Section V. Claim Provisions

Most Providers will file claims directly with us. However, you are responsible for filing a claim with us if the Provider does not file it. The following provisions give you the information you need in order to properly file claims with us.

Notice of Loss/Claim

1. In order to properly file a claim, you must send us: a) a notice of the loss or notice of your claim; and at a later time b) a proof of loss. In the following paragraphs we describe these notices, what is required for each one, and the deadlines for submitting them.
2. We must receive your written notice of loss or claim within 20 days after the date of any covered loss. "Loss" as used in this context means the medical expenses you Incur resulting from a covered Illness or Injury. We do not require that the written notice be on a particular form; rather, you can simply send us a letter in which you inform us that you have Incurred medical expenses that you believe are Covered Expenses under this Certificate. If we have not received the written notice within 20 days of the date of loss, we will not deny or reduce a claim as long as you send us the notice as soon as is reasonably possible.
3. Within 15 days of our receipt of the notice of a claim, we will send you the forms you will need for filing a proof of loss. If we fail to provide the necessary forms within the stated time, you will be considered to have satisfied the proof of loss requirements if written proof of loss is submitted within the time requirements as stated in the Proof of Loss provision below.

Proof of Loss

1. Proof of loss as required in this Certificate means evidence of loss satisfactory to us. Our receipt, acknowledgment or investigation of a claim will not waive our rights to defend against any claim.
2. The proof of loss must include all of the following:
   a. Your name and Certificate number.
   b. The name of the Covered Person who Incurred the claim.
   c. The name and address of the Provider of the services.
   d. An itemized bill from the Provider of the services that includes all of the following (as applies):
      (1) International Classification of Diseases (ICD) diagnosis codes;
      (2) International Classification of Diseases (ICD) procedures;
      (3) Current Procedural Terminology (CPT) codes;
      (4) Healthcare Common Procedure Coding System (HCPCS) level II codes; and
      (5) National Drug Codes (NDC).
   e. A statement indicating whether the Covered Person has coverage for the services related to the Illness or Injury under any Other Insurance plan or program. If the Covered Person has other coverage, include the name and certificate or policy number of the other coverage.
3. We must receive written proof of loss no later than 90 days after the date of the loss ("Written Notice Period").
4. If we have not received written proof of loss within the Written Notice Period, we will not deny or reduce a claim as long as you send us the proof of loss as soon as is reasonably possible. Except in the case of documented legal incapacity, in no event will we accept proof of loss beyond one year after the end of the Written Notice Period.

5. After we receive written proof of loss, we may require additional information from you in order to evaluate your claim. You must furnish all such information pursuant to the Right to Collect Information provision below. We will not pay benefits if the required information, or an authorization for its release, is not furnished to us.

Right to Collect Information

To determine our liability, we may request additional information from a Covered Person, Provider, facility, or other individual or entity. A Covered Person must cooperate with us, and assist us by obtaining the following information within 30 days of our request. Charges will be denied if we are unable to determine our liability because a Covered Person, Provider, facility, or other individual or entity fails to do any of the following:

1. Authorize the release of all medical records to us and/or fails to authorize the release of other information we request;
2. Provide us with information we request about pending claims, Other Insurance coverage or proof of creditable coverage;
3. Provide us with information as required by any contract with us or a network including, but not limited to, repricing information;
4. Provide us with information that is accurate and complete;
5. Have any examination completed as requested by us; or
6. Reasonably cooperate with any requests made by us.

Such charges may be considered for Benefits upon receipt of the requested information, provided that we receive all necessary information before the expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.

Examination

We have the right to require that you be examined by a Physician of our choice, at our own expense, as often as we may require. In the event of your death, we have the right to require an autopsy, unless otherwise prohibited by law.

Payment of Claim

1. Benefits will be paid to you unless benefits have been assigned to the Provider. We are not responsible for verifying the validity of the assignment.
2. If we determine that you are not legally able to receive such payment, we may at our option pay the Benefits to:
    a. Providers; or
    b. Your estate; or
    c. Your closest living relative.
3. We reserve the right to allocate any Covered Expenses to any Deductible and to apportion the benefits to you and to any assignees. Such actions will be binding on you and the assignees.
4. Upon receipt of the required written proof of loss, we normally will pay claims within 30 days of our receipt of the written proof of loss.

Overpayment or Erroneous Payment

If a benefit is paid under this Certificate and it is later determined that a lesser amount or no amount should have been paid, we are entitled to recover the excess amount from you, the beneficiary or the Provider. We may offset the overpayment or erroneous payment against future benefit payments.

Utilization Review Process

You must call the toll-free number on your identification (ID) card to obtain our authorization for the services listed in the "When to Call" provision below. Benefits will be reduced as described in the "Reduction of Payment" provision below if a Covered Person does not comply with this Utilization Review Process and does not obtain authorization.

A review by the Utilization Review Manager does not guarantee that benefits will be paid. Payment of benefits will be subject to all other terms, limits and conditions in this Certificate.

1. **Utilization Review Procedures**.

   a. In order to obtain authorization for the services, the Covered Person must contact our Utilization Review Manager by calling the toll free number on the ID card. Please have all of the following information on hand before calling:

      (1) Your Certificate number for this Certificate;

      (2) The Provider's name and telephone number;

      (3) The service, procedure and diagnosis;

      (4) The proposed date of admission or date the service or procedure will be performed; and

      (5) The facility's name and phone number.

   b. The Utilization Review Manager may review a proposed service or procedure to determine any of the following:

      (1) Medical Necessity;

      (2) Whether it is a Cosmetic service or an Experimental or Investigational service;

      (3) Location of the Treatment; and

      (4) Length of stay for an Inpatient Confinement.

2. **When to Call.**

   a. **Contact the Utilization Review Manager for authorization of the following services:**

      (1) **Inpatient Confinements:** Call us to obtain authorization for an admission to an Inpatient facility, or transfer between Inpatient facilities, or any other Inpatient Confinement that will exceed 24 hours as follows:

         (a) ***Non-Emergency Confinements:*** Call at least 3 business days prior to an Inpatient admission for a nonemergency Confinement that will exceed 24 hours in length.

         (b) ***Emergency Care Confinements:*** Call within 24 hours, or as soon as reasonably possible, after admission for an Emergency Care Confinement that will exceed 24 hours in length. The Covered Person must provide or make available to the Utilization Review Manager the full details of the Emergency Care Confinement.

         (c) ***Extended Confinement for Complication of Pregnancy:*** In the event of a Complication of Pregnancy that results in an Inpatient Confinement exceeding 48 hours following a normal, vaginal delivery or 96 hours following a caesarean section delivery, the Covered Person must call prior to the end of the Confinement, or as soon as reasonably possible. Any other Inpatient Confinements because of Complications of Pregnancy that occur during a pregnancy must be authorized in accordance with the Non-Emergency Confinements and Emergency Confinements provisions above.

(d) ***Continued Stay Review:*** We may request additional clinical information during an Inpatient Confinement. Failure of the Physician or facility to provide the requested information will result in nonauthorization of benefits for continued Inpatient Confinement. No benefits will be considered until we receive the additional information. No benefits will be paid for the days of Inpatient Confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Utilization Review Manager based on review of the additional information provided.

(2) **Outpatient Procedures:** Call us to obtain authorization for the following procedures that are performed in an Outpatient setting. Call at least 3 business days before receiving any of the following nonemergency Outpatient services (if you have the particular benefit):

(a) Surgical procedures;

(b) Home Health Care;

(c) Home infusion;

(d) Hospice care;

(e) Physical medicine including physical therapy, occupational therapy or speech therapy.

(3) **Transplants:** Call at least 7 business days prior to any transplant evaluation, testing, preparative Treatment or donor search.

b. The review process must be repeated if Treatment is received more than 30 days after review by our Utilization Review Manager or if the type of Treatment, admitting Physician or facility differs from what the Utilization Review Manager authorized. A determination by the Utilization Review Manager does not alter, limit or restrict in any manner the attending Provider's ultimate patient care responsibility.

3. **Reduction of Payment**. If you do not obtain authorization from us for the course of Treatment for the services listed in the When to Call provision above, benefits will be reduced for otherwise Covered Expenses by 25% if any of the following occur:

a. The Covered Person does not contact the Utilization Review Manager within the required time frame;

b. The type of Treatment, admitting Physician or facility differs from what was authorized by the Utilization Review Manager; or

c. The Treatment is Incurred more than 30 days after review by the Utilization Review Manager.

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Access Fee, Coinsurance, Copayment, Deductible or Out-of-Pocket Limit.

Case Management Program

1. You may be referred to our Case Management Program if you have a complex Illness or Injury requiring ongoing medical care. Our Case Management Program is a voluntary program. If you participate in the Case Management Program, one of our trained registered nurses ("a Care Manager") will coordinate with you and your Provider in the development of a health care treatment plan that is intended to:

a. Respond to your health care needs; and

b. Be cost-effective and promote efficient use of Certificate benefits.

2. The proposed health care treatment plan must be approved by us to ensure that any care provided pursuant to the treatment plan is Medically Necessary, cost-effective and involves efficient use of Certificate benefits. The health care treatment plan is also subject to approval by you and your Physician.

3. The Case Management Program may be initiated by:

a. You;

b. Your family members;

c. Your Physician or Provider; or

d. Us.

4. It is your decision whether or not to participate in our Case Management Program. Our Case Management Program does not replace the care received from your Physician. You and your Physician remain in charge of your health care treatment plan.

5. Through Case Management we may agree on a limited basis to modify certain terms or conditions of this Certificate. Providing benefits under the Case Management Program in a particular case does not commit us to do so in another case, nor does it waive or modify the terms and conditions of this Certificate, render them unenforceable or prevent us from strictly applying the benefits, limitations and exclusions of this Certificate at any other time or for any other insured person, whether or not the circumstances are similar or the same.

Coordination of Benefits

1. Coordination of Benefits (COB) may limit benefits when you are insured under more than one plan (certificate or policy). The Benefits payable under this Certificate may be reduced, under the rules shown below, so that you will receive no more than 100% of Covered Expenses from all plans combined.

2. The plans with which this Certificate coordinates benefits are:

   a. Group insurance;

   b. Individual insurance;

   c. Other arrangements, whether insured or uninsured, covering individuals in a group;

   d. Blue Cross and Blue Shield plans on an individual or group basis;

   e. Plans of Hospital or medical service organizations on a group basis;

   f. Group practice plans;

   g. Group prepayment plans;

   h. Federal government plans or programs;

   i. Medicare Parts A and B;

   j. Coverage required or provided by law;

   k. Student insurance, except that COB will not apply to accident-only coverage for elementary, middle, or high school students;

   l. Group auto insurance, including group no-fault auto insurance; and

   m. Individual no-fault auto insurance, by whatever name called.

3. We will pay the regular benefits if we are determined to be the primary plan. If we are determined to be the secondary plan, we will pay the excess of Covered Expenses after the primary plan pays its regular benefits. In any event, we will not pay more than the regular benefits of our Certificate.

4. The following rules determine which plan is primary and which is secondary:

   a. Any plan that does not have a COB provision will be the primary plan and pay first.

   b. For a plan having a COB provision, the following rules apply:

      (1) The plan that covers the Covered Person as an employee, member or nondependent will pay its benefits first.

(2) The plan that covers the Covered Person as a dependent (spouse or children) will be considered the secondary plan and pay after any other plan.

(3) For covered dependent children:

(a) The benefits of the plan of the parent whose birthday (month and day only) falls earlier in a year will apply for the covered dependent children before those of the plan of the parent whose birthday falls later in that year.

(b) If both parents have the same birthday (month and day only), the benefits of the plan that covered the parent longer will apply for the covered dependent children before those of the plan which covered the other parent for a shorter period of time.

(c) If the other plan does not have the birthday rule described 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 based upon the gender of the parent will determine the order of benefits.

c. If the natural parents of the covered dependent child are divorced or otherwise separated, the following coordination of benefit rules apply:

(1) If the parent with custody of the child has not remarried, the plan which covers the child as a dependent of that parent will be considered before the plan that covers the child as the dependent of the parent without custody.

(2) If the parent with custody of the child has remarried, the plan which covers the child as a dependent of that parent will be considered before the plan that covers the child as a dependent of the current stepparent. The plan that covers the child as a dependent of the parent without custody will be considered last.

(3) If there is a court decree that establishes financial responsibility for the medical, dental or other health care expenses with respect to the child, (i) and (ii) above will not apply. The plan that covers the child as a dependent of the parent with such financial responsibility will be considered before any other plan that covers the child as a dependent.

d. When the rules above do not apply, the plan that has insured the person the longest will be primary, except that a plan insuring the individual as a retired or laid off employee will pay as secondary plan.

5. An allowable expense is a Medically Necessary expense under this Certificate and covered, at least in part, by one of the other plans. If a plan provides benefits in the form of services rather than cash payments, we will determine a reasonable cash value for each service that is provided and that cash value will be considered the allowable expense and the amount paid by the other plan.

6. Benefits will be coordinated on a Calendar Year basis or any portion of a Calendar Year in which the person was insured by us.

7. For purposes of this COB provision, any or all of the following may apply:

a. You are required to furnish us with complete information concerning all plans and benefits paid or payable from other plans.

b. As permitted by law, we may without your consent:

(1) Obtain information from all plans involved;

(2) Reimburse such other plans, if we determine that benefits have been paid by another plan that should have been paid by us. Such reimbursement will be a valid payment under the terms of this Certificate.

c. We may obtain reimbursement from any other plan, and/or from you, if we have paid benefits that should have been paid by any other plan. Such reimbursement is a valid payment under the other plan.

d. We may obtain a refund of any amount that exceeded 100% of Covered Expenses as a result of our payment as a secondary plan.

Cost Containment

We reserve the right to initiate, conduct and maintain, or to contract for, various programs and procedures directed at containing medical costs. Such programs and procedures include, but are not limited to:

1. Utilization Review;
2. Continued stay review;
3. Retrospective review;
4. Auditing of expenses including, but not limited to, the review of coding and payment. We will pay appropriate medical claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. We will not pay for any of the following:
   a. Charges that are billed separately as professional services when the procedure requires only a technical component;
   b. Charges that are billed incorrectly or billed separately but are an integral part of another billed service;
   c. Other claims that are improperly billed; or
   d. Duplicates of previously received or processed claims.
5. Our auditing process also includes adjustments when a Physician bills for a secondary or tertiary procedure. A secondary or tertiary procedure is a procedure that is separate and distinct from the primary procedure, but which is performed by the same Physician during the same operative session. A procedure is considered secondary or tertiary because the patient only requires anesthesia or analgesia one time, the procedure room is used only one time, and set up for the separate procedure is done at the same time. For secondary or tertiary procedures performed during the same operative session, the Covered Expenses for the Physician's bill will be:
   a. One hundred percent of the Usual and Customary Charge for the primary procedure;
   b. Fifty percent of the Usual and Customary Charge for the secondary procedure; and
   c. Twenty-five percent of the Usual and Customary Charge for each additional procedure.
6. Negotiated Payment Arrangements.

Workers' Compensation

This Certificate is not a workers' compensation policy. This Certificate does not satisfy any governmental requirements for coverage by workers' compensation insurance.

Time Limit on Certain Defenses

After 2 years from the Issue Date, no misstatements made by the applicant in the Application for this Certificate, except fraudulent misstatements, shall be used to void the Certificate or to deny a claim for loss Incurred or Total Disability commencing after the expiration of such 2 year period. No claim for loss Incurred or Total Disability commencing after 2 years from the Issue Date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Issue Date.

Appeal of (Claim) Decision

You have the right to request a review of all adverse claim decisions. A review must be requested within 365 days following your receipt of the notice that the claim was denied or reduced.

Legal Actions

All of the following limitations apply to your ability to file an action at law or equity relating to this Certificate:

1. You cannot file such an action at law or equity before the expiration of 60 days after proof of loss has been furnished to us in accordance with the requirements of this Certificate;
2. You cannot file such an action at law or equity unless you have fully complied with this Certificate's appeal procedures; and
3. You cannot bring an action at law or equity unless you bring it within three years from the expiration of the time by which proof of loss is required under the terms of this Certificate.

Right of Reimbursement

1. If a Covered Person Incurs expenses for an Illness or Injury that occurred due to the negligence of a third party:
    a. We have the right to reimbursement for all Benefits we paid if damages are collected from the third party for those same expenses. This right of reimbursement exists regardless of whether such damages are recovered by action at law, settlement, or compromise, by you, your parents if you are a minor, or your legal representative; and
    b. We are assigned the right to recover from the third party or his or her insurer, to the extent of the benefits we paid for the Illness or Injury.
2. We shall have the right to first reimbursement out of all funds you, the Covered Person's parents (if the Covered Person is a minor) or the Covered Person's legal representative, are or were able to obtain for the same expenses we paid as a result of that Illness or Injury.
3. You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.
4. You must provide us with timely written notification in the event that a Covered Person suffers an Illness or an Injury in which a third party might be responsible and the Covered Person seeks recourse against any person, entity or Other Insurance coverage by suit, settlement, judgment or otherwise. Such a notice must inform us of all of the following:
    a. The nature of the Illness or Injury;
    b. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Covered Person;
    c. A description of the accident or occurrence that the Covered Person reasonably believes was responsible for the Illness or Injury at issue and the approximate date(s) on which such accident or occurrence happened; and
    d. The name of any legal counsel retained by a Covered Person in connection with any such accident or occurrence.
5. If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with any such accident or occurrence, you or your attorney must provide us with copies of all pleadings, notices and other documents and papers that are related to our right to reimbursement under this Certificate. We reserve the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect our right to reimbursement under this Certificate.
6. Upon recovery of any portion of our reimbursement interest by way of settlement or judgment, we will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs Incurred by the Covered Person and/or the Covered Person's attorney in obtaining the settlement or judgment.

7. A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of Benefits paid under this Certificate.