault or Abuse

You are covered for emergency medical services, including care for injury and trauma, sustained as a victim of sexual assault or sexual abuse or an attempt to commit such offense. ***Covered Services*** include, but are not limited to, examination and testing to establish whether sexual contact occurred and the presence or absence of a sexually transmitted disease or infection; and examination and treatment of injury and trauma sustained as a victim of such offense. Co-payments or Coinsurance amounts for services received in the emergency room for sexual assault or abuse will be waived if you are a victim of such offense.

No ***Prior Authorization*** required.

Sleep Studies

Covered Service. Prior Authorization required.

Your PCP will refer You to a Participating Pulmonologist or ENT for an evaluation. Sleep studies require separate Prior Authorization. If the results of the evaluation meet PersonalCare criteria, a sleep study may be authorized.

Specialty Care Services
You are ***covered*** for specialty care services, including consultation, diagnosis and treatment, which are beyond the scope of services provided by your Primary Care Physician.

Some procedures performed in a Physician's office (i.e., lesion removal) and certain injectable medications require ***Prior Authorization.*** Contact PersonalCare's Customer Service Department for further information.

You are not covered for the following specialty care services:

1. Specialty care services that are redundant or duplicative.
2. Specialty services, treatments or supplies that are not Medically Necessary for the treatment of an injury or illness or are outside generally accepted health care practice.
3. Specialty services, treatments or supplies that are otherwise not a Covered Benefit under other sections of this Evidence of Coverage (Certificate)
4. Physical examinations, immunizations, evaluations, or preparation of reports required by third parties and/or not required for health reasons. Examples may include, but are not limited to, services to secure insurance, meet employment requirements, obtain licenses, for foreign travel, to allow participation in recreational activities, or to comply with a court order.
5. Services or charges for which workers compensation is the primary payor.

Speech Therapy
Covered Service when delivered by, or under the direct supervision of, a licensed speech therapist, and each of the following conditions has been met:

1. The speech therapy must be required and Medically Necessary due to a documented medical condition (i.e., to restore speech loss or speech impairment due to trauma, stroke, a surgical procedure, child's hearing condition or other acute condition);
2. You must have a loss of speech function as a result of the medical condition;
3. The speech therapy must be significantly likely to substantially improve Your speech function with in a period of two (2) months; and
4. The speech therapy must not be able to be effectively provided in a lesser setting or through an alternative program (including, but not limited to, a school speech therapy program).

Limited benefit. ***Prior Authorization*** required. Please refer to Your Description of Coverage for benefit maximums.

You are not covered for:

1. Rehabilitative services provided for long-term, chronic medical conditions.
2. Rehabilitative services whose primary goal is to maintain Your current level of function, as opposed to improving Your functional status.
3. Rehabilitative services whose primary goal is to return You to a specific occupation or job, such as work-hardening or work-conditioning programs.
4. Educational or vocational therapy, schools or services designed to retrain You for employment.
5. Rehabilitative services whose purpose is to treat or improve a develop-mental/learning disability or delay or congenital anomalies.
6. Rehabilitation services that are experimental or have not been shown to be clinically effective for the medical condition being treated.
7. Speech therapy that is effectively provided through an alternative program, such as a school speech therapy program.

Substance Abuse Services
See Section 6.3.

Surgical Services
Covered Service for covered surgeries performed at a Participating hospital, outpatient or surgical center.

Prior Authorization required. For oral surgery services, see Dental & Oral Surgical Services.

Termination of Pregnancy
Not ***Covered*** unless the life or physical health of the mother or fetus would be endangered if the fetus were carried to term or if fetal abnormalities are detected.

Prior Authorization required.

Transplants
See Section 6.5.

Urgent Care
See Section 6.2.

6.1 Emergency Benefits
In the event You experience an Emergency Medical Condition, You should contact Your PCP for advice if time permits. If You are unable to contact Your PCP, seek help immediately at the nearest Participating Hospital, Participating Physician's office or other Participating emergency facility. If You are unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital emergency room would result in an increased risk to your life or health, or if you are outside of PersonalCare's Service Area, You should obtain medical attention from the nearest Hospital emergency room or

through 911 emergency services (where available). Emergency medical screening examinations, evaluation, treatment and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and do not require Prior Authorization. Once Your Emergency Medical Condition has been stabilized and the Emergency no longer exists, You must obtain all further care from Participating Providers and Hospitals to receive continued coverage for the condition.

You or someone on Your behalf should contact Us within 48 hours of the onset of an Emergency Medical Condition or as soon as is reasonably possible under the circumstances. The determination of Covered Services for services rendered in an emergency facility is based on Our review of Your presenting symptoms as documented in the medical records at the time care was sought. Services rendered by Non-Participating Providers or in Non-Participating facilities are not a Covered Service if Your condition was not an Emergency Medical Condition or You remain in a Non-Participating facility after We have made the appropriate arrangements for transfer to a Participating facility.

6.1.1 What is an Emergency Medical Condition?
An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Some examples of an Emergency Medical Condition include but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing;
- Vaginal bleeding during pregnancy.

6.2 Urgent Care Benefits

Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. Your PCP can help You determine whether You need to receive care at an Urgent Care facility. Urgent Care services must be obtained through Participating Urgent Care facilities as designated in Your Provider Directory in order to be covered. Some examples of Urgent Care cases include but are not limited to:

- High fever;
- Non-severe bleeding;
- Sprains.

The above examples may be expanded by PersonalCare when You are out of the Service Area, and You obtain Prior Authorization from PersonalCare for those services.

6.3 Mental Health, Alcoholism and Substance Abuse Benefits

PersonalCare contracts with an outside vendor to coordinate, determine the Medical Necessity of and preauthorize the diagnosis and treatment of all mental illnesses, psychiatric conditions, and alcoholism and substance abuse issues ("Mental Health and Substance Abuse").

Prior Authorization for Mental Health and Substance Abuse must be obtained through the contracted vendor. The vendor and its telephone number are listed on Your ID card and in PersonalCare's Provider Directory.
If You have any questions about Your Mental Health and Substance Abuse coverage or the appropriate way to access coverage, please either contact the mental health vendor or PersonalCare at (800) 431-1211. The following Mental Health and Substance Abuse services are covered:

6.3.1 Medically Necessary individual outpatient mental health or rehabilitation care visits to Participating Providers as may be necessary and appropriate for evaluation, short-term treatment and crisis intervention services. Group outpatient care visits may be substituted on a two-to-one basis for individual outpatient visits as deemed appropriate by your PCP and as authorized in advance by PersonalCare. You should consult Your Description of Coverage to determine the amount of Your payment responsibility per visit and any applicable annual benefit maximums.

6.3.2 Medically Necessary inpatient mental health or rehabilitation care at a Participating Provider. Care in a day hospital, residential non-hospital or intensive outpatient treatment may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by your PCP. Inpatient services are subject to Prior Authorization by PersonalCare except in the event of an Emergency. You should consult Your Description of Coverage to determine the amount of Your payment responsibility per hospitalization and any applicable annual benefit maximums.

6.3.3 Diagnosis, detoxification and treatment of

the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. Coverage for these inpatient hospital services are the same as coverage for non-mental health inpatient services for any other illness, condition, or disorder.

6.4 Transplant Services
Services related to Medically Necessary organ transplants are covered when Prior Authorized by Us, performed at a Coventry Transplant Network participating facility approved by Us, and are not Experimental or Investigational.

Donor screening tests are covered and are subject to a lifetime benefit maximum of $10,000 when performed at a Coventry Transplant Network participating facility approved by Us.

If not covered by any other source, the cost of any care, including complications, arising from an organ donation by a non-covered individual when the recipient is a covered Member will be covered for the duration of the contract of the covered individual when approved by Us. The cost of any care, including complications, arising from an organ donation by a covered individual when the recipient is not a covered individual is Excluded.

6.4.1 Travel for Transplant Services
Travel expenses for Members and living donors are covered according to Our trans plant travel benefit. Members are covered when PersonalCare is the primary insurer and a Coventry Transplant Network participating facility approved by Us is used.

VII. Exclusions and Limitations

7.1 The Health Plan does not cover the following items:

1. Any service or supply that is not provided or arranged by Your PCP and coordinated through Participating Providers in accordance with our utilization management policies and procedures, except that Emergency Services shall be covered in accordance with the terms and conditions set forth in this Agreement;
2. Any service or supply that is not Medically Necessary;
3. Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-covered service;
4. Any service or supply for which You have no financial liability or that was provided at no charge;
5. Non-emergency services provided outside the Service Area, including elective care, routine prenatal care or delivery when You are outside the Service Area against medical advice (except due to circumstances beyond Your control), follow-up care of an illness or injury, or care required as a result of circumstances that could have been reasonably foreseen by You before leaving the Service Area;
6. Procedures and treatments that We determine in our sole and absolute discretion to be Experimental or Investigational;
7. Services or supplies rendered as a result of injuries sustained during the commission of an illegal act; and
8. Court-ordered services or services that are a condition of probation or parole.

7.2 Specifically excluded services include, but are not limited to, the following (this is not an exhaustive list):

1. Alternative or complimentary medicine, including, but not limited to, holistic, homeopathic or naturopathic care, aroma therapy, massage therapy, acupressure and the like
2. Ambulance service except as outlined in the Schedule of Covered Services
3. Any services to the extent that payment for such services is, by law, covered by any governmental agency as a Primary Plan
4. Behavior modification
5. Biofeedback, unless in conjunction with electrostimulation as part of the treatment for fecal/urinary incontinence
6. Braces and supports needed for athletic participation or employment
7. Care rendered to You by a relative
8. Charges resulting from Your failure to appropriately cancel a scheduled appointment
9. Cosmetic services and surgery and the complications incurred as a result of those services and surgeries
10. Custodial and domiciliary care, residential care, protective and supportive care, including, but not limited to, educational services, rest cures, and convalescent care
11. Dental care, appliances, dentures, implants, or x-rays, including any Physician Services or x-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums
12. Diagnostic tests not done to evaluate current health problems or symptoms, unless otherwise specified as a preventive service under Section 6.
13. Equipment or services for use in altering air quality or temperature
14. Educational testing or psychological testing,

unless part of a treatment program for Covered Services
15. Exams for employment, camp, licensing, insurance, adoption, marriage or those ordered by a third party
16. Exercise or fitness equipment or other equipment used to promote health or exercise
17. Eye exercises and therapy
18. Food or food supplements
19. Hair analysis, hair transplants and wigs (except for hair loss as a direct result of chemotherapy or radiation therapy with a $250 lifetime limit)
20. Health education classes, such as risk-factor modification, smoking cessation, and childbirth education classes
21. Hearing aids, ear molds, and other equipment intended to improve hearing
22. Home services to help meet personal/family/domestic needs
23. Hypnotherapy
24. Immunizations for travel or employment or unexpected mass immunizations directed or ordered by public health officials for general population groups
25. Infertility services and supplies, including, but not limited to, costs associated with cryo preservation and storage of sperm, eggs, and embryos, and non-medical costs of an egg or sperm donor
26. Injectable medications for athletic performance enhancement
27. Marriage or relationship counseling; family counseling; vocational or employment counseling; and sex therapy
28. Maternity services (routine prenatal care or delivery) when You are outside the Service Area against medical advice (except due to circumstances beyond Your control)
29. Mental health care in lieu of detention or correctional placement or that is required to be treated in a public facility
30. Newborn home delivery or doulas
31. Non-FDA approved drugs, vitamins, minerals or supplements
32. Non-healthcare related items, such as shipping charges, copying and postage
33. Over-the-counter supplies, such as ACE wraps/elastic supports/finger splints, and orthotics
34. Oral surgery required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, involving removal of symptomatic bony impacted third molars
35. Orthodontia and related services
36. Personal comfort and convenience items, such as television and telephone
37. Private duty nursing
38. Private inpatient room, unless Medically Necessary
39. Prohibited services
40. Psychiatric evaluation or therapy when related to judicial or administrative proceedings or orders, when employer requested, or when required for school
41. Radial keratotomy, laser eye surgery and similar surgeries for the correction of a refractive disorder
42. Replacement items, including, but not limited to, batteries, tires and light bulbs
43. Repair or replacement of DME due to misuse, loss or neglect or for upgrade
44. Services not ordered or prescribed by a physician
45. Sex transformation procedures, treatments, or studies
46. Spinal manipulations for all non-musculoskeletal diseases and injuries or musculoskeletal disorders that are not improved with short-term chiropractic care
47. Sterilization reversal
48. Surgery performed solely to address psychological or emotional factors
49. Surrogate motherhood medical services rendered for purposes of child birth, including, but not limited to, prenatal care and delivery of the baby
50. TMJ (temporomandibular joint syndrome) treatment, except in limited circumstances. See Section 6 Covered Services for further information.
51. Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-covered individual
52. Travel, other than Medically Necessary transportation authorized by Us
53. Treatment of mental retardation, unless otherwise covered as a mental illness
54. Treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions, such as autism
55. Vision care and optometric services
56. Vocational therapy
57. War-related sickness, injury, services or care for military services-connected disabilities and conditions for which You are legally entitled to Veteran's Administration services and for which facilities are reasonably accessible to You, including services resulting from war or acts of war
58. Work-hardening or work-conditioning programs
59. Work-related injuries or illnesses when covered

by Workers Compensation laws

60. Weight reduction therapy, supplies and services, including, but not limited to, diet programs, diet pills, tests, examinations or services and medical or surgical treatments, such as intestinal or gastric bypass surgery, stomach stapling, balloon dilation, wiring of the jaw and other procedures of a similar nature, except where We determine them to be Medically Necessary

VIII. Coordination with other Coverage

8.1 Coordination With Other Plans

This coordination of benefits ("COB") provision applies when a Member has health care coverage under more than one Plan. "Plan" is defined below. The order of benefit determination rules below determine which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

8.2 Definitions

8.2.1 "Allowable Expense" means any necessary, reasonable and customary item of expense for heath care, at least a portion of which is covered by one or more Plans covering the person 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 either in terms of generally accepted medical practice or as specifically defined in the Plan. 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.

8.2.2 "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this coordination of benefits section or a similar provision takes effect.

8.2.3 "Plan", for purposes of this coordination of benefits section only, means any of the following which provides benefits or services for care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental Plan or coverage that is 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 (42 USCA 301, et seq.) as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. In the event Medicaid or any other social program directs services, PersonalCare will cover the resulting charges only if you have followed the requirements as set forth in this Evidence of Coverage (Certificate).
- Each contract or other arrangement for coverage under (i) or (ii) above is a separate Plan. Also, if an arrangement has two parts and coordination of bene fits rules apply only to one of the two, each of the parts is a separate Plan.
- Plan also includes the medical benefits coverage, including any funds available under uninsured motorist or underinsured motorist provisions, in group auto mobile contracts, in group or individual automobile "no-fault" contracts, in traditional automobile "fault" type contracts, individual or otherwise, to the extent benefits provided under such contracts must be determined without taking the existence of any other Plan into consideration.

8.2.4 "Primary Plan/Secondary Plan" is defined by the order of benefit determination rules, which state whether This Plan is a Primary Plan or Secondary Plan (another Plan covering the Member). When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of benefits received from the Primary Plan. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

8.2.5 "This Plan" means the group health Plan

offered by PersonalCare that provides benefits for health care expenses as described in this Evidence of Coverage (Certificate).

8.3 Effect on Benefits

If the order of benefit determination rules as set for below are applied and it is determined that This Plan determines its benefits before another Plan, the benefits of This Plan shall not be reduced and shall be paid without regard to the other Plan.

If the order of benefit determination rules are applied and it is determined that another Plan determines its benefits first, the benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this coordination of benefits section; and
- The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this coordination of benefits section, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan. * Note: Reimbursement will not exceed one hundred percent of the total Allowable Expenses incurred under This Plan and any other Plan.

8.4. Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules which applies:

8.4.1 Plan with No Coordination of Benefits Provisions. A Plan which contains no provisions for coordination of benefits is considered to pay its benefits before a Plan that contains such a provision.

8.4.2 Non-Dependent/Dependent. The benefits of a Plan which covers the person as an employee, Member or Subscriber (that is, other than as a Dependent) shall be primary over a Plan which covers the person as a Dependent, except that if the person is also a Medicare beneficiary, Medicare is:

i. Secondary to the Plan covering the person as a Dependent; and

ii. Primary to the Plan covering the person as other than a Dependent (for example, a retired employee)

8.4.3 Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 8.4.4 below, when This Plan and another Plan cover the same child as a Dependent of different persons called "parents":

i. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

ii. If both parents have the same birthday, the benefits of the Plan, which covered one parent longer, are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in subsection (i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

8.4.4 Dependent Child/Separated or Divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

i. First, the Plan of the parent with custody of the child;

ii. Then, the Plan of the spouse of the parent with custody of the child; and

iii. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply to any Claim Determination Period or contract year during which any benefits are actually paid or provided before the entity has actual knowledge.

8.4.5 Dependent Child/Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in subparagraph 8.4.3 above.

8.4.6 Active/Inactive Employee. The benefits of a Plan which covers a person as an employee

who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

8.4.7 Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

i. The Plan covering the person as an employee, Member or Subscriber (or as that person's dependent) will be primary;

ii. The benefits under the continuation coverage will be secondary.

8.4.8 Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Member or Subscriber longer are determined before the benefits of the Plan which covered that person for the shorter term.

8.5 Right to Necessary Information

PersonalCare may need certain facts in order to apply the above coordination of benefits rules. PersonalCare has the right to decide which facts it needs. You or any other person claiming benefits under This Plan agree to notify PersonalCare of the existence of any other group coverage and to provide any information PersonalCare may need to coordinate the insurance benefits and pay the claim. PersonalCare may get needed facts from or give them to any other organization or person, with or without the consent of any person.

8.6 Right to Recover

If the amount of the payments made by PersonalCare is more than it should have paid under this coordination of benefits provision, it has the right to recover the excess from any person or organization to whom, or for whom, the excess payment has been made. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

8.7 Facility of Payment

Sometimes a payment made under another Plan may include an amount, which should have been paid under This Plan. If this happens, PersonalCare may adjust the payment and specifically reserves the right to pay that amount to the organization which made that payment. Any amount paid to the organization will then be treated as a benefit paid under This Plan. PersonalCare will not be liable for payment of that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

8.8 Credit Bank Savings

If you are covered by two insurance Plans, and PersonalCare is the secondary payor, the difference between what was paid by PersonalCare as a secondary payor and what it would have paid if it was the primary payor creates a savings. Those savings, which accumulate on a calendar year basis, may be used to pay expenses for claims incurred by You during the same calendar year, which may not otherwise be paid by PersonalCare. For example, PersonalCare may make payments for services received by you that are received from Non-Participating Providers; or provided outside Your Service Area; or are Not Covered Services. However, the service must be a covered benefit under one of the Plans, and the savings and the expenses must arise out of the same Claims Determination Period.

8.9 Coordination of Benefits with Medicare

8.9.1 Active Employees and Spouses Age 65 and Older

If an employee is eligible for Medicare and works for a Group with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, then Medicare will be the primary payer. Medicare will pay its benefits first. This Health Plan will pay benefits on a secondary basis.

If an employee works for a Group with more than 20 employees for each working day in each of 20 or more calendar weeks in the current or preceding Health Plan Year, the Health Plan will be primary. However, an Employee may decline coverage under this Health Plan and elect Medicare as primary. In this instance, this Health Plan, by law, can not pay benefits secondary to Medicare for Medicare covered services.

You will continue to be covered by this Health Plan as primary unless You (a) notify Us, in writing, that You do not want benefits under this Health Plan or (b) otherwise cease to be eligible for benefits under this Health Plan.

8.9.2 Disability

If You are under age 65 and eligible for Medicare due to disability, and actively work for a Group with fewer than 100 employees, then Medicare is the primary payer. This Health Plan will pay benefits on a secondary basis.

If You are age 65 or older and actively work for a Group with at least 100 employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) this Health Plan will be primary for You and Your eligible Dependents and Medicare will pay benefits on a secondary basis.

8.9.3 End Stage Renal Disease (ESRD)

If You are entitled to Medicare due to End Stage Renal Disease (ESRD), this Health Plan will be primary for the first 30 months. If this Health Plan is currently paying benefits as secondary, this Health Plan will remain secondary upon Your entitlement to Medicare due to ESRD.

8.9.4 Coordination of Benefits for Retirees

If You are retired and You or one of Your Dependents is covered by Medicare Part A and/or Part B (or would have been covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:

- Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;
- Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been covered by Medicare; or
- Amounts paid under all other Plans in which You participate.

8.10 Right to Receive and Release Needed Information

By accepting Coverage under this Agreement, You agree to:

- Provide Us with Information about other coverage and promptly notify Us of any coverage changes;
- Give Us the right to obtain information as needed from others to coordinate benefits; and
- Return any excess amounts to Us if We make a payment and later find that the other Coverage should have been primary.

IX. Conversion

You may have the right to convert Your coverage from Group coverage to non-Group conversion coverage without furnishing evidence of insurability in the following circumstances:

- Upon loss of eligibility for coverage under the Group Contract;
- Upon cancellation of the Group Contract; or
- Upon non-renewal of the Group Contract.

The conversion coverage will cover You and eligible dependents who were covered by the Group coverage on the date of loss of eligibility, cancellation or non-renewal of coverage. The conversion coverage shall conform to the minimum standards as set forth by law and shall at a minimum provide coverage for basic health care services.

However, the conversion coverage may not contain all of the covered medical expenses or on the same level of benefits as provided in the Group coverage. We may require Co-payments, Coinsurance and Deductibles under conversion coverage that differ from the Group coverage. The conversion coverage will be subject to all rules and provisions of PersonalCare that are in effect at the time application for conversion is made.

In order to convert to non-Group conversion coverage, a completed written application for conversion must be submitted to PersonalCare and the application premium paid within thirty-one (31) days after the date coverage under this Agreement is terminated. The first premium must be received before conversion coverage will be put into force. Conversion coverage will then be effective on the date that Group coverage ends. You may contact Our Customer Service Department at (800) 431-1211 for further information regarding conversion coverage.

Conversion coverage will be terminated if any of the following circumstances occur:

- You fail to make the premium payments for Your conversion coverage on a timely basis.
- You become eligible for coverage under another health insurance plan or become entitled to Medicare.
- You move outside of the Service Area.

You do not have the automatic right to convert to non-Group conversion coverage absent termination of Your coverage as set forth in this Section.

You will not be entitled to conversion coverage if:

- Your coverage under the Group Contract is cancelled for failure to make timely premium payments; for fraud or material misrepresentation in enrollment or in use of services or facilities; or for material violation of the terms of the Agreement.
- You are covered by or are eligible for benefits under Medicare.
- You are covered by similar hospital, medical, or surgical benefits under state or federal law.
- You are covered by similar hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group whether on an insured or uninsured basis.

- You are covered for similar benefits through individual coverage.
- You have not been continuously covered during the three-month period immediately preceding cancellation of Your coverage.
- You have moved outside of the Service Area.
- Your coverage has been cancelled because the Health Plan has been placed in rehabilitation or liquidation proceedings pursuant to section 5-6 of the Illinois Health Maintenance Organization Act.
- The Group Contract has been discontinued in its entirety, and there is a succeeding carrier providing coverage to the Group in its entirety.

X. Resolving Complaints and Grievances

10.1 Complaints
A complaint is any expression of dissatisfaction expressed by a Member or a Member's authorized representative regarding an issue in the Health Plan or a Provider that does not involve a decision made by the Health Plan specific to a particular incident or adverse benefit determination. Complaints not related to clinical care or service are generally handled by Our Customer Service Department. All quality of care and service complaints are reviewed by PersonalCare's Medical Director in conjunction with Our Quality Improvement Department.

10.2 Appeals
An appeal is a request by a Member or a Member's authorized representative for reconsideration of an adverse benefit determination of a health service request or a benefit that the Member believes he or she is entitled to receive. There are two different types of appeals:

- **Healthcare Service Appeals.** A health care service appeal is an appeal to change a previous decision made by the Health Plan where the denial has been issued for medical necessity or medical appropriateness or which relates to a medical decision.
- **Administrative Appeals.** An administrative appeal involves non-healthcare related issues, such as coverage issues, which are administrative in nature.

There are also three different categories of appeals:

- **Pre-Service Appeals.** Pre-service appeals are those appeals for which a requested service requires Prior Authorization, an adverse benefit determination has been rendered, and the requested service has not been provided.
- **Post-Service Appeals.** Post-service appeals are those appeals for which an adverse benefit determination has been rendered for a service that has already been provided.
- **Urgent Care Appeals.** An urgent care appeal is an appeal that must be reviewed under an expedited appeal process because the application of non-urgent care appeal time frames could seriously jeopardize: (a) the life or health of the Member; or (b) the Member's ability to regain maximum function. In determining whether an appeal is an urgent care appeal, the Health Plan will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An urgent care appeal is also an appeal involving: (a) care that the treating physician deems urgent in nature; or (b) the treating physician determines that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

Pre-Service and Post-Service Appeals
If You are dissatisfied with an adverse benefit determination and wish to file a pre-service or post-service appeal with PersonalCare, You have the right to request such an appeal. In order to request a pre-service or post-service appeal from PersonalCare, You or Your authorized representative must submit a written request to Us and include the following:

- Your name;
- Provider name;
- Date(s) of service;
- Your mailing address and/or the mailing address of your authorized representative;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should reverse the adverse bene fit determination; and
- Copy of documentation to support the reversal of the decision.

You or Your authorized representative may also include written comments, documents, records and other information relevant to the appeal. PersonalCare will notify You or Your authorized representative within three (3) business days from receipt of the appeal of any additional information We will need to evaluate Your appeal.
Your appeal will be investigated and reviewed by PersonalCare. For both administrative and healthcare service appeals, your appeal will be reviewed by individuals who were not involved in any previous reviews and are not the subordinate of an individual who made any prior adverse benefit determination. For health care service appeals based in whole or in part upon a medical judgment, your appeal will be handled in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

PersonalCare will notify You or Your authorized representative in writing of Our decision on appeal within fifteen (15) business days after receipt of the required information. The notice will contain all information as required by applicable state and federal laws and regulations. In addition, You have the right to receive, upon request and free of charge, reasonable access to and/or copies of all documents, records and other information relevant to Your appeal.

Urgent Care Appeals
If You have an appeal which meets the definition of an urgent care appeal as set forth above, You or Your authorized representative may request an expedited appeal. Such an appeal can be requested in writing, or orally, by contacting Our Customer Service Department at (800) 431-1211 at any time. The request can also be made by a provider acting as Your authorized representative.

If the appeal constitutes an urgent care appeal, We will call You or Your authorized representative within twenty-four (24) hours from receipt of the appeal to provide notice of any additional information We will need to evaluate Your appeal. Your urgent care appeal will be investigated and reviewed by PersonalCare. Your appeal will be reviewed by individuals who were not involved in any previous reviews and are not the subordinate of an individual who made any prior adverse benefit determination. For health care service appeals based in whole or in part upon a medical judgment, your urgent care appeal will be handled in consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. PersonalCare will notify You or Your authorized representative of Our decision on appeal as expeditiously as possible but not later than twenty-four (24) hours after receipt of the required information. If the initial decision is not conveyed to You orally, We will provide written confirmation to you within three calendar days thereafter. The notice will contain all information as required by applicable state and federal laws and regulations.

10.3 External Independent Review
If Your healthcare service appeal is denied for reasons including, but not limited to: the service, procedure, or treatment is not viewed as Medically Necessary; denial of specific tests or procedures; denial of referral to specialist physicians; or denial of hospitalization requests or length of stay requests, You or Your authorized representative may request an external independent review. If You wish to initiate an external independent review in these circumstances, You must send to the Health Plan a written request for an external independent review within thirty (30) calendar days after You receive written notice of an adverse appeal determination. You should include with Your request any information or documentation to support Your request for the Covered Service or claim for a Covered Service.

Within thirty (30) calendar days after We receive Your request for an external independent review, We will provide You with a mechanism for the joint selection of an external independent reviewer by You, Your physician or other health care provider and the Health Plan, and We will forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues, including a statement of Our decision, the criteria used, and the medical and clinical reasons for that decision. For purposes of this section, an external independent reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the appeal; and (c) have not been informed of the specific identity of the Member. PersonalCare will be solely responsible for paying the fees of the external independent reviewer who is selected to perform the review.

Within five (5) calendar days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the healthcare service or claim for the healthcare service is medically appropriate. We will notify You of the reviewer's decision within twenty-four (24) hours of receipt of the decision by Us. The decision by the independent reviewer is final. If the external independent reviewer determines the healthcare service to be medically appropriate, We will pay for the healthcare service.

When a delay in requesting and seeking an external independent review through the above process would significantly increase the risk to Your health or when extended healthcare services for You undergoing a course of treatment prescribed by a healthcare provider are at issue, You or Your authorized representative may request an expedited external independent review. We will make a determination and provide notice of the determination no more than twenty-four (24) hours after the receipt of all necessary information under these circumstances. We will notify You orally and in writing of the reviewer's decision upon receipt of the decision by Us. The decision by the independent reviewer is final.

10.4 Illinois Department of Insurance
If at any time and for any reason You are not satisfied with PersonalCare or its decisions, You may contact the Department of Insurance at the following addresses:

Illinois Department of Insurance
Consumer Services Section
320 West Washington Street
Springfield, IL 62767

or

Illinois Department of Insurance
Consumer Services Section
100 West Randolph, Suite 15-100
Chicago, IL 60601-3251

XI. Members' Rights and Responsibilities

As a PersonalCare member, You receive excellent health care and other benefits. We believe You have certain "rights" we want You to use to get the health care You need. We also believe You have certain "responsibilities" to help Us protect Your well-being and want You to know what We expect from You.

11.1 Your Rights

You have the right to be treated as a partner when You decide what health care You receive. You work with Your doctor to figure out what is best for Your health and well-being. You control the following choices:

1. You can choose Your own Primary Care Physician from a list of health care experts who work with the Health Plan to take care of You and You can change Your Primary Care Physician any time.
2. Any female member may designate a Woman's Principal Health Care Provider (WPHCP) in addition to a Primary Care Physician. The WPHCP must be a Participating Physician specializing in Family Practice or Obstetrics and Gynecology.
3. You can get information from doctors and others to help You decide how to manage Your health care.
4. You can have PersonalCare arrange for a second opinion about advice from Your doctor by calling the Health Plan or by having your Primary Care Physician call the Health Plan.
5. You have the right to discuss the appropriateness or Medical Necessity of treatment options for Your conditions, regardless of cost or benefit coverage.

You have the right to receive information about what the Plan does for You. We also are happy to answer Your questions about what We send to You. You receive these items:

1. Your Evidence of Coverage and Description of Coverage, which tells in detail what benefits You receive and what You will pay for services You receive.
2. Your member identification card, which helps others recognize You as a Health Plan Member.
3. A Provider Directory that tells what doctors, hospitals, pharmacies and other places work with the Health Plan to take care of You.
4. Your member handbook, which helps You know how to get the care You need from the Health Plan.
5. A description of Your rights and responsibilities, which are distributed each year through Our member publication, PersonalBest.

You have the right to be treated with dignity and respect. We honor Your rights in these ways:

1. We respect Your privacy. In the course of providing the health benefits We offer, We must access nonpublic personal information. We consider this information private and confidential, and, therefore, We have policies and procedures to protect the information against unlawful use or disclosure.
2. We strive to treat You as We would like to be treated.
3. We value Your personal dignity and preferences.

You have the right to voice Your concerns or problems with PersonalCare or with the care You receive in three ways. You may take each step below if You have a problem:

1. Call our Customer Service Department to tell someone about Your problem. Our phone number is 1-800-431-1211.
2. Send a letter about Your concern to Our Customer Service Department. Our local address is 2110 Fox Drive, Champaign, Illinois 61820.
3. Write to the Illinois Department of Insurance, Attention Consumer Services Section. Their address is 320 W. Washington, Springfield, Illinois 62767.

You have the right to make recommendations regarding PersonalCare's members' rights and responsibilities statement. This statement was reviewed by PersonalCare's Consumer Advisory Committee, which is comprised of PersonalCare Members. You may send a letter to our Quality Improvement Department at 2110 Fox Drive, Champaign, Illinois 61820 to provide feedback or recommendations about this document.

11.2 Your Responsibilities

You have the responsibility to help PersonalCare and Your doctor provide for Your health care services. We expect You to do these things:

1. Be polite and respect the people taking care of You.
2. Allow no one else to use Your Identification Card.
3. Provide true and complete details about Your past and present state of health.
4. Give no false details that may mislead the people taking care of You and limit their ability to give You proper medical care.
5. Understand Your health problems and

participate with Your doctor in developing treatment goals.
6. Follow the treatment plan You and Your doctor agree will help keep You well. If You believe You cannot accept a treatment, tell Your doctor and work with Your doctor to select other treatment plans.
7. Pay premiums for Yourself and family members covered by the Plan by the due date.
8. Pay the Co-payments/Coinsurance amounts required by your Description of Coverage and as required by Your provider.
9. Provide PersonalCare with requested information, including medical records, physician statements regarding care and treatment, and any information regarding Your physical condition.

XII. Right to Recovery (Third Party Liability)

If You are injured, become ill or die as a result of the acts or omissions of a third party (other than an injury, illness or fatality covered under the Workers' Compensation Act), You are entitled to receive benefits for services and supplies as otherwise set forth in this Evidence of Coverage (Certificate). However, if You have a legal right to receive payment from an individual or organization because another party was responsible for Your illness, injury or other loss, We have a right of subrogation in any funds recovered as a result of this right. In other words, if You accept coverage for Covered Services under this Agreement, You must agree to reimburse Us in full from any settlement, judgment or other payment You or Your attorney may receive as a result of Your personal injury the reasonable cash value of the medical services and supplies furnished for such illness or injury. It does not matter how these payments are characterized, why they are paid, or whether they are labeled as being compensation for Your medical bills or lost wages. The benefits provided to You by PersonalCare for such injury or illness are subject to the following subrogation and reimbursement provisions:

12.1 Subrogation
If You suffer injury or illness and a third party is, or may be, liable for Your injury or illness, then PersonalCare is subrogated to any and all recoveries You receive from, or legal rights to recover which You may have against, such third party for the reasonable cash value of the medical services and supplies provided relating to Your injury or illness. PersonalCare is entitled to assert its right of subrogation independently of You.

By enrolling with PersonalCare and accepting the insurance benefits provided You in this Evidence of Coverage (Certificate), You agree and are obligated to:
- Notify PersonalCare in writing of any claim made or lawsuit filed by You against a third party relating to any illness or injury suffered by You.
- Cooperate with PersonalCare for the protection of its subrogation rights.
- Furnish PersonalCare with any and all relevant information and assistance as requested by it to preserve its subrogation rights.
- Complete, execute and deliver any and all forms PersonalCare may require to enforce its subrogation rights.
- Obtain the consent of PersonalCare before releasing any party from liability for the payment of medical expenses.
- Not take any action that would prejudice PersonalCare's subrogation rights, whether through settlement negotiations, litigation or otherwise.
- Notify Us (or have Your attorney notify Us) of any legal action or settlement agreement at least ten (10) days prior to settlement or trial.

Generally the costs of Our legal representation in matters related to subrogation shall be borne solely by Us. The costs of Your legal representation shall be borne solely by You. However, in the event You fail or refuse to fulfill the above obligations, and PersonalCare is required to take legal action to enforce its subrogation rights, You will be responsible for the payment of any and all costs incurred by PersonalCare in bringing such action, including, but not limited to, reasonable attorneys' fees.

12.2 Right of Reimbursement
PersonalCare is also granted a right of reimbursement from the proceeds of any settlement, damage award, judgment or other type of monetary payment You receive from a third party for the reasonable cash value of the medical services and supplies provided relating to Your injury or illness. The right of reimbursement is cumulative with and not exclusive of PersonalCare's subrogation rights but only to the extent of the benefits provided under this Certificate of Insurance.

By enrolling with PersonalCare and accepting the insurance benefits provided You in this Evidence of Coverage (Certificate), You agree and are obligated to:
- Notify PersonalCare in writing of any claim made or lawsuit filed by You against a third party relating to any illness or injury suffered by You.
- Cooperate with PersonalCare for the protection of its right of reimbursement.
- Furnish PersonalCare with any and all relevant information and assistance as requested by it to preserve its right of reimbursement.
- Grant to PersonalCare and consent to a first priority lien against the proceeds of any settlement, damage award, judgment or other

type of monetary payment You receive from a third party.

- Assign to PersonalCare any benefits You may have under any other policy of insurance, including automobile insurance, to the extent of its claim for reimbursement.
- Complete, execute and deliver any and all forms PersonalCare may require to enforce its right of reimbursement, protect its lien or effectuate an assignment of benefits.
- Obtain the consent of PersonalCare before releasing any party from liability for the payment of medical expenses.
- Not take any action that would prejudice PersonalCare's right of reimbursement.
- Not enter into any settlement agreement which specifically excludes or attempts to exclude the benefits paid by PersonalCare on Your behalf.
- Not enter into any settlement agreement which would have the effect of reducing or limiting PersonalCare's ability to seek reimbursement.
- Not incur any expense on behalf of PersonalCare in pursuit of its rights (In particular, You may not deduct court costs or attorneys fees from PersonalCare's recovery without its prior, written consent, and You shall not utilize the "fund doctrine" or "common fund doctrine" in an attempt to defeat PersonalCare's right of reimbursement).
- Promptly reimburse PersonalCare from the proceeds of any settlement, damage award, judgment or other type of monetary payment You receive from a third party the reasonable value of the medical benefits which PersonalCare paid on Your behalf.

In the event You fail or refuse to fulfill the above obligations and PersonalCare is required to take legal action to enforce its right of reimbursement, You will be responsible for the payment of any and all costs incurred by PersonalCare in bringing such action, including, but not limited to, reasonable attorneys' fees.

XIII. Definitions

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement:

13.1 "Agreement"
The Evidence of Coverage (Certificate) and any amendments or endorsements, the Enrollment Form, Applicable Riders, and the Group Contract together form the Agreement.

13.2 "Authorized/Authorization/Prior Authorization"
PersonalCare has given advance written approval for payment for certain services to be performed and an Authorization Number has been assigned. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review under criteria established by PersonalCare. If You need specialty services from a Non-Participating Provider, an Authorization means the Member's PCP or WPHCP has recommended a Non-Participating Provider for treatment of a specific condition, and PersonalCare has assigned an Authorization for a certain number of visits or days. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

13.3 "Basic Health Care Service"
Includes emergency care, physician services, outpatient diagnostic, imaging, pathology services, radiation therapy, inpatient services, maternity care, blood transfusion services, preventive health services, mental health services, care for alcoholism and drug abuse, and outpatient rehabilitative therapy. PersonalCare shall provide benefits for Basic Health Care Services in accordance with this Evidence of Coverage (Certificate), subject to applicable Co-payments, Prior Authorization requirements and other requirements as set forth on Your Description of Coverage.

13.4 "Calendar Year"
The twelve-month period commencing January 1 and ending December 31.

13.5 "Center of Excellence"
A facility that has a written contract with the Health Plan and is designated as a Center of Excellence for particular transplants or other treatment modalities.

13.6 "Coinsurance"
The percentage amount You must pay above the specified benefit payable as a condition of the receipt of certain services as provided in this Evidence of Coverage (Certificate).

13.7 "Contract Year"
The period during which the total amount of yearly benefits under Your coverage is calculated. The Contract Year is the period of twelve (12) consecutive months commencing on the Group Effective Date and each subsequent anniversary.

13.8 "Co-Payment"
A specified dollar amount You must pay as a condition of the receipt of certain services as provided in this Evidence of Coverage (Certificate). The schedule of Your applicable Co-Payments is contained on the Description of Coverage. Co-Payments shall not exceed fifty percent (50%) of the Maximum Allowable Charge for the service rendered.

13.9 "Cosmetic Services and Surgery"
Plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

13.10 "Coverage" or "Covered"
The entitlement by a Member to Covered Services under the Evidence of Coverage (Certificate), subject to the terms, conditions, limitations and exclusions of the Evidence of Coverage (Certificate), including the following conditions: (a) health services must be provided when the Evidence of Coverage (Certificate) is in effect; and (b) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Evidence of Coverage (Certificate) occur; and (c) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Evidence of Coverage (Certificate); and (d) health services must be Medically Necessary.

13.11 "Covered Services"
The services or supplies provided to You for which PersonalCare will make payment, as described in the Agreement.

13.12 "Deductible"
The specific dollar amount or percentage of the cost of health care Covered Services that You are responsible for paying before benefits subject to the Deductible are payable under this Agreement. No single deductible for Basic Health Care Services may exceed fifty percent (50%) of the Maximum Allowable Charge for the service rendered.

13.13 "Dependent"
Any member of a Subscriber's family who meets the eligibility requirements as outlined in this Evidence of Coverage (Certificate).

13.14 "Description of Coverage"
The document provided with this Evidence of Coverage (Certificate) which describes Your Co-Payment and Coinsurance requirements and benefit maximums under this Evidence of Coverage (Certificate) for a designated plan year.

13.15 "Effective Date"
The date of Coverage as determined by the Group and agreed to by Us, as set forth in the Group Contract.

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

13.17 "Emergency Out of Area"
Covered Services provided when a Member is temporarily absent from the Service Area, that are immediately required as a result of:

1. an unforeseen illness, injury, or condition; and
2. it is not reasonable given the circumstances to obtain services through the PersonalCare net work of Participating Providers.

13.18 "Emergency Services"
Transportation services, including, but not limited to, ambulance services, and Covered inpatient and outpatient hospital services furnished by a Provider qualified to furnish those services that are needed to evaluate or stabilize an Emergency Medical Condition. It does not mean post-stabilization medical services.

13.19 "Enrollment Form"
The application for enrollment in the Health Plan.

13.20 "Experimental or Investigational"
A health product or service is deemed experimental or investigational if one or more of the following conditions are met:

Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing;
Any health product or service that is subject to Investigational Review Board (IRB) review or approval;
Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations or is otherwise being studied to determine its safety, efficacy or its efficacy as compared with standard means of treatment or diagnosis; or
Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.

13.21 "Family Member"
Immediate relatives, to include: husband or wife, natural parent, child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, or grandchild. Members of the beneficiary's household are persons sharing a common

abode with the beneficiary as part of a single family unit, including those related by blood, marriage or adoption, or domestic employees and others who live together as a part of a single family unit. A roomer or boarder is not included.

13.22 "Formulary"
A listing of prescription drugs approved by PersonalCare for Coverage under this Agreement. These are dispensed through Participating pharmacies to Members. This list is subject to periodic review and change by PersonalCare. The Formulary is available for review in Participating Provider offices or by contacting Our Customer Service Department.

13.23 "Grace Period"
A period of ten (10) days from the premium due date within which the Group shall make premium payments to PersonalCare. Coverage under this Evidence of Coverage (Certificate) shall remain in effect if payment is made during the Grace Period. If payment is not made within the Grace Period, coverage under this Evidence of Coverage (Certificate) shall terminate as of the end of the period for which premium payments have been made.

13.24 "Group"
The organization or firm contracting with PersonalCare to arrange health care services for Subscribers and their Dependents through which eligible Subscribers and Dependents become entitled to the Covered Services described herein.

13.25 "Group Contract" or "Group Enrollment Agreement"
The agreement between the Group and Us that states the agreed upon contractual rights and obligations of PersonalCare, the Group, and Members, and that describes the costs, procedures, Covered Services, conditions, limitations, exclusions, and other obligations afforded to Members.

13.26 "Group Effective Date"
The date that is specified in the Group Contract as the effective date of this Agreement.

13.27 "Group Enrollment Period"
A period of time occurring at least once annually during which time any eligible employee may enroll with PersonalCare for coverage under this Evidence of Coverage (Certificate).

13.28 "Health Plan"
PersonalCare Insurance of Illinois, Inc., a Coventry Health Care Plan, organized and existing under the laws of the State of Illinois.

13.29 "Hospital"
An institution, operated pursuant to law, which: (a) is primarily engaged in providing Health Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVIII of the Social Security Act (the Medicare program). A facility that is primarily a place for rest, custodial care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

13.30 "Hospital Services"
Those Medically Necessary Covered Services for registered bed patients which are (i) generally and customarily provided by general acute-care Hospitals, and (ii) prescribed, directed or authorized by a Participating Provider (except as expressly limited or excluded by this Evidence of Coverage (Certificate).

13.31 "Infertility"
The inability to conceive after one (1) year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

13.32 "Late Enrollees"
Individuals who fail to enroll with PersonalCare for Coverage under the Agreement during the required thirty-one (31) day period when they first become eligible for Coverage. This term does not include Special Enrollees.

13.33 "Maximum Allowable Charge"
The fee as reasonably determined by PersonalCare that is based on the fee which the Provider who renders the service usually charges its patients for the same service and the fee is within the range of usual fees other providers of similar type, training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

13.34 "Medical Director"
The Physician specified by Us as the Medical Director or other Health Plan staff designated to act for, under the general guidance of, and in consultation with the Medical Director.

13.35 "Medically Necessary"
Medically Necessary services and/or supplies provided to a Member are those
determined by the Health Plan to be:

a) Medically appropriate, which means that the expected health benefits (such as increased life expectancy, improved functional capacity,

prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin;
b) Necessary to meet the basic health needs of the member as a minimum requirement;
c) Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
d) Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the plan;
e) Consistent with the diagnosis of the condition;
f) Required for reasons other than the comfort or convenience of the covered person or his or her physician; and
g) Of demonstrated value based on clinical evidence reported by peer reviewed medical literature and by generally recognized academic medical experts; that is, it is not experimental (investigational).

13.36 "Medical Services"
Those Medically Necessary professional services of physicians and allied health professionals, including medical, surgical, diagnostic, therapeutic and preventive services, and which are performed, prescribed or directed by Participating Physicians (except as expressly limited or excluded by this Evidence of Coverage (Certificate).

13.37 "Member"
Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions.

13.38 "Member Effective Date"
The date entered on Our records as the date when Coverage for a Member under this Agreement begins in accordance with the terms of this Agreement, which Coverage shall begin at 12:01 a.m. on such date.

13.39 "Non-Participating Provider"
A Provider who has no written agreement with the Us to provide health services to Members.

13.40 "Out of Area Services"
Those Covered Services provided outside PersonalCare's Service Area. Coverage is limited to Emergency Services or services that are authorized by the Member's Primary Care Physician and approved in advance by PersonalCare's Medical Director or his/her designee.

13.41 "Participating Provider"
A Provider who has entered into a written agreement with Us to provide health services to Members. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory delivered to You in connection with the Agreement. It does not include Our tertiary care facilities. The participation status of Providers may change from time to time.

13.42 "Peer-Reviewed Medical Literature"
A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the uniform Requirements for Manuscripts submitted to biomedical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

13.43 "Physician"
Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is duly licensed and qualified under the law of the state where treatment is received.

13.44 "Primary Care Physician (PCP)"
A Participating Physician who practices in the field of internal medicine, family practice or pediatrics [or for women, an OB-GYN] who is designated as a PCP by Us and who is responsible for providing, arranging, coordinating, or referring care to Members who have chosen and have been accepted as patients by that Physician. A Member shall select from among Participating Physicians a PCP, whose office must be located within a thirty (30) mile radius of the Member's residence or work or whose office the Member can reach within thirty (30) minutes of normal travel time.

13.45 "Provider"
A Physician, Hospital, Skilled Nursing Facility, Home Health Agency, Hospice, pharmacy, podiatrist, optometrist, chiropractor or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the state where care or treatment is received.

13.46 "Provider Directory"
A listing of Participating Providers. Please be aware the information in the Provider Directory is subject to change.

13.47 "Retiree"
A former employee of a Group who meets the Group's definition of retired employees to whom the Group offers Coverage under this Evidence of Coverage (Certificate).

13.48 "Schedule of Covered Services"
Description of Covered Services contained in the chart in Section 6 of this Evidence of Coverage (Certificate).

13.49 "Service Area"
The geographic area served by PersonalCare as approved by the State of Illinois Department of Insurance and shown on the Service Area description in this Evidence of Coverage (Certificate). PersonalCare's Service Area is subject to change.

13.50 "Special Enrollment Period"
The period set forth in Section 2.6 of this Evidence of Coverage (Certificate).

13.51 "Specialty Care Physician/Specialist"
A Physician who provides Medical Services to Members within the range of a medical specialty.

13.52 "Subscriber"
The eligible employee or Retiree who has elected PersonalCare Coverage for himself/herself and any eligible Dependents through submission of an Enrollment Application and for whom, or on whose behalf, premiums have been received by Us.

13.53 "Total Disability"
For a Subscriber, his/her inability to perform his/her regular or customary occupational duties because of injury or disease and, after benefits have been paid for twenty-four (24) months, the covered person cannot perform the duties of any gainful occupation for which h/she is reasonably fitted by training, education or experience. For Dependents or Retirees, the inability because of injury or disease to engage in substantially all of the normal activities of a person in good health of like age and sex.

13.54 "We/Us or Our"
The Health Plan.

13.55 "Woman's Principal Health Care Provider"
A Physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology or family practice. Female Members may select a Woman's Principal Health Care Provider in addition to a Primary Care Physician.

13.56 "You/Your"
A Member Covered under this Evidence of Coverage (Certificate).

XIV. General Provisions

14.1 Acceptance of Terms
By electing health care coverage pursuant to this Evidence of Coverage (Certificate) or by accepting services or benefits hereunder, You acknowledge You are capable of legally contracting or represent another who is incapable of legally contracting and that You accept and agree to all terms, conditions and provisions contained in this Evidence of Coverage (Certificate).

14.2 Applicability
The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all benefits and privileges made available to You shall be available to Your Dependents.

14.3 Arbitration
In the event of any dispute or controversy which is not resolved by PersonalCare's complaint and appeal process concerning the construction, interpretation, performance, or breach of this Evidence of Coverage (Certificate), arising between the Group, a Subscriber or eligible Dependent or the heir-at-law or personal representative of such person, and PersonalCare, whether involving a claim in tort, contract or otherwise, the same must be submitted to arbitration under the rules of the American Arbitration Association.

14.4 Choice of Law
This Agreement will be administered under the laws of the State of Illinois.

14.5 Clerical Error
Any clerical error by either PersonalCare or Your Group in quoting benefits or in processing or maintaining any record relating to Your coverage under this Evidence of Coverage (Certificate) will not invalidate coverage otherwise validly in force or continue coverage validly terminated.

14.6 Entire Agreement
This Evidence of Coverage (Certificate), including any applicable endorsements, amendments and riders; the Group's application and enrollment forms; and the Group Enrollment Agreement; constitute the entire Agreement between the parties. As of the Effective Date hereof, the Agreement supersedes all other agreements between the parties.

14.7 Exhaustion of Administrative Remedies
Neither You nor a Group may bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth in this Agreement have first been exhausted.

14.8 Guaranteed Renewability
PersonalCare will renew or continue this Evidence of Coverage (Certificate) in force at the option of Your Group. PersonalCare may not renew or discontinue coverage based on one or more of the following events:

- Non-payment of premiums. The Group has failed to pay premium payments or contributions in accordance with the terms of the health

insurance coverage or We have not received timely premium payments.

- Fraud. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
- Violation of participation or contribution rules. The Group has failed to comply with a material plan provision relating to employer contribution or group participation rules pursuant to the Group Enrollment Agreement and applicable state law.
- Termination of coverage. PersonalCare is ceasing to offer coverage in the market in accor dance with applicable state law.
- Movement outside of Service Area. There is no longer any Subscriber in connection with the Plan who lives, resides or works in the PersonalCare Service Area.

14.9 NonTransferable
The benefits and covered services provided under this Evidence of Coverage (Certificate) are personal to You. You may not assign or transfer Your right to receive benefits or Covered Services or Your right to payment for Covered Services. This Certificate of Insurance is not assignable or transferable by the Group without the express written consent of PersonalCare.

14.10 Notices

- Sent by PersonalCare to You. Any notices to be sent by PersonalCare under this Evidence of Coverage (Certificate) will be in writing and sent by United States mail, first class, postage prepaid, to either Your Group at the address listed in Our records or to the Subscriber's last known address as shown in Our enrollment records. (It is Your responsibility to notify PersonalCare of any change in Your address.) Such notice will be deemed given on either the date the notice is 1) received by the Group or 2) mailed to the Subscriber.
- Sent by You or Your Employer to PersonalCare. Notice sent by Your Employer or You to PersonalCare will be in writing and sent by United States mail, first class, postage prepaid and addressed as follows:

  PersonalCare Insurance
  2110 Fox Drive
  Champaign, IL 61820

  Your name and Member number must be included in any notice sent to PersonalCare. Such notice will be deemed given on the date it is actually received by PersonalCare.

14.11 Policies and Procedures
PersonalCare reserves the right to adopt any and all reasonable policies, procedures, rules and interpretations as may be necessary to promote the uniform, consistent and efficient administration of this Evidence of Coverage (Certificate). By electing health care coverage pursuant to this Evidence of Coverage (Certificate) and by accepting services or benefits hereunder, You agree to be bound by said policies and procedures.

14.12 Relationship Among Parties Affected by Agreement
The relationship between PersonalCare and its Participating Providers is that of independent contractors. Participating Providers are not agents or employees of PersonalCare, nor is PersonalCare or any employee of PersonalCare an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with You and are solely responsible to You for all Participating Provider services. PersonalCare has entered into agreements with Participating Providers for them to provide Medically Necessary covered services to Our Members and to cooperate with PersonalCare in its quality assurance and utilization review programs. These agreements may contain compensation arrangements, which may include incentives for providers to provide for efficient utilization of resources and health care services and/or improve the quality of services rendered to Members.

Neither the Group nor You is an agent or representative of PersonalCare, and neither shall be liable for any acts or omissions of PersonalCare for the performance of services under this Agreement.

14.13 Reservations and Alternatives
We reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

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

14.15 Valid Amendment
No change in this Agreement shall be valid unless approved by a duly authorized officer of PersonalCare and evidenced by endorsement on this Agreement and/or by amendment to this Agreement. Such amendment will be incorporated into this Evidence of Coverage (Certificate). No other agent of PersonalCare has the authority to amend or modify the Evidence of Coverage (Certificate), to waive any conditions, restrictions or limitations contained in this Evidence of Coverage (Certificate), to extend the time for making payments

hereunder or to bind PersonalCare through any promise or representation.

14.16 Waiver
The failure of PersonalCare, the Group, or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

14.17 Entire Agreement
This Agreement shall constitute the entire agreement between the parties. All statements, in the absence of fraud, pertaining to coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate coverage of a Member shall be used in any context to void the coverage, with respect to which such statement was made or to decrease Benefits hereunder after the coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

XV. Service Area Description

The Service Area for PersonalCare includes the following counties:

Champaign
Christian
Clark
Coles
Cook
Crawford
Cumberland
DeWitt
Douglas
Edgar
Effingham
Fayette
Ford
Iroquois
Jasper
Kankakee
LaSalle
Livingston
Logan
Macon
Macoupin
Marshall
McLean
Menard
Montgomery
Morgan
Moultrie
Piatt
Sangamon
Shelby
Vermilion
Will
Woodford