WELBORN HEALTH PLANS

HEALTH SERVICES AGREEMENT

2010 Member Certificate

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WELBORN HEALTH PLANS

~ As of January 2010 ~

FORM #WHP/POS2010.CER

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Management and administrative services are provided to Welborn Health Plans by U.S. Healthcare Holdings, LLC, an insurance administrator licensed by the State of Indiana

EMPLOYER AND MEMBER HEALTH SERVICES AGREEMENT

This Employer and Member Health Services Agreement (herein "Agreement") is an Agreement betw[illegible] NHI[illegible] Indiana LLC, a limited liability company organized under the laws of the State of Indiana, doing business [illegible] Welborn H[illegible]lth Plans" (herein "WHP") and the Employer group (herein "Employer") named in Figure 1. This [illegible]ment is effective between the Agreement Start Date and the Agreement End Date specified in Figure 1. WHP [illegible]ers p[illegible]aid health care services programs to an Employer who wishes to make available a health care program to [illegible]ir employe[illegible]nd their eligible dependents through WHP. The Member Handbook, Member Application, Medica[illegible]Questionnaire ([illegible]pplicable), Underwriting Summary Sheet (on-file with WHP and the Employer only), Benefit Summary, [illegible]d any applicat[illegible] Riders are made part of this Agreement by reference.

The Employer and WHP both have copies of this Agreement. This Agreem[illegible]t explains the rights and duties of Memb[illegible]. WHP is licensed under the laws of the State of Indiana. Benefits are pr[illegible]ded through Participating Providers. Questions about what is Covered, what is available, and limits on ser[illegible]es can be answered by contacting WHP's Customer Services Department.

WHP and Employer agree as follows:

SECTION 1. DEFINITIONS

The words and phrases defined in this Section a[illegible]ted throughout this Agreement an[illegible]l E[illegible]bits, Riders and the Member Handbook. The remaining words us[illegible] this [illegible]eement have the normal mean[illegible]s of daily language.

1.1 **Agreement**. The documents that govern h[illegible]y WHP admin[illegible] the Employer's health care benefits including, but not limited to:
   a. Figure 1 – Administration/Eligibility Gu[illegible]lines.
   b. Exhibit 2 – Rates (available to Employer o[illegible]y).
   c. Exhibit 3 – Employer Terms and Condition[illegible]vailable to Employer only).
   d. Exhibit 4 – H[illegible]AA Cer[illegible]ation (available to Employer only).

1.2 **Agreemen[illegible]tart Date**. The [illegible]te on which coverag[illegible]gins under this Agreement, as stated in Figure 1 – Admini[illegible]on/ Eligibility G[illegible]delines.

1.3 **Anniversary D[illegible]**. The[illegible]te when the Agree[illegible]nt may be renewed. The date begins midnight of the day of the Agreement End Da[illegible]shown in Figure 1 of this Agreement.

1.4 **Appe[illegible]**. A request rece[illegible]d from the Member, an authorized person, or a provider acting on behalf of the Member to review a[illegible]enial of servic[illegible]

1.5 **Appeals Comm[illegible]tee**. Seco[illegible]level complaints will be reviewed and decided upon by a designated physician outside of WHP.

1.6 **Appropriate Ca[illegible] (Appropriateness)**. Health care services and items that are clinically justified. This term is sometimes used [illegible]terchangeably with Medically Necessary. It is sometimes used to refer to whether the use of a [illegible]ticular sit[illegible] care (e.g., Hospital), site of treatment, length of treatment, or plan of treatment is justified.

1.7 **Appr[illegible] Referral**. A communication (oral, written, or electronic) sent by a PCP or other Participating Provider that [illegible]cifies the health services to be rendered by another Provider identified in such communication and approved by the WHP Health Services Department (HSD) or WHP Medical Director. This approval is not a

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guarantee that WHP will Cover the requested health service or item because of other provisions in this Agreement. Exhibits, Eligibility, Exclusions, Limitations, Coordination of Benefits, the Benefit Summary and any applicable Riders also control whether a requested health service or item will be Covered by WHP.

1.8 **Association**. An entity, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

1.9 **Autism**. A condition affecting a Member ages two (2) through twenty-one (21) years of age with a lack of social or emotional reciprocity. This includes a total of six (6) or more items from the following subparagraphs of this definition, with at least two (2) from the first subparagraph and one (1) each from the second and third subparagraphs.

1. Qualitative impairment in social interaction, as manifested by at least two of the following:
   a. Marked impairment in the use of multiple, nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
   b. Failure to develop peer relationships appropriate to developmental level;
   c. A lack of spontaneous seeking to share enjoyment, interests, or achievement with other people
2. Qualitative impairments in communication as manifested by at least one of the following:
   a. Delay in, or total lack of, the development of spoke language;
   b. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;
   c. Stereotyped and repetitive use of language or idiosyncratic language, or
   d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.
3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
   a. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
   b. Apparently inflexible adherence to specific nonfunctional routines or rituals;
   c. Stereotyped and repetitive motor mannerisms; or
   d. Persistent preoccupation with parts of objects.
4. Delays or abnormal functioning in at least one of the following areas, with onset prior to three years of age:
   a. Social interaction;
   b. Language as used in social communication;
   c. Symbolic or imaginative play;
   d. The disturbance is not better accounted for by Rett's Disorders or Childhood Disintegrative Disorder.

1.10 **Benign Skin Lesions**. Any non-malignant skin lesions.

1.11 **COBRA**. The Consolidated Omnibus Budget Reconciliation Act of 1985, as enacted by Public Law 99-272, and may be amended from time to time.

1.12 **Coinsurance**. The percent of Eligible Charges that the Member must pay to a Provider. Required Coinsurance amounts are shown in your Benefit Summary.

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1.13 **Complaints**. The formal expression of a grievance concerning, but not limited to, Coverage, Providers or benefits.

1.14 **Copayment or Copay**. A fixed dollar amount that must be paid by a Member to a Provide[illegible]or Covere[illegible]ervices. Required Copayment amounts are shown in your Benefit Summary.

1.15 **Cosmetic.** Services performed to improve appearance or to correct a disease, def[illegible]or conditi[illegible]hat does not cause a significant problem in body function.

1.16 **Cover, Covered, Coverage or Covered Services.** The services arrange[illegible] paid for [illegible] WHP and for [illegible]ich benefits apply.

1.17 **Creditable Coverage.** Creditable Coverage means, with respec[illegible] an individual, coverage of the individu[illegible] under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consis[illegible] solely of benefits under section n1928;
5. Chapter 55 of Title 10, United S[illegible]s Code;
6. A medical care program of th[illegible]lth Service or of a tribal organ[illegible]on;
7. A state health benefits risk[illegible]ol;
8. A health plan offered un[illegible] Chap[illegible]89 of Title 5, [illegible]ed States Code;
9. A public health plan, as defined in [illegible]ulations; o[illegible]
10. A health benefit plan under section 5[illegible]) of the [illegible]ace Corps A[illegible](22 U.S.C sec. 2504(e));
11. Title XXI of the Social Security Act, s[illegible]h [illegible]ne State Chi[illegible]en's Health Insurance Program.

1.18 **Custodial, Custo[illegible] Care, [illegible]esidential Care, o[illegible] Long-Term Care.** Care in an inpatient or outpatient setting to protect or mai[illegible]n a stable le[illegible]l of functioning in [illegible]patie[illegible] whose general condition and physical findings remain substantiall[illegible]onstant, and for [illegible]hich, in the opinion [illegible]f [illegible] Medical Director, no improvement is expected. Such care is C[illegible]dial even if the l[illegible]el of maintenance ca[illegible]requires services of some skilled health professionals.

1.19 **Deductible (ap[illegible]ies to t[illegible]Welborn Heal[illegible]tions and Welborn Health Options ~ SELECT products only).** The amoun[illegible]f [illegible]gible Charges for Covered services that Members must first pay directly to Providers before WHP provide[illegible]nefits during a calendar year. Deductible amounts, if any, are indicated in your Benefit Sum[illegible].

1.20 **Dental Serv[illegible]s.** Professiona[illegible]vices for the diagnosis and treatment of disease or defects of, or accidental injury to, the te[illegible]h, gums, ja[illegible] and associated structures. Dental Services include dental examination and consultations, o[illegible] surgery and hospitalization for dental-related care.

1.[illegible] **Dependent.** Ple[illegible]e refer to Section 2 - Eligibility and Enrollment of this Agreement for definition.

1.22 [illegible]**rable Me[illegible]al Equipment (DME).** Products that are required for treatment, rehabilitation of, or co[illegible]ensat[illegible] for medical disability that are primarily medical, non-disposable, and intended for repeated use.

1.23 **Eligi[illegible]e Charge.** The amount of money WHP allows for Covered services. This amount includes what both WHP and the Member are to pay.

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1.24 **Eligible Employee.** An employee who works at least thirty (30) hours each workweek and who meets the applicable waiting period required by his Employer. This term excludes an employee who works on a temporary, contract or substitute basis or who is a seasonal employee. All Eligible Employees must live and/or work in the WHP Service Area unless Covered under the Point-Of-Service ~ SELECT Rider.

1.25 **Emergency Medical Condition**. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably be expected to result in:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

1.26 **Employee Welfare Benefit Plan or Welfare Plan**. Any plan, fund, or program that was or will be established or maintained by an Employer, an employee organization or association, to the extent that the plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, including:

a. Medical, surgical, or hospital care.
b. Benefits in the event of sickness, accident, disability, death or unemployment.
c. Vacation benefits.
d. Apprenticeships or other training programs.
e. Day care centers.
f. Scholarship funds.
g. Prepaid legal services.
h. Any benefit described in the Employee Retirement and Income Security Act of 1974 (ERISA), Title 29, Chapter 7, Subchapter IV, Section 186(c) other than pensions on retirement or death, and insurance to provide such pensions.

1.27 **Enrollment Form.** A form provided by WHP to gather specific information about a Subscriber and his Dependents. The form is to be signed by the Subscriber to show the Subscriber's agreement to accept and comply with the terms of this Agreement.

1.28 **ERISA.** The Employee Retirement and Income Security Act of 1974, as amended; 29 U.S.C. §1001 et seq.

1.29 **Experimental/Investigative.** A health care service is Experimental/Investigative if WHP's Medical Management staff determines:

a. It is a drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration ("FDA") and FDA approval has not been given at the time the drug or device is proposed to be used; or
b. It is a drug, device, medical treatment, or procedure, for which:
    i. 21 C.F.R. §50.20 and/or 45 C.F.R. §46.116 require(s) that a patient informed consent document be used; and
    ii. Federal law requires the review and approval of such drug, device, medical treatment or procedure by the treating facility's Institutional Review Board or other body serving a similar function; or
c. It is a drug, device, medical treatment or procedure that reliable evidence shows:

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i. Is the subject of on-going phase I, phase II or phase III clinical trials;
ii. Is under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared with a standard means of treatment or diagnosis; or

d. It is a drug, device, medical treatment or procedure needing further studies as shown by reliable evidence that establishes that the current prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness or its effectiveness as compared with the standard means of treatment or diagnosis; or

e. With regard to treatment of the Member's diagnosed condition, disease or injury, reliable evidence has not established the effectiveness of the proposed medical treatment or procedure or the proposed use of the drug or device for that particular condition, disease or injury.

Reliable evidence is published reports in the Hayes, Inc Knowledge Center addressing the specific technology in the absence of such statements, peer-reviewed articles in authoritative medical and scientific literature.

1.30 **Grievance Committee**. A committee comprised of five (5) individuals designated by WHP. The Committee is composed of four (4) individual consumers who are Members of WHP and one (1) physician. The committee will consider, review, and attempt to resolve disputes between WHP and Members.

1.31 **Grievance Procedure**. The process by which a Member, an authorized person, or a provider acting on behalf of the Member presents a Complaint.

1.32 **Group Health Plan**. An employee welfare benefit plan [as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)], including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 791 (a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)], including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

a. Has fifty (50) or more participants [as defined in section 3(7) of ERISA, 29 U.S.C.1002(7)]; or
b. Is administered by an entity other than the Employer that established and maintains the plan.

1.33 **Health Care Professional**. A duly licensed person providing services within the scope of an applicable license. This includes any Health Care Professional rendering services, which are required by applicable state law to be covered when rendered by such Health Care Professional. The term Health Care Professional includes, but is not limited to, physicians, audiologists, chiropractors, dentists, dieticians, nurse clinicians, optometrists, physical therapists, physicians' assistants, podiatrists, psychologists, social workers, speech therapists and other professionals who perform health services.

1.34 **Health Services Department**. A Department within WHP composed of the following three (3) areas:

a. Utilization Management: Utilization Management is responsible for administering WHP's Medical Management programs including Referrals, Prior Authorization, Concurrent Review and Discharge Planning.
b. Case Management: Case Management is responsible for assisting and coordinating the care of patients with catastrophic illnesses or injuries. The goal is to enhance the Member's quality of life while encouraging the most cost-effective use of his medical benefits. Members and Physicians are informed of the Member's plan benefits and possible treatment options to give the Members more choices. Needed services are also coordinated to foster Member independence.
Quality Improvement: Quality Improvement provides a continuous and efficient monitoring of Provider processes and outcomes. Quality Improvement objectives are put into action and maintained to ensure compliance with State, Federal and other accrediting, licensing, or reviewing agency requirements.

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1.35 **HIPAA**. Health Insurance Portability and Accountability Act of 1996.

1.36 **Home Health Care**. Health Care services given in the home that are Medically Necessary and not Custodial in nature. A licensed Health Care Professional who is not related to the Member receiving care shall provide these services. These services shall include, but are not limited to, skilled nursing visits, physical therapy, speech therapy, and/or occupational therapy.

1.37 **Hospice Care**. Services provided to or for the benefit of a Member diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. The term also includes services given in agreement with Medicare-certified programs, under the direction of a Physician.

1.38 **Hospital**. An institution:

a. Constituted, licensed and run according to the laws of the state in which it is located.
b. Has the inpatient facilities needed to diagnose and treat injury and sickness.
c. Provides services under Medicare.

The term "Hospital" will not include an institution that is, other than incidentally, a nursing home or a Federal Hospital.

1.39 **Human Chorionic Gonadotropin** is a hormone produced by the placenta during pregnancy. In its purified form, it can be injected to induce ovulation in women who are otherwise having difficulty ovulating.

1.40 **Infertility**. Infertility services are medical/surgical services performed to investigate and treat the causes of Infertility. Causes of Infertility include the inability to conceive (get pregnant) or cause pregnancy, maintain pregnancy until full term, or maintain or improve future desired fertility. Services are limited to: (i) Diagnostic services for the Member or Covered partner(s) to decide cause or reason for infertility; (ii) Pathology and laboratory services; (iii) Surgical services and, (iv) Drugs prescribed for Infertility treatment.

a. To be Covered, all Infertility services must be requested by a PCP and approved by the Medical Director. Covered Services will only be provided to Members. Partners or spouses who are not Members are ineligible for Covered infertility diagnostic and treatment services. In order to be considered for Covered Services related to the evaluation and treatment of Infertility, a Member must meet the following criteria:
    1. The Member must be married and the Member and the Member's spouse must have had unprotected intercourse without conception for at least one (1) year; and
    2. The male partner must have had a sperm analysis performed:
        aa If the male partner is a Member, a Participating Provider must have performed the sperm analysis.
        bb If the male partner is not a Member, the results of a sperm analysis must be sent to the Member's PCP.
        cc The female partner must have been unable to achieve and sustain two (2) successful pregnancies in her lifetime.

b. Limitations:
    1. Benefits for Covered Infertility evaluation and treatment services do not extend beyond two (2) years.
    2. If pregnancy is achieved, but is ended through spontaneous abortion or premature birth, Covered Infertility benefits will be extended for a one (1) year period following the fetal loss as long as the Member is still eligible for Coverage under a valid Infertility Rider.
        aa In no circumstances will services for Infertility be Covered beyond two (2) successful pregnancies resulting in living infant birth. These services are Covered only if the current

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Agreement or Rider covering Infertility is still in force and the Member is still an eligible Member.

bb Services in Infertility evaluation and treatment will only be Covered as long as the treated person is a Member.

1.41 **Inherited Metabolic Disease**. Defined as:

a. Caused by inborn errors of amino acid, organic acid, or urea cycle metabolism; and

b. Treatable by the dietary restriction of one (1) or more amino acids or through combination of pharmaceutical and dietary therapies.

1.42 **Lifetime Benefit Maximum**. The total dollar amount in benefits per Member that will be paid under this Agreement. This amount is not renewable. This benefit applies to the lifetime of the Covered Member.

1.43 **Limiting Age**. The age when a child of a Subscriber ceases to qualify as a Dependent as defined in Figure 1 of this Agreement.

1.44 **Maternity Services**. Obstetrical services rendered to a woman from the time the diagnosis of pregnancy is established until six weeks after delivery or termination of pregnancy or discharge from the hospital or other facility for rehabilitation services.

1.45 **Medical Director**. A Physician designated by WHP to direct its medical affairs.

1.46 **Medical Food**. Defined as:

Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

Formulated to be consumed or administered enterally under the direction of a Physician.

1.47 **Medical Transportation Services**. The transportation of a sick, injured, infirm, or otherwise disabled person by ambulance or other medical transportation vehicle that is licensed, operated, and equipped in agreement with applicable state or local statutes, ordinances, or regulations.

1.48 **Medically Necessary**. A health care service or item that, in the judgment of the Medical Director or his designee:

1. Is appropriate and consistent with the diagnosis and that could not have been omitted without harming the patient's condition or the quality of medical services received, as in agreement with accepted medical standards within the WHP Service Area.
2. Is required for reasons other than (i) the convenience of the Member or his Physician or (ii) solely for Custodial Care, comfort, convenience, appearance, educational, recreational, vocational or maintenance reasons.
3. Is performed in the most appropriate manner in terms of treatment method, setting, frequency and intensity taking into consideration the Member's medical condition and type of setting appropriate for the condition.
4. As to inpatient care or institutional care, could not have been provided in a Physician's office, the outpatient department of a Hospital or a non-residential facility without harming the patient's condition or quality of health services received.
5. Is not excluded by Medicare Guidelines.

1.49 **Medically Necessary Leave of Absence.** A Medically Necessary Leave of Absence is a dependent child's leave from activities as a full time Student, certified by the dependent child's treating physician, to be medically necessary as a result of serious injury that would otherwise cause the child to loose Student eligibility.

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1.50 **Member(s)**. A Subscriber or Eligible Dependent for whom WHP has agreed to provide health ca[illegible]ervices pursuant to this Agreement.

1.51 **Member Effective Date**. Date Member becomes eligible under this Agreement as defi[illegible]n Section 2. – Eligibility and Enrollment.

1.52 **Morbid Obesity**. Defined as:

1. A body mass index (equals weight in kilograms divided by height in meters [illegible]ared) of at lea[illegible]hirty-five (35) kilograms per meter squared with co morbidity or coexisting [illegible]dical cond[illegible]ons such as hypertension, cardiopulmonary conditions, sleep apnea, or dia[illegible]es; o
2. A body mass index of at least forty (40) kilograms per mete[illegible]quared without co morbidity.

1.53 **Non-Participating**. A person or institution that does not hav[illegible] contract or arrangement with WHP to pr[illegible]ide Covered Services to Members.

1.54 **Open Enrollment**. The period of time, prior to the Agreement St[illegible] Dat[illegible] Anniversary Date, as designated by the Employer. Subscribers and Dependents are eligible to enroll und[illegible]is Agreement during Open Enrollment.

1.55 **Orthotic**. Biomechanical devices used to correct diseases or disorders of [illegible]motion.

1.56 **Out-Of-Area**. A location outside of t[illegible]WH[illegible]vice Area. The Subscriber m[illegible]ve or work in the Service Area to be eligible for coverage un[illegible] th[illegible] Agreeme[illegible]less Covered under th[illegible]oint-Of-Service ~ SELECT Rider. Please refer to Section 19[illegible] this A[illegible]eement for a l[illegible] of counties included in the Service Area.

1.57 **Out-Of-Plan**. Covered Services that are not [illegible]ovided[illegible]y a Member'[illegible]CP or obtained by an approved referral from the Member's PCP. For example, seekin[illegible]ca[illegible]rom a Physici[illegible] who is not a Participating Provider for non-Emergency conditions is Out-Of-Plan. Out-Of-[illegible] services will not be Covered or paid for unless (i) WHP gives advance authoriz[illegible] (Pri[illegible]uthorization) to th[illegible]Member to obtain such services or (ii) the services are Covered by a valid Poi[illegible]Of-Service ~ [illegible]LECT Rider. If [illegible]t-Of-[illegible]an services are Precertified by WHP, the Member is responsible[illegible] submitting cla[illegible]s to WHP within ni[illegible]90) days and for paying any applicable Copayments, Coinsur[illegible] and Deductibles[illegible] A Member is respon[illegible]e for paying all costs of obtaining Out-Of-Plan services that a[illegible] not [illegible]certified or [illegible]valid Point-Of-Service ~ SELECT Rider. Members Covered under a valid Point-Of-[illegible]vice R[illegible] ~ SELECT are [illegible]onsible for applicable Copayments, Coinsurance and Deductibles and charges exce[illegible]e allowed amount.

1.[illegible] **Out[illegible]Pocket Maxim[illegible]**. The maximum amount of money a Member has to pay during a calendar year for Eligible C[illegible]rges for Cover[illegible] Ser[illegible]s.

1.59 **Participate(s)[illegible]g)**. A Prov[illegible]r who is under contract with WHP to provide services to Members pursuant to this Agreement.

1.[illegible] **PHI (Protected [illegible]ealth Information)**. Information that contains individually identifiable health information.

1.61 **[illegible]ysician**. A[illegible]erson who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and wh[illegible]holds [illegible]alid unlimited license to practice medicine or osteopathic medicine in the state in which he practices.

1.62 **Plan [illegible]ponsor**.

a. The Employer in the case of an Employee benefit plan established or maintained by a single Employer;

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b. The employee organization in the case of a plan established or maintained by an employee organization; or
c. In the case of a plan established or maintained by two (2) or more Employers or jointly by one (1) or more Employers and one (1) or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

1.63 **Pre-Existing Condition**. A condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date.

a. Medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law; and
b. The six (6) month period ending on the enrollment date begins on the six (6) month anniversary date preceding the enrollment date.

1.64 **Prescription Drugs**. Drugs or medications, the sale or dispensing of which legally requires the order of a Physician or a Provider and that carry the Federally required proper legend stipulation that such drug may not be dispensed without a prescription. Prescription Drugs must be dispensed by a Participating pharmacy.

1.65 **Preventive Care**. Preventive Care includes the "evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance, risk factor reduction, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures.

If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine service, that service may be separately billed.

Typical services performed during Preventive Care visits may include but are not limited to: Height and Weight measurement, measurement of vital signs, testing of visual and hearing acuity, administration of scheduled or annual immunizations, screening for risk factors, preventive counseling and the ordering of pertinent screening laboratory or diagnostic services. Examples (not all inclusive list):

- Immunization for usual childhood diseases
- Annual immunization for influenza
- Periodic booster immunizations for diphtheria and tetanus
- Taking of family, occupational, or social history
- Counseling about tobacco use, drug and alcohol use, use of automobile restraint devices, use of helmets when riding bicycles, dental hygiene and periodic dental care, household firearm safety, obesity, depression, sexually transmitted diseases, and other risk factor appraisal
- Physical examinations to screen for heart, lung, liver, endocrine, breast, gynecologic, prostate, musculoskeletal or neurologic disease
- Ordering of screening tests for lead exposure, breast and cervical cancer, colon cancer, heart disease and blood, endocrine, metabolic, or sexually transmitted disorders
- Family planning services for female adolescents or adults

Preventive Care does not include:

- Sports, school, or work examinations
- Immunizations or prescriptions for international travel
- Evaluation and management of a pre-existing condition

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1.65 **Primary Care Physician (PCP).** A pediatrician, family practice Physician, or internal [illegible]icine Physician who is a Participating Provider. This Physician is selected by the Member and named by WH[illegible] to m[illegible]ge all of the Member's health needs.

1.66 **Prior Authorization.** This is the process for obtaining approval for a proposed hea[illegible] service. The r[illegible]uesting provider must submit complete clinical information justifying the medica[illegible]essity of [illegible]roposed treatm[illegible]t or service. Once a service is prior authorized, there is not a guarantee of [illegible]yme[illegible]ince the Member must be [illegible]ible for benefits on the date of service the treatment is rendered.

1.67 **Prosthetic.** Devices that are prescribed to replace all or part [illegible]n absent body part or to replace all or pa[illegible] of the function of a permanently inoperable or malfunctioning bo[illegible]art.

1.68 **Provider.** A Health Care Professional, licensed health care insti[illegible]ion (a H[illegible]pi[illegible] Skilled Nursing Facility, or Rehabilitation Facility), or a supplier.

1.69 **Reconstructive.** Services required to correct a significant defect in bodi[illegible]unction caused by a birth defect or an injury/disease. In the case of injury or disease the service must be provided [illegible]ile a m[illegible]ber of WHP and received within one (1) year from the date of the [illegible]l injury/disease. For children or [illegible]ast reconstruction, the one (1) year time limit does not apply.

1.70 **Referral or Referred.** A communication [illegible]t by a PCP o[illegible] Participating Provider (oral, written, or electronic) that specifies health services to b[illegible]rendered [illegible] another [illegible]r identified in such communication.

1.71 **Rehabilitation Facility.** A facility providing [illegible]x medical or [illegible]navioral treatment and skilled nursing services intended to r[illegible]e an individual to a m[illegible]mum level of functioning following a disabling disease or injury.

1.72 **Residenti[illegible]reatment Facil[illegible].** A Provider consti[illegible], licensed and operated as set forth in applicable state law. Ex[illegible]les include, but a[illegible] not limited to:

a. A facility [illegible]viding in[illegible]ent care a[illegible]ment for persons who are being treated for mental health, chemical an[illegible]al[illegible]ol dependency, eating disorders, or behavioral disorders for which the length of stay is anticipated to b[illegible]ore than 10 days.
[illegible]est, educationa[illegible] custodial Provider or similar place.

1.73 **Rider.** An[illegible]tional benefit [illegible] Member's Employer may elect to include as Covered Services under this Agreement.

1.74 **Selected Benign [illegible]kin Lesions.** Defined as: Lipomas, Sebaceous cysts, Viral warts, Molluscum, and inflamed seborrheic kerato[illegible]s.

1.75 **Semi-Private.** [illegible] room in a Hospital, Skilled Nursing Facility or any other inpatient facility containing two (2) or [illegible]e beds a[illegible]or classified as Semi-Private by such facility.

1.76 **Servi[illegible]rea.** The counties and states where WHP provides or arranges for the health care services to WHP Men[illegible]ers. The Subscriber must live or work in the Service Area to be eligible for coverage under this Agreement

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unless Covered under a valid Point-Of-Service ~ SELECT Rider. WHP's Service Area includes the counties listed in Section 19 of this Agreement. All other locations are outside the Service Area or "Out-of-Area."

1.77 **Skilled Nursing Facility**. A facility that:

a. Is primarily engaged in providing skilled nursing care and related services on a twenty-four (24) hour a day basis to inpatients requiring medical or skilled nursing care.
b. Is recognized and eligible to be paid under Medicare as a Skilled Nursing Facility.

1.78 **Special Enrollee**. Please refer to Section 2.4.4 for definition.

1.79 **Subscriber**. An employee of the Employer who is either:

a. Eligible under the Employer's medical benefit plan.
b. Eligible under other established standards of the Employer and WHP who lives or works in WHP's Service Area unless Covered under a valid Point-Of-Service ~ SELECT Rider, and who has enrolled in WHP.

1.80 **Therapy Services**. Services and supplies used to promote recovery from an illness or injury. These services shall include services provided by Physical, Occupational, and Speech Therapists in accordance with their scope of practice under state law. It shall also include organized programs of cardiac or pulmonary rehabilitation.

1.81 **Total Disability.** The individual is unable to work in any occupation and the disability has lasted or is expected to last one year, or is expected to result in death. In the case of a child under age [illegible] individual is physically or mentally impaired such that he/she is prevented from functioning and developing normally and the impairment is expected to last at least one year.

1.82 **Trauma**. An injury or damage to a body part, organ or tissue caused by an external force or agent, even if self-inflicted. Injury or damage to a body part, organ, or tissue caused by forces or substances from within the body shall not be considered due to trauma for the purposes of the Certificate.

1.83 **Urgent or Urgent Condition**. An acute health problem that starts suddenly and is not expected. It is not a threat to life, but has serious danger to health if not treated within twenty-four (24) hours. An Urgent Condition is one, in the opinion of a physician with knowledge of the Member's medical condition, which would subject the Member to severe pain that cannot be adequately managed without care or treatment. Examples of Urgent Conditions can be simple fractures, [illegible] stitches and serious infections.

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SECTION 2. ELIGIBILITY AND ENROLLMENT

2.1 **Eligible Subscriber.** The Employer and WHP define the standards used to determine an employee's eligibility to enroll for Coverage under this Agreement. If the Employer and WHP have agreed on eligibility rules different than those listed in this Section, the agreed upon eligibility rules are described in Figure 1 of this Agreement.

2.1.1 An eligible Subscriber is:

a. The employee of an Employer group, including employers participating in the Association, who is entitled to participate in the benefit plan arranged by the Employer and who has satisfied any probationary or waiting period established by the Employer and other eligibility criteria established by the Employer; and/or

b. An employee of the Employer who is entitled to Coverage under an employment contract.

c. A Retiree of an Employer that allows Coverage for Retirees. (Please refer to Exhibit 2 of this Agreement to determine if your Employer provides Retiree Coverage). The following requirements need to be met in order to be eligible as a Retiree:

i. Subscriber must currently be enrolled by WHP.

ii. All health plans offered by the Employer must offer Retiree Coverage.

iii. Retirees must elect to continue Coverage at the time of retirement and will not be allowed to re-enroll under the Employer plan after a break in Coverage.

iv. The Employer must contribute toward the Retiree's premium according to WHP's underwriting guidelines.

v. Premiums must be paid directly by the Employer to WHP.

vi. A Retiree who has coverage with another employer offered health insurance plan may not enroll under this Agreement if the Retiree had previously declined Retiree coverage with WHP. Please refer to Exhibit 3, Section 2 of this Agreement if retiree eligibility is applicable.

2.2 **Eligible Dependents.** All employee's Dependents must enroll through the Subscriber.

To be eligible to enroll, a Dependent must qualify under one (1) or more of the eligibility guidelines listed below and must not already be enrolled as a Subscriber of the Employer. If the Employer and WHP have agreed on eligibility rules different than those listed in this Section, the agreed upon eligibility rules are described in Figure 1 of this Agreement.

To be eligible to enroll, a Dependent must be:

- Spouse: The Subscriber's lawful spouse.
- Domestic Partner (only for eligible Employees whose Employer offers coverage for Domestic Partners, either same sex, opposite sex, or both, as defined in Figure 1 of this Agreement). The Subscriber's domestic partner if the Subscriber and his domestic partner (same or opposite sex) have maintained a long term relationship of indefinite duration who together:
  a. Have an exclusive mutual commitment similar to that of marriage,
  b. Have agreed to be responsible for each other's welfare, and
  c. Meet the following other requirements:
     i. Are not related by blood.
     ii. Are not married to or legally separated from anyone else.
     iii. Are at least eighteen (18) years of age and meet the marriage age requirement of the state in which they reside.

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iv. Currently share a household, have been doing so continuously for at least twelve (12) months, and plan to continue to do so indefinitely.
v. Have filed a domestic partnership agreement or registration if available in the [illegible] and/or city) of residence.
vi. Are financially interdependent as can be demonstrated by one (1) or mo[illegible] the following criteria:
aa. Joint ownership of real property;
bb. Common ownership of an automobile;
cc. Joint bank accounts;
dd. Driver's license listing a common address;
ee. Assignment of a durable power of attorney or hea[illegible] care [illegible]wer of attorney; or
ff. A will, retirement plan, or life insurance policy [illegible]signating the other as a primary benefic[illegible].

- Dependent child under the age limit specified in Figure [illegible] this Agreement. Subscriber's or Subsc[illegible]r's spouse's unmarried children by birth or legal adoptio[illegible] Dependent child includes:

a. A stepchild of the Subscriber.
b. A newly adopted child based on the earlier of:
i. the date of placement for the purpose of [illegible]tion; or
ii. the date of the entry of an order granting th[illegible]doptive parent custody of the child for purposes of adoption.
c. A child for whom Subsc[illegible]ber or his lawful spouse has been is[illegible]ed a [illegible]alified Medical Child Support Order.
d. A child for whom S[illegible]bsc[illegible]ber or his [illegible]ful spouse has obtained [illegible]gal guardianship and is related by blood or mar[illegible]ge. If t[illegible] Subscriber's [illegible]se is the child's sole guardian, Subscriber's spouse must be a Member.
e. An emancipated minor child [illegible] not an[illegible]gible Depen[illegible]t.

A Dependent child must be under the age li[illegible] specified in Figure 1 of this Agreement. A child will continue to be an eligi[illegible]epen[illegible]t past the age limi[illegible]pecified in Figure 1 only if the child is:

Disable[illegible] The child's dis[illegible]ility may be physic[illegible]o[illegible]ental and must render him unable to work for self-supp[illegible] In addition, the [illegible]ild must meet all of t[illegible] qualifications of a dependent as determined by the United St[illegible]s I[illegible]nal Revenue [illegible]rvice and must have been declared on the employee's federal personal income tax return for [illegible]h year of [illegible]overage. The [illegible]'s disability must occur before he would have been ineligible for Coverage und[illegible] thi[illegible] Agreement. WHP must certify the child's disability. Subscriber must give WHP proof of the disabled chi[illegible] eligibility for continuation of Coverage within one hundred twenty (120) days after the [illegible] limit defined in [illegible]gure 1 of this Agreement is reached. WHP may ask the Subscriber to provide proof of the c[illegible]'s continuing [illegible]abilit[illegible]o more than once a year.

Student. [illegible] child must[illegible] a full-time student in an accredited school that is not a correspondence school. A full-time stu[illegible]nt may be a day or evening student. The child must have a course load of not less than 12 undergradua[illegible] credit hours per semester or not less than 9 graduate credit hours per semester to be considered full-time. O[illegible] Emergency or Urgent conditions are Covered for a child located out of the Service Area.

Subscribe[illegible]ust provide WHP proof of full-time student status. If the child is no longer a full-time student [illegible]nd not[illegible] a Medical Necessary Leave of Absence, Subscriber must notify WHP within thirty (30) days of the [illegible]ation of the child's full-time student status. Failure of Subscriber to notify WHP that the child is no l[illegible]ger a full-time student and not on a Medical Necessary Leave of Absence will result in WHP terminating Coverage as of the date the child lost full-time student status. WHP may recover from the Subscriber and the

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child any amounts paid for services after Coverage stops, including but not limited to costs and reasonable attorney fees including the cost of collection and reasonable legal fees for any services given after Coverage terminated.

A Child who is eligible as a Student in accordance with this Section 2.2 shall remain eligible if the child takes a Medically Necessary Leave of Absence. In order to remain eligible, a written request must be submitted that includes a certification from the child's treating physician that describes the circumstances requiring the child's Medically Necessary Leave of Absence. Eligibility extended for a Medically Necessary Leave of Absence will not terminate until the earlier of (1) one year after the first day of the approved medically necessary leave of absence or to the date under which coverage under this Agreement would otherwise terminate.

Dependent of a Dependent of a Subscriber.

A grandchild of a Subscriber or his lawful spouse is not an eligible child unless Subscriber or his lawful spouse legally adopts the grandchild or the Subscriber or his lawful spouse, who is also a member, is appointed legal guardian of the grandchild.

Dependent Children Between the Age Limit Specified in Figure 1 of this Agreement and Age 24 (Extended Coverage Dependents), for whom an extension of Coverage is requested by the Subscriber, including:

a. Biological or adopted children of the Subscriber, regardless of support, and
b. The following children who depend on the Subscriber for more than fifty percent (50%) of the individual's total support:
   1. Step-child of the Subscriber,
   2. Child subject to legal guardianship by the Subscriber,
   3. Grandchild of the Subscriber,
   4. Blood relative of the Subscriber.

Coverage for a Dependent already enrolled as of the age limit specified in Figure 1 will automatically terminate effective as of the end of the last day of the month in which the Dependent reaches the age limit specified on Figure 1 unless the Subscriber makes a written request to WHP for extended Coverage for the Dependent. The written request must be made no sooner than six (6) months prior to the date that Coverage for the Dependent would otherwise terminate.

Extended Coverage Dependents who are newly eligible must enroll with WHP within thirty-one (31) days of becoming eligible for extended Coverage or wait until the next Open Enrollment period to make the written request for extended Coverage.

2.3 **A Dependent who is Newly Eligible**. A Dependent who is newly eligible must enroll with WHP within thirty-one (31) days. If this is not done, the Dependent must wait until the next Open Enrollment period.

2.3.1 Newborn Child.

a. A baby born to a Subscriber or his spouse is Covered for thirty-one (31) days after birth for care of injury, and sickness and for treatment of birth defects. This coverage starts on the date of birth. However, if the child is not enrolled in WHP within thirty-one (31) days from the date of birth, any coverage for the Dependent stops at midnight of the thirty-first (31st) day. The child must wait to enroll with WHP until the next Open Enrollment period.

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b. If a new baby born to a Subscriber or his spouse needs routine newborn care, this coverage is only available if the child is enrolled with WHP within thirty-one (31) days from the date of birth. If the child is not enrolled during this initial period, no coverage exists, and the child may wait to enroll until the next Open Enrollment period.

2.3.2 Adopted Child. An adopted newborn or child is Covered under the terms and conditions of this Agreement for thirty-one (31) days from the date of filing of the petition for adoption. To continue coverage, the child must be enrolled within thirty-one (31) days of such date. If a child who is adopted is not enrolled with WHP within thirty-one (31) days of such date, the child may not be enrolled until the Employer's next Open Enrollment period.

2.3.3 New Spouse. A new spouse is Covered if enrolled with WHP within thirty-one (31) days of the date of marriage. If not enrolled within thirty-one (31) days, the new spouse must wait to enroll until the Employer's next Open Enrollment period

2.3.4 Dependent Child of New Spouse. The Dependent child of a new spouse is Covered if enrolled within thirty-one (31) days of the date of marriage of the parent or the date of birth if later.

2.4 **Enrolling in WHP**. Eligible Employees and any Dependents who are eligible may enroll with WHP during an Open Enrollment period. The Eligible Employee or Dependent must complete all steps of the enrollment process.

2.4.1 Selecting a PCP. Members may choose a PCP from the list of Participating PCPs named by WHP. WHP has the right to change its list of Participating PCPs at any time. WHP will choose a PCP for Members who do not make their own selection.

a. Changing Your PCP. Members are allowed to change their PCP up to twice annually. If the Member requests a PCP change through WHP's Customer Service Department on or before the fifteenth (15th) of the month, the change of PCP will be effective the first day of the following month. Otherwise, the change will be effective on the first day of the second month following the request. If the Member's PCP ceases to be a Participating PCP, WHP will notify the Member in writing and assist the Member in selecting a new PCP. Members who have already changed their PCP the maximum number of times allowed and wish to express dissatisfaction with their current PCP, may use the Grievance Procedure defined in Section 15.

b. PCP Initiated Change. The PCP has the right to have a Member transferred to another Participating PCP. The PCP must submit the request in writing to WHP with at least thirty (30) days advance notice. During that time, the PCP must continue to provide or otherwise arrange for medical care for the Member until the Member has been successfully transferred to another Participating PCP. WHP will work with the PCP and the Member to determine the timing of the transfer.

A Member may be transferred to another PCP under the following circumstances as defined by the PCP:

i. The Member's behavior is disruptive, abusive and/or threatening.
ii. The Member does not comply with the PCP's directions and the PCP believes that a reasonable medical alternative does not exist.
iii. A change in the physical condition of the Member requires services that are not within the specialty of the Physician as jointly determined by WHP and the PCP.
iv. The Member was previously unable to establish a proper patient-Physician relationship.
v. The Member repeatedly makes but fails to keep appointments for health services.

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2.4.2 Initial Open Enrollment Period. Before the initial Agreement Start Date, employees have the chance to enroll themselves and any eligible Dependents. All Eligible Employees who do not elect to enroll at this time must complete and sign a Waiver of Coverage form. During this period, the Employer permits WHP to impose restrictions that apply to Late Enrollees.

2.4.3 Enrollment of New Employees. Employees who become eligible or are hired after an Employer's Agreement Start Date may enroll themselves and any eligible Dependents on the date they become eligible.

2.4.4 Special Enrollment Periods. Special Enrollee means an Eligible Employee or their Dependent or Eligible Employee who did not request enrollment with WHP during the initial Open Enrollment period during which they were first entitled to enroll. A Special Enrollee may enroll within thirty (30) days of a Status Change. The term "Status Change" includes:

a. An Eligible Employee or eligible Dependent who
   i. Was Covered under another health insurance plan or had other health insurance coverage at the time coverage was previously offered to them and who stated in writing that coverage under another health insurance plan was the reason for declining the enrollment; and
      aa. Was under a COBRA continuation provision and the coverage under that provision is now exhausted; or
      bb. The Employer offers multiple health insurance plans and the Eligible Employee or their eligible Dependent is now applying during an Open Enrollment Period; or
      cc. The coverage was lost as a result of loss of eligibility for the coverage. Such circumstances could include legal separation, divorce, death, loss of employment, or loss of coverage due to a reduction in number of employment hours or termination of the other health plan.

b. If a Special Enrollee does not enroll within thirty (30) days of a Status Change, the Special Enrollee must wait until the next Open Enrollment Period to enroll.

c. The term Special Enrollee also does not include an Eligible Employee, the Eligible Employee's spouse, or a minor Dependent child where:
   i. A court has ordered that health insurance coverage be provided for the spouse, minor child, or Eligible Dependent child or an Eligible Employee.
   ii. The request for enrollment is made before that thirty (30) days after the issuance of the court order.

2.4.5 Notification of Change in Eligibility. The Subscriber must let WHP know of any changes in name, address, marital status, and/or eligibility of any Covered family members within ten (10) days of any changes.

2.4.6 Other Rules of Enrollment
   a. A person who previously had coverage voided under this Agreement or another WHP plan for any of the following reasons may not enroll under this Agreement:
      i. Fraud;
      ii. Misrepresentation;
      iii. Misuse of ID card;
      iv. Failure to pay Copayments, Coinsurance or Deductibles;
      v. Failure to make premium payment; or
      vi. Prior disenrollment from WHP due to disruptive behavior toward a WHP Provider, Member or employee.

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2.5 **Identification (ID) Card**. Identification Cards issued by WHP to Members pursuant to this Agreement are for identification only. Possession of a WHP ID card confers no rights to services or other benefits under this Agreement. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member for whom all required payments under this Agreement have been made. Any person receiving services or other benefits to which he is not entitled pursuant to the provisions of this Agreement will be liable for all charges for such services and benefits. All ID cards are the property of WHP and must be surrendered to WHP upon request. A Member must let WHP know immediately if his ID card is lost or stolen. A Member who allows any other person to use his ID card will be terminated pursuant to Section 10.1 of this Agreement.

2.6 **Nondiscrimination**. No person, who is eligible to enroll, will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability or age.

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SECTION 3. PLAN DELIVERY RULES

3.1 **Air Ambulance Transport** must be for a life-threatening condition to the nearest participating facility with the medical capacity to deal effectively with the medical condition.

3.2 **Breast Reduction** when Medically Necessary: Medical Necessity criteria include type and duration of symptoms, age, body mass index and grams of tissue proposed to be removed.

3.3 **Cardiac and Pulmonary Rehabilitation** is limited to twenty-four (24) visits each plan contract year. Pulmonary rehabilitation patients must be smoke-free for sixty (60) days prior to beginning program.

3.4 **Co-payments and Coinsurance** must be paid at the time of service.

3.5 **Deductible.** There is only one deductible for all benefits, incorporated within the Benefit Summary. Certain riders may have separate deductibles.

3.6 **Methadone Maintenance**. Welborn Health Plans will cover methadone maintenance of opiate-addicted patients under the following circumstances:

1. The member must first be evaluated by a participating, board-certified specialist in addiction medicine. The addiction specialist must agree that short-term methadone maintenance is an appropriate course of therapy and refer the patient to the federally certified treatment facility.
2. Methadone treatment is considered a bridge to opiate detoxification and withdrawal, not a long-term solution. Duration of covered maintenance shall not exceed 180 consecutive days.
3. Methadone maintenance will only be covered in a federally certified methadone treatment facility. WHP will compensate the provider at a flat rate of $95.00 per week. The member will be responsible for one (1) specialist office visit copay per week for detoxification.
4. Services that fall outside of the aforementioned or exceed 180 days duration are the member's financial responsibility.

3.7 **Preventive Care** includes the "evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction, and the ordering of appropriate immunization(s), and laboratory/diagnostic procedures."

If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine service, that service may be separately billed.*

Typical services performed during Preventive Care visits may include but are not limited to: Height and Weight measurement, measurement of vital signs, testing of visual and hearing acuity, administration of scheduled or annual immunizations, screening for risk factors, preventive counseling and the ordering of pertinent screening laboratory or diagnostic services. Examples (not an inclusive list):

- Immunization for usual childhood diseases
- Annual immunization for influenza
- Periodic booster immunizations for diphtheria and tetanus

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- Taking of a family, occupational, or social history
- Counseling about tobacco use, drug and alcohol use, use of automobile restraint devices, use of helmets when riding bicycles, dental hygiene and periodic dental care, household firearm safety, obesity, depression, sexually transmitted diseases, and other risk factor appraisal.
- Physical examinations to screen for heart, lung, liver, endocrine, breast, gynecologic, prostate, musculoskeletal or neurologic disease.
- Ordering of screening tests for lead exposure, breast and cervical cancer, colon cancer, heart disease and blood, endocrine, metabolic, or sexually transmitted disorders.
- Family planning services for female adolescents or adults.

Preventive Care does not include:

- Sports, school, or work examinations.
- Immunizations or prescriptions for international travel.
- Evaluation and management of a pre-existing medical condition.

*Excerpted from "Current Procedural Terminology 2007 Professional Edition". Copyright American Medical Association.

3.8 **Additional information** on Member health benefits can be obtained by visiting www.velbornhealthplans.com, contacting Customer Services at 812-421-2500, 800-521-0265, or toll free Indiana Relay at 800-743-3333, or by writing to:

Velborn Health Plans
ATTN: Customer Services
1201 S.E. Third St.
Evansville, IN 47708

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SECTION 4. COVERED SERVICES

4.1 **General Conditions**. All Covered Services are dependent upon the timely payment of premiums. The Covered Services that WHP agrees to provide or arrange for are subject to the terms that follow. Except for life-threatening Emergencies and Out-Of-Area Urgent Conditions, services are only Covered when provided by or directed by a Member's PCP. Some services also require prior approval. Services that are not listed are not Covered.

4.1.1 Covered services may be subject to Copayments, Coinsurance, Deductibles, Out-Of-Pocket Maximums and Lifetime Benefit Maximum. Please refer to your Benefit Summary for applicable Member cost sharing.

4.1.2 Please read Sections 5 and 6 to see what services are limited or excluded as there may be some limits to the services listed as Covered.

4.1.3 Unless stated otherwise in this Agreement, services and supplies are Covered only if provided, ordered, prescribed or Referred in advance by the Member's PCP. Charges that are received from a Provider who is not listed as the Member's PCP on their WHP ID card and no Approved Referral is in place will be the Member's financial responsibility. This does not apply to services provided by Participating OB/GYN Physicians and Eye Care Providers that do not require a Referral.

4.2 **Covered Health Care Professional Services.**

4.2.1 Health Care Professional office visits and services for diagnosis, treatment, therapy, surgery, and consultation. These services must be performed under the guidelines of WHP's Medical Management program.

4.2.2 Inpatient and outpatient Health Care Professional services. Non-emergency Inpatient Physician services must be precertified.

4.2.3 Preventive Care services:
a. Periodic physical examinations as medically indicated by the age, sex, and medical history of the Member.
b. Routine immunizations to age eighteen (18).
c. Routine Pap smears, screening mammograms, prostate screening, colonoscopy screening, lab and x-rays associated with annual physical exams.

4.2.4 Allergy injections, testing and treatment.

4.2.5 Diagnostic laboratory and x-ray services received in a Physician's office.

4.2.6 Injectables including human blood products and chemotherapy. Self-injectable medications are Covered as part of a valid Prescription Drug Rider. These products must be obtained from a Participating pharmacy.

4.2.7 Mammograms, performed on dedicated equipment that meets the guidelines established by the American College of Radiology, for any Member, regardless of age, who has been diagnosed with breast disease upon referral by a health care practitioner acting within the scope of the practitioner's license.

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4.2.8 Obstetrical care. Physician services for routine care before delivery, during delivery and after a baby is born only if Covered under a valid Rider and your Benefit Summary states that these services are covered. This includes services for an eligible, enrolled Dependent child of a Subscriber. These services do not need a Referral from a PCP

4.2.9 Office surgery performed in a Physician's office. This includes but is not limited to diabetic foot care and vasectomy. Selected Benign Lesions treated in a Physician's office or outpatient facility are Covered. These include lipomas, sebaceous cysts, viral warts, mulluscum and inflamed seborrheic keratoses. The Member Copayment in your Benefit Summary applies to the Covered services for Selected Benign Lesions. This includes the professional and facility charges, if applicable.

4.2.10 Second opinion consultation with any participating health care provider.

4.3 **Educational Services/Dietician Consultations** for the management of glucose intolerance, elevated cholesterol, obesity, eating disorders and gluten intolerance.

4.4 **Medical Transportation Services** when such services are:
a. Provided in connection with Medically Necessary Emergency services; or
b. Provided with a Referral from the Member's PCP or Participating Physician and approved in advance by WHP.
c. Transportation by air must be for a life-threatening condition and only to the closest participating facility with the expertise to deal effectively with the Member's medical condition.

4.5 **Emergencies**. In an Emergency, the Member should seek care at the nearest facility. No PCP Referral is required for Emergency services. The Member should call their PCP within forty-eight (48) hours or as soon as reasonably possible. Then the PCP can continue managing the Member's care.

4.5.1 Covered Emergency services include only supplies and services needed until the Member can, without harm or injury, receive care from or through the Member's PCP. Emergency services are Covered when: The emergency is from a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:
1. placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part or

with respect to a pregnant woman who is having contractions:
1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

4.5.2 Medically Necessary Emergency services provided outside the WHP Service Area.

4.5.3 A Member goes to a Hospital emergency room and is admitted directly to the Hospital **as an inpatient**, the emergency room Copayment is waived. The Member must contact his PCP within forty-eight (48) hours or as soon as reasonably possible. This allows the PCP to be informed of the Member's condition

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and the PCP can coordinate his care. (NOTE: If the Member is a minor, his parent or guardian must contact the PCP.)

4.5.4 Follow-up services are Covered only when they are provided or arranged by the Member's PCP and authorized by WHP.

4.6 **Urgent Care – In Area**. Urgent Care arising inside the WHP Service Area and all follow-up care must be provided or directed by the Member's PCP.

4.7 **Inpatient Services** in the following settings:

a. Hospital.
b. Skilled Nursing Facility, subject to the benefit limitations listed in your Benefit Summary.
c. Rehabilitation Facility, as subject to the benefit limitations listed in your Benefit Summary.
d. Obstetric services for labor, delivery and post-partum care to the Member only if Covered under a valid Rider and your Benefit Summary states that these services are covered.

The services included in these settings are:

i. Semi-Private rooms or private rooms when Medically Necessary and when consistent with written Hospital rules for isolation.
ii. General nursing care.
iii. Meals (including special diets when Medically Necessary).
iv. Operating room and related services.
v. Intensive care unit and related services.
vi. X-ray services.
vii. Laboratory, pathology and other diagnostic tests.
viii. Drugs, medications and biologicals.
ix. Anesthesia and oxygen services.
x. Radiation and inhalation therapy.
xi. Medical/surgical supplies.
xii. Administration of whole blood and blood products.
xiii. Short-term rehabilitative services and physical therapy when provided on an inpatient basis.
xiv. Medical and surgical services performed by interns and residents-in-training, as defined in section 1861(b) of Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*
xv. Specialty nursing when Medically Necessary.

4.8 **Outpatient Services** including:

4.8.1 Hospital and other facility services such as day surgery and radiation.

4.8.2 Diagnostic services including: diagnostic radiology, laboratory and pathology tests and nuclear medicine services.

4.8.3 Radiation therapy services including radioactive isotope therapy.

4.8.4 Rehabilitation therapy services including physical therapy, occupational therapy, cardiac and pulmonary rehabilitation, and speech therapy.

Physical therapy, occupational therapy and pulmonary rehabilitation are Covered when needed as a result of injury, external trauma, cancer, stroke or surgery.

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b. Cardiac rehabilitation is Covered when needed as a result of myocardial infarction, unstable angina, coronary artery bypass graft surgery (CABG) or percutaneous transluminal coronary angioplasty (PTCA).
c. Speech therapy is Covered for the following conditions:
   i. Restoration of function lost or impaired as a result of external trauma, cancer, surgery, or neurologic conditions including but not limited to stroke, multiple sclerosis, Parkinson's disease or other acquired conditions of the nervous system.
   ii. Enhancement of function in congenital conditions or deformities including but not limited to cleft palate or lip, maxillofacial deformities or motility disorders of the esophagus.
   iii. Enhancement of speech function for hearing-impaired individuals, including those who have received cochlear implants, if the hearing impairment occurred prior to the fifth birthday.
   iv. Autism/Pervasive Developmental Disorder (PDD) as described in Section 4.9 of this agreement.
   v. Delay of speech development in individuals between the ages of 18 months and 5 years where hearing impairment and Autism/Pervasive Developmental Disorder (PDD) have been excluded.
d. Rehabilitation therapy services must be authorized by the Medical Director and be expected to result in marked improvement within sixty (60) days of starting therapy.
e. Rehabilitation therapy services are subject to limitations as indicated in your Benefit Summary.

4.8.5 Skilled Home Health services (when not Custodial in nature and subject to the rehabilitation benefit limits as defined in your Benefit Summary) including:
a. Nursing care given or supervised by a skilled health professional who works for a state licensed Home Health agency.
b. Physical, occupational, respiratory therapy by a qualified therapist.
c. Medical supplies and lab services.

4.8.6 Hospice care.

4.9 **Other Covered Services.**

4.9.1 Alcohol/drug detoxification services, subject to the benefit limitations as listed in your Benefit Summary. Services for substance abuse and chemical dependency, when required in the treatment of a mental illness, will be provided at the same benefit level as other medical or surgical conditions.

4.9.2 Autism/Pervasive Developmental Disorder (PDD). Pervasive Developmental Disorder is a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Covered services for PDD are limited to treatment prescribed by the Member's PCP in agreement with a treatment plan. Other limitations and exclusions defined in the Agreement do not apply to services associated with PDD.

4.9.3 Bone density testing for women age thirty-five (35) years and older to obtain baseline data for the purpose of early detection of osteoporosis.

4.9.4 Breast reconstruction following a mastectomy as dictated by the Women's Health and Cancer Rights Act of 1998 (please see Section 17).

4.9.5 Breast reduction when Medically Necessary.

4.9.6 Cochlear implants and related services and supplies, when Medically Necessary.

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4.9.7 Corneal transplants when Medically Necessary.

4.9.8 Dental services needed for the treatment or repair of damage because of trauma to sound natural teeth. Treatment must be performed within twelve (12) months of injury. Replacement of teeth with artificial teeth, dental prosthesis or dental implants are not Covered.

4.9.9 Diagnosis and treatment of endometriosis and endometritis.

4.9.10 DME services including but not limited to crutches, glucometers, wheelchairs, apnea monitors, home uterine monitors, oxygen, and oxygen related supplies/equipment and bone growth stimulators.

4.9.11 First pair of frames and lenses or contact lenses following cataract surgery up to the WHP maximum approved amount.

4.9.12 Hemodialysis services.

4.9.13 Hospital care related to Dental Services, including anesthesia services, for Dependent children under the age of nineteen (19) or Dependents with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual.

4.9.14 Medical Food formulas for the treatment of Inherited Metabolic Disease may be covered as a medical benefit.

4.9.15 Medical supplies including but not limited to casts, splints, ostomy supplies, and lancets and test strips used with glucometers.

4.9.16 Orthotic devices including, but not limited to, back braces, ankle foot orthosis, and thoracic lumbar orthosis. Replacement or repair after four (4) years of use **may be** considered by WHP if due to normal wear and tear.

4.9.17 Out-of-Area coverage of health services is limited to Urgent and Emergent conditions except as stated in Section 4.

4.9.18 Out-of-Area coverage for lab testing, oxygen supplies, or dialysis for Members with (i) diabetes, (ii) chronic lung or obstructive lung disease, or (iii) chronic renal failure, respectively, who voluntarily leave the Service Area. These services must have WHP Approval in advance. Coverage is limited to a period of no more than three (3) weeks in a calendar year. No coverage for these services will be provided for Members with such conditions who must travel outside the Service Area by reason of their occupation or employment.

4.9.19 Purchase of the initial prosthetic devices including, but not limited to, artificial limbs, external breast prosthesis [limited to two (2) external breast prosthesis per year], and eye Prosthesis.

4.9.20 Reconstructive services provided while a Member of WHP are Covered for one (1) year from the date of original injury/disease. For children or for breast reconstruction, the one (1) year time limit does not apply. Reconstructive services do not include penile prosthesis.

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4.9.21 Repairs, maintenance or replacement of DME, Prosthetics and Orthotic devices if medically necessary to restore or maintain the enrollee's ability to perform activities of daily living or essential job-related activities and are not solely for comfort or convenience.

4.9.22 Screening examination to determine the need for hearing correction.

4.9.23 Selected Benign Lesion services for removal if performed in a Physician's office, subject to the benefit limitations in your Benefit Summary:
a. Lipomas;
b. Sebaceous cysts;
c. Viral warts;
d. Molluscum;
e. Inflamed seborrheic keratosis.

4.9.24 Skin Lesion removal of the following if performed in a Physician's office:
a. Nevi (moles) proven to be malignant by biopsy or on an individual with previous history of skin cancer;
b. Actinic keratosis;
c. Other malignant or pre-malignant skin lesions.

4.9.25 Smoking Cessation Programs when provided through WHP's Finally Quit Smoking program. Enrollment in this program provides up to two (2), twelve (12) week smoking cessation attempts per member per year and includes the following medications to help WHP members stop smoking:
a. Medication, patches and gum with a member copay at the prescription drug benefit rate specified in the Benefit Summary.
b. Hypnosis with a member copay at the specialist office visit rate specified in the Benefit Summary.
c. Monthly support and counseling from a WHP healthcare professional.

4.9.26 Temporomandibular Joint (TMJ) syndrome coverage is limited to $1,500 per contract year and includes evaluation, radiologic studies including MRI, intraoral appliances and surgery.

4.9.27 Treatment for port-wine stains when determined to be medically necessary by the medical director.

4.9.28 Trimming of toenails is Covered when a severe disease could cause damage to the feet. Examples include diabetes, vascular disease, peripheral neuropathy, and other severe qualifying diseases as defined by the Medical Director.

4.9.29 Voluntary family planning services, including surgical sterilization.

4.9.30 Wellness programs when provided through WHP's Welcare department. Employer may purchase programs that are not Covered at an additional fee. Covered programs are limited to:
a. Basic health fair screenings (height, weight and blood pressure).
b. Educational presentations (such as back care, women's health issues, dealing with stress, proper body mechanics).

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SECTION 5. LIMITED SERVICES

Benefits and limits may vary by Employer. Unless stated otherwise in your Benefit Summary or any amendment to this Agreement, the following services are limited.

5.1 **General - Limitations.**

5.1.1 A Member who is Covered at the same time by more than one (1) WHP Agreement is entitled to the maximum limit of the WHP Agreement or valid Rider with the higher benefit.

5.2 **Limited Services.**

5.2.1 Anesthesia and hospital or facility charges are Covered for dental services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nineteen (19) years, persons with serious mental.

5.2.2 Chiropractic Services including office visits, spinal manipulation, electrical stimulation, ultrasound and other physical modalities performed in a Chiropractor's office and x-rays taken and interpreted in a Chiropractor's office. Services must be obtained from a participating Chiropractor and are subject to a maximum annual benefit of $750. Copayment, coinsurance and deductible amounts (if any) as specified in your Benefit Summary apply.

5.2.3 Disposable or consumable medicals and medical equipment and/or supplies (including, but not limited to, sterile disposable supplies, needles and syringes) are excluded unless provided as a part of a skilled nursing visit. Please note: needles and syringes may be Covered under a valid Rider. Lancets and test strips used with glucometers are Covered when received from a Participating Provider.

5.2.4 Hearing aids for children. For coverage of a hearing aid, the hearing loss must be at least 40db in the most affected ear and the hearing loss must have been diagnosed prior to the child's fifth birthday. Coverage shall be limited to $1400 per ear. Replacement of hearing aids every three (3) years when Medically Necessary, for these individuals will be covered until their 18th birthday, if they are still covered under this Certificate. The $1400 per ear limit also applies to replacement.

5.2.5 Occupational and physical therapy services are limited as shown in your Benefit Summary.

5.2.6 Surgical treatment of Morbid Obesity is limited to one (1) surgical procedure per Member per lifetime and must be performed by a Participating Provider and authorized in advance by WHP. Services for and related to surgical treatment of Morbid Obesity will only be Covered if the treated person is a Member and these services are Covered under a valid Rider and your Benefit Summary states that these services are Covered.

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SECTION 6. EXCLUDED SERVICES

Benefits and exclusions may vary by Employer. Unless stated otherwise in your Benefit Summary or any amendment to this Agreement, the services following are excluded.

6.1 **General - Exclusions**.

6.1.1 Services that are not listed as Covered in this Agreement are not Covered and are specifically excluded under this Agreement unless otherwise Covered by a valid Rider to your Benefit Summary stating that this service is Covered.

6.1.2 Services that exceed the limits stated in your Benefit Summary (such as number of days or visits, dollars, year limits, or condition limits) are excluded.

6.1.3 Claims are not eligible for consideration if not filed within ninety (90) days after the date of service. Member is financially responsible for any non-participating Provider claims not submitted to WHP within ninety (90) days from date of service.

6.2 **Excluded Services**.

6.2.1 Abortion services except when failure to treat will jeopardize the life of the mother.

6.2.2 Acupuncture or acupressure.

6.2.3 Administrative charges including but not limited to preparation of insurance forms and reports.

6.2.4 Ambulance services when WHP determines that the Member could be safely moved in another way.

6.2.5 Any type of care, treatment, supplies or equipment for a work-related illness, injury, or condition.

6.2.6 Appearing and testifying in any legal proceeding.

6.2.7 Aquatic therapy.

6.2.8 Autopsies and related services.

6.2.9 Bedside commode, raised toilet seats and tub/shower chairs.

6.2.10 Breast enlargement except as stated in Section 4.9.4.

6.2.11 Community reentry programs that provide services to help a disabled individual restore the functions necessary to reenter community life.

6.2.12 Complications as a result of a non-Covered service.

6.2.13 Cosmetic services.

6.2.14 Custodial Care, Residential Care, or Long-Term Care.

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6.2.15 Dental Services, including but not limited to the treatment of diseases and conditions of the teeth and gums, dental exams, dental-related use of drugs, outpatient visits, surgery, orthognathic surgery, orthodontic surgery, dental prosthesis, dental implants, replacement of teeth with artificial teeth, and removal of wisdom teeth unless Covered by a valid Rider and your Benefit Summary states that these services are Covered.

6.2.16 Dentures and devices to improve communication that do not specifically improve speech are excluded as well as the evaluation or fitting of such items.

6.2.17 Developmental stimulation programs.

6.2.18 Dietary formulas, Medical Food formulas and nutritional supplements, except for the treatment of the following Inherited Metabolic Diseases:

1. Phenylketonuria;
2. Hyperphenylalaninemia;
3. Tyrosinemia (types I, II, and III);
4. Maple syrup urine disease;
5. A-ketoacid dehydrogenase deficiency;
6. Isovaleryl-CoA dehydrogenase deficiency;
7. 3-methylcrotonyl-C[illegible]carboxylase deficiency;
8. 3-methylglutaconic-C[illegible] hydratase deficiency;
9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency);
10. B-ketothiolase deficiency;
11. Homocystinuria;
12. Glutaric aciduria (types I and II);
13. Lysinuric protein intolerance;
14. [illegible] hyperglycinemia;
15. Propionic acidemia;
16. Gyrate atrophy;
17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
18. Carbamoyl phosphate synthestase deficiency;
19. Ornithine carbamoyl transferase deficiency;
20. Citrullinemia;
21. Arginosuccinic acideuria;
22. Methylmalonic academia; and
23. Argininemia.

6.2.19 Directed blood donation services for anyone other than the Member.

6.2.20 Disposable or consumable bandages and medical equipment and/or supplies (including, but not limited to, sterile disposable supplies, needles, and syringes) are excluded unless provided as a part of a skilled nursing visit. Please note: needles and syringes may be Covered under a valid Rider. Lancets and test strips used with glucometers are Covered when received from a Participating Provider.

6.2.21 Donor related services when the Recipient is not a Member.

6.2.22 Driving evaluations.

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6.2.23 Educational and testing services.

6.2.24 Elective Medical Transportation services including, but not limited to, transportation [illegible] or fr[illegible]a Provider.

6.2.25 Emergency services outside the WHP Service Area for:
a. Full-term pregnancy or childbirth resulting from full-term pregnancy.
b. Health care services, the need for which could reasonably have been [illegible]seen prior to [illegible]arture from the WHP Service Area.

6.2.26 Equipment provided mainly for the convenience of the patient, [illegible]his [illegible]ily or for an adaptation to [illegible] home environment.

6.2.27 Equipment that is provided in the absence of a medic[illegible]ondition.

6.2.28 Exercise equipment and exercise programs inclu[illegible]ng e[illegible]ipment of a[illegible]lical nature designed to exercise paralyzed muscles using electrical stimulation and/or pass[illegible] moti[illegible].

6.2.29 Experimental/Investigative services and/or devices. A treatme[illegible]rocedure, drug or device is considered experimental/investigational if it is currently the subject of a Phase[illegible]Phase II o[illegible]hase III trial at any healthcare institution within the U.S. Furthermore, in order to be con[illegible]ered [illegible]gible for coverage, a treatment, procedure, drug or [illegible]ice [illegible]t be endorsed by an authoritativ[illegible]tement from a specialty society, the National Institu[illegible]of [illegible]ealth, the [illegible]ters for Disease Contr[illegible]nd Prevention or the Center for Medicare and Medicaid [illegible]rvices a[illegible]d supported b[illegible]r-reviewed medical literature or consensus expert opinion.

6.2.30 Genetic testing for carrier status.

6.2.31 Hair anal[illegible]erformed for diagn[illegible]is of an underlying medical condition.

6.2.32 He[illegible]services in anti[illegible]pation of or arising [illegible]a lawsuit.

6.2.33 [illegible]ea[illegible]services for i[illegible]sustained while the Member is driving under the influence of alcohol or drugs.
a. Di[illegible]ng shall [illegible]an operation [illegible]elf-propelled motorized vehicle, watercraft or aircraft.
b. Unde[illegible]e i[illegible]uence of alcohol shall mean a documented blood or breath alcohol concentration in excess o[illegible]e legal limit allowed under the laws of the state or other governmental jurisdiction in which the i[illegible]ry occurs.
c. Under the infl[illegible]ce of [illegible]legal drugs shall mean a positive blood or urine test for any drug listed as a [illegible]ntrolled substa[illegible]y the United States Drug Enforcement Administration. This does not apply to a co[illegible]olled substa[illegible]e for which the Member has a valid prescription.

6.2.34 Health s[illegible]vices mandated by a court as a stipulation of parole, probation, sentencing or any other reason. All servi[illegible]s received while incarcerated or in custody of law enforcement.

6.2.35 Home [illegible]fibrillators and portable defibrillators.

6.2.3[illegible] [illegible]me health services that do not require skilled nursing care.

6.2.37 Infertility services unless Covered by a valid Rider and your Benefit Summary states that these services are Covered.

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6.2.38 Maternity/Obstetrical Services and complications of pregnancy and/or childbirth, unless Covered by a valid Rider and your Benefit Summary states that these services are Covered.

6.2.39 Medically unnecessary services according to generally accepted standards of medical practice including but not limited to:
a. Human Chorionic Gonadotropin injections unless Covered by a valid Rider and your Benefit Summary states that these injections are Covered;
b. Behavioral training;
c. Sex change procedures;
d. Prayer or spiritual healing.

6.2.40 Any services delivered at a Residential Treatment Facility.

6.2.41 Military service disability or injury for which the Member is entitled to be treated in a government facility.

6.2.42 Non-Participating Provider services, except as otherwise covered regarding emergency services.

6.2.43 Non-surgical treatment for obesity services, including but not limited to:
a. Participation in a diet program;
b. Participation in an exercise program;
c. Pharmacologic treatment, such as Xenical®.

6.2.44 Oral surgery services unless provided for under Section [illegible] Covered by a valid Rider and your Benefit Summary states that these services are Covered.

6.2.45 Organ and tissue transplants unless Covered by a valid Rider and your Benefit Summary states that these services are Covered.

6.2.46 Orthopedic or custom shoes unless attached to a brace or for diabetic foot deformity. Arch supports, foot orthotics, and heel pads or cups unless the patient has peripheral neuropathy, diabetic foot disease or vascular disease of the foot.

6.2.47 Penile implants including services related to insertion, repair or replacement.

6.2.48 Personal and comfort items.

6.2.49 Prescription drugs except (i) when provided while the Member is an inpatient (ii) and/or provided for by a valid Rider and your Benefit Summary states that these services are Covered.

6.2.50 Private duty nursing.

6.2.51 Rehabilitative services for drug or alcohol abuse except detoxification services, or when required in the treatment of a mental illness, or Covered by a valid Rider and your Benefit Summary states that these services are Covered.

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6.2.52 Repairs, maintenance or replacement of DME, Prosthetics and Orthotic devices, except for changes due to growth of a child. Replacement or repair after four (4) years of use **may be** considered by WHP if due to normal wear and tear.

6.2.53 Respite care for homebound members being cared for by family members.

6.2.54 Routine foot care such as cutting, trimming or removing corns, calluses or the free edge of the toenail except where the patient has peripheral neuropathy, diabetic foot disease or vascular disease of the feet.

6.2.55 Reversal of voluntary sterilization.

6.2.56 Self-help, convenience and/or environmental devices that are not primarily medical in nature or supplies which are common household items including but not limited to hot tubs, vacuum cleaners, humidifiers, folding beds, myoelectric prosthetic devices, blood pressure cuffs (unless used for home dialysis) or lift chairs.

6.2.57 Services performed by a midwife outside of a hospital or ambulatory birthing facility.

6.2.58 Services required for travel, school, employment, licenses, adoption, custody, life or disability insurance, and legal purposes including, but not limited to, exams, immunizations, medications, x-rays and lab tests.

6.2.59 Services to improve athletic performance or accelerate the return to prior levels of performance to compete in organized sporting activities are excluded. This shall include, but not be limited to, programs, therapies, or custom/non-custom devices. These excluded services shall be considered services for personal and/or convenience purposes.

6.2.60 Skin Lesion removal, unless specifically provided for in Section 4.9, is excluded. Lesions include, but are not limited to:

a. Moles;
b. Seborrheic Keratoses;
c. Skin tags;
d. Keloid Scars;
e. Scar revision;
f. Tattoo Removal;
g. Vitiligo (including PUVA treatment and medications);
h. Hemangiomas, Angiomas, Telangiectasias;
i. Xanthelasma;
j. Lichenform lesions;
k. Spider veins;
l. Other lesions of the skin.

6.2.61 Surgery to remove excess tissue/skin due to weight loss or obesity.

6.2.62 Transportation to or from a Provider's office by any means including but not limited to ambulance or wheelchair transport.

6.2.63 Travel expenses related to services received under this Agreement, except for those services Covered by a valid Transplant Rider, if applicable.

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6.2.64 Treatment for hair loss or baldness unless an underlying systemic disease such as lupus or thyroid disease is present. Wigs, hairpieces, or scalp prostheses are not covered for any reason.

6.2.65 Vagal stimulator implant for depression and related services.

6.2.66 Vision services, refractive surgery, eye refractions, eye exercises; eyeglasses or contact lenses (except the first pair of eyeglasses or contact lenses following cataract surgery. Please refer to Section 4.9); other eye appliances; or low vision aids and the replacement or fitting of such items are excluded unless Covered by a valid Rider and your Benefit Summary states that these services are Covered.

6.2.67 Vocational rehabilitation that is the process used by individuals with disabilities to obtain or regain skills necessary to pursue a trade or career.

6.2.68 Wellness programs not specifically stated as Covered in Section 4.9.

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SECTION 7. PAYMENTS

7.1 **Premium Payment Schedule**. The premium payment schedule for the initial term of this Agreement is listed in Exhibit 4 (available to Employer only).

7.2 **Copayments, Coinsurance and Deductibles**. All Copayments, Coinsurance and Deductibles required in your Benefit Summary must be paid at the time services are received. A Member must identify the Provider that he is a Member. The Provider may collect at the time of service all applicable Copayments and may also, at its option, collect any applicable Coinsurance owed. All billings from Providers for Copayments, Coinsurance and Deductibles are due upon receipt. WHP and the Provider reserve the right to fine late charges for delinquent Copayments, Coinsurance or Deductibles. If the Copayment, Coinsurance or Deductible amount is not paid within thirty-one (31) days of billing, WHP may, at its discretion, disenroll the Member upon fifteen (15) days prior written notice to the Employer and the Member.

7.3 **Charge for Missed Appointments**. If a Member fails to appear for a scheduled appointment for health services provided pursuant under this Agreement, WHP has the right to authorize the Provider to charge the Member an amount not to exceed the usual, customary and reasonable charges for the rescheduled appointments.

7.4 **Charge for Non-Referred Care and Non-Authorized Care**. Except as otherwise provided in Section 4 of this Agreement, any health services received from a Provider that were not provided by or on the order of the Member's PCP or pursuant to an authorized Referral are not Covered under this Agreement and will be billed directly to the Member by the Provider.

7.5 **Payment for Services Rendered to Non-Members**. If a non-Member uses the ID card of a Member to fraudulently obtain health services, the Member whose ID card was used will be required to pay the usual, customary, and reasonable charges and fees for the services provided to the non-Member. The Member also will be subject to disenrollment unless WHP was notified that the Member's ID card was lost or stolen prior to the fraudulent use of the card.

7.6 **Non-Payment of Premiums by Employer**. WHP may end this Agreement if the Employer fails to timely pay premiums to WHP. Members will be responsible for all fees and charges for services received during any period for which premium payment has not been received.

7.7 **Direct Billing with an Employee/Member**. WHP may upon mutual agreement with the Employer, enter into a direct billing arrangement with an employee/Member. If so, the employee/Member must pay all required premiums on or before the first day of each month. If premiums are not paid within thirty-one (31) days of the due date, WHP may end the Member's coverage retroactively to the date the premium was due. The Member will be responsible for all fees and charges for services received during any period for which premium payment has not been received.

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SECTION 8. MEDICAL MANAGEMENT

8.1 **General.** In order to be Covered under this Agreement and any applicable Riders, all health services and items must be provided directly by the Member's PCP, as Emergency care, or through an approved Referral.

The WHP Utilization Management Program (UMP) establishes the procedures for obtaining a Referral for health care services and items. Emergency services may be provided without a Referral. Emergency admissions will be subject to review and possible post-service denial of coverage. The UMP specifies procedures for obtaining approval of health care services. This includes procedures relating to: Referrals, Prior Authorization, Concurrent Review, Discharge Planning and Case Management. It is the responsibility of the PCP seeking the Referral to follow the procedures of the UMP. Failure to follow UMP procedures may result in WHP's denial of coverage for a health service or item. The procedures outlined in this Agreement are for general information purposes. The PCP should contact WHP for specific information and requirements.

The Medical Director may give his authority to approve a request for coverage to the Health Services Department (HSD) of WHP. A Referral will be approved only when the health service or item requested is determined to be Medically Necessary and signifies Appropriate Care. An Approved Referral will be confirmed verbally or by issuing a number or letter to the requesting PCP.

If the Medical Director decides that the Referral is not Medically Necessary or not Appropriate Care, the request will be denied. This denial is for benefit payment purposes. Only the Medical Director may deny a request. The HSD will notify the requesting PCP and the Member of the denial in writing or electronically. The PCP or Member may appeal the denial. The procedure for appeal is in Section 15.

An Approved Referral only shows that the HSD has found the requested health service or item is Medically Necessary and signifies Appropriate Care. An Approved Referral does not guarantee that WHP will Cover the requested health service or item because of other provisions in this Agreement. Exhibits, Eligibility, Exclusions and Limitations, Coordination of Benefits, the Benefit Summary and any applicable Riders also control whether a requested health service or item will be Covered. Approved Referrals are valid for the time stated on the Approved Referral, until the end of the contract year or loss of eligibility, whichever occurs first, and are subject to benefit limits as stated in your Benefit Summary.

8.2 **Prior Authorization** is the process that determines whether a health service or item requested by the PCP is Medically Necessary and signifies Appropriate Care. The PCP should submit the request for decision at least two (2) days prior to the anticipated date of service. A decision on routine requests will be within two (2) days of receipt of all necessary clinical information. Urgent and emergency requests will be acted upon within one (1) day of receipt of all necessary clinical information.

8.3 **Concurrent Review** is the screening process used by the HSD to assess the need for inpatient admission or continued inpatient care. Inpatient care is defined as an admission to a Hospital, Skilled Nursing Facility, or Rehabilitation Facility. The HSD will review all admissions within one (1) business day of notification. HSD will report its decision within one (1) business day.

8.4 **Discharge Planning** consists of processes initiated by the HSD to identify possible post-Hospital home care needs. This may occur at any time from the Referral approval to the Concurrent Review process.

8.5 **Case Management** is a program designed to assist and coordinate care of patients with catastrophic illnesses or injuries. The goal is to enhance the Member's quality of life and promote cost effective use of his medical

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benefits. The program informs Members and Physicians of the Member's benefits and possible treatment options. The HSD also arranges and coordinates needed services fostering a Member's independence.

8.6 **Claims and Appeal Process**. If a Prior Authorization request is denied, the PCP, Member, his representative, may seek review of the request pursuant to the procedures described in Section 15 of this Agreement.

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SECTION 9. GENERAL PROVISIONS

9.1 **Gender**. The use of the masculine gender in this Agreement is for the convenience of the par[illegible] and [illegible]here necessary for comprehension, may be replaced by the feminine article.

9.2 **Headings and Titles**. The headings and titles in this Agreement are for convenience [illegible] refer[illegible]ce only and shall not be interpreted to define or limit any of the terms herein or affect the meanings [illegible]interpreta[illegible]s of this Agreement.

9.3 **Parts Not Valid**. If any part of this Agreement, your Benefit Summary, [illegible]lid Riders [illegible]ttached to this Agreement cannot be enforced, then the rest shall still be in effect unl[illegible] the [illegible]igations of the parties are materially changed.

9.4 **Entire Agreement**. There are no other promises, terms, con[illegible]ons, or obligations outside of this Agreen[illegible]t and those documents that are a part of this Agreement.

Only an officer of WHP may:
a. Change this Agreement.
b. Waive any provisions of this Agreement.
c. Extend the time for making payments.
d. Waive any of WHP's rights or requir[illegible]ents.

No change in this Agreement will h[illegible]val[illegible]unless it [illegible]pported by an endorse[illegible]nt or amendment signed by an officer of WHP and specifically [illegible]reed to [illegible]writing by th[illegible]nployer.

9.5 **No Assignment**. A Member or Employer ma[illegible]not ass[illegible]n or transfer [illegible] benefits or the right to receive benefits under this Agreement.

9.6 **Adding New Me[illegible]ers.** [illegible]group originally in[illegible]red may add, from time to time, new Eligible Employees or Dependents of [illegible]embers, as th[illegible]case may be, in ac[illegible]rdan[illegible]with the terms of the Agreement.

9.7 **No Wai[illegible]**. If WHP fails to[illegible]ave a Member follo[illegible]e terms or conditions of the Agreement, it does not mean that th[illegible]Me[illegible]r will not ha[illegible]ly in the f[illegible]ure. WHP is not bound by any coverage that was given in error at a prior time.

9.8 **Delay of Service.** W[illegible]P is not responsible for delays in providing services caused by events that are beyond W[illegible]ontrol, such as, [illegible]ar, riot, terrorist activities, weather, ruined facilities, disabled Providers, major disasters or epidem[illegible]

9.9 **Administratio[illegible]f Agreem[illegible]**. WHP may adopt such policies, procedures, rules, regulations, and interpretations as it deems nece[illegible]ary to promote orderly and efficient administration of this Agreement and the benefits hereunder. Adop[illegible]on of such policies, procedures, rules, regulations, and interpretations are part of the routine administration o[illegible]ealth services and will not require consents from the Employer or Members. WHP retains the right to subcont[illegible]t the administration of this Agreement to a related or unrelated third party.

9.10 **Be[illegible]fit Sr[illegible]mary**. The insurer will furnish to the Agreement holder, for delivery to each employee or Member of the [illegible]red group a statement in summary form of the essential features of the insurance Coverage of such empl[illegible]ee or Member and to whom benefits there under are payable. If Dependents are included in the Coverage, only one (1) statement need be issued for each family unit.

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9.11 **Claims Processing.** To process claims, WHP uses the processing standards approved by the Am[illegible]an Medical Association, including but not limited to CPT coding, HCPCS and Hospital revenue codes.

9.12 **Payment of Claims.** The Member must provide to WHP any information reasonably re[illegible]ted by WHP, and cooperate with WHP in the investigation of the Member's claim(s). Failure of a Mem[illegible]r to [illegible]perate in the investigation of a claim will lead to delay or denial of such claim(s). WHP shall r[illegible]n the righ[illegible] deny any claim not resolved (regardless of cause) within one year from date of service. Claim w[illegible]become Memb[illegible]s responsibility.

9.13 **Relationships Among Parties Affected by this Agreement.**

9.13.1 WHP and the Members.

a. WHP and the Members are independent parties t[illegible]ch other and will not be considered agen[illegible] representatives, or employees of each other fo[illegible] purpose wh[illegible]ever.

b. By receiving benefits under this Agreement, [illegible]e M[illegible]ber accept[illegible] Agreement. This means that all terms and rules of this Agreement are binding on the [illegible]mbe[illegible]. The Member agrees to observe and obey all the rules of WHP as they are written in this agre[illegible]nt and all other WHP-initiated communications.

9.13.2 Participating Providers. WHP h[illegible]reated a network of Participating [illegible]vid[illegible]. The relationship between WHP and the Participating Pr[illegible]ders [illegible]contractual relationship betwe[illegible]ndependent contractors. Participating Providers hav[illegible]on[illegible]lete contr[illegible]er the manner in whic[illegible]ney provide services, the time that services are perform[illegible], and t[illegible]method(s) use[illegible]perform the services. No Participating Provider is an employee of WHP nor is WHP a[illegible]employee o[illegible]gent [illegible]y P[illegible]ticipating Provider. Participating Providers will maintain the Provider-[illegible]tient r[illegible]ionship with[illegible] intervention from WHP. Participating Providers will be solely responsible fo[illegible]all[illegible]dical advice[illegible]and treatment of Members for the performance of health services within t[illegible]WHP Service Area. WHP will not be liable for the negligent or intentiona[illegible]nten[illegible]al acts or omissio[illegible]of Providers or their agents or employees. Nothing listed in this A[illegible]ement will b[illegible]nterpreted to requ[illegible]WHP or any Provider to recommend or carry-out any pro[illegible]ure or course o[illegible]reatment that it dee[illegible]dically unacceptable. WHP reserves the right to make c[illegible]nges to its networ[illegible]of Participating Prov[illegible]rs. Participating Providers for WHP may change from time to t[illegible] WHP does[illegible]t guarantee the leng[illegible]of time any Participating Provider will stay in the network. Specia[illegible]ircumsta[illegible]es may be ide[illegible]by a treating provider, who is no longer participating in the network, [illegible]y request, with the agreement of the Member or authorized person, that the Member be permitted to [illegible]ntinue treatment under this provider's care unless the provider has been terminated for a [illegible]eason related t[illegible]uality.

9.14 **Medical Re[illegible]ds and Confi[illegible]ality.** By enrolling in WHP, the Member agrees to make available to WHP, its agents and rep[illegible]entatives, a[illegible]of the Member's medical records, whether a Participating Provider or a Non-Participating Pr[illegible]der keeps such records. Where necessary, the Member agrees to execute any release or authorization for[illegible]s necessary for release of medical records to WHP. However, the Subscriber's signature on the WHP enrollment[illegible]orm shall serve as proof of the Member's authorization to release medical records to WHP as permitted by law. WHP will hold confidential all information contained in Member's medical records. Member's [illegible]nfidential i[illegible]rmation will not be released without the Member's or his representative's authorization, except fo[illegible]

a. [illegible]ent – The provision and coordination by WHP of health care services provided by a Physician, H[illegible]pital or Health Care Professional.

b. Payment – The activities used by WHP to collect premiums and pay claims under WHP for health care services received by the Members.
c. Operations – The basic business functions necessary to operate WHP, such as quality assessment studies, case and disease management services, legal, actuarial and auditing services and for the resolution of Complaints and Grievances.
d. Other uses or disclosures required and authorized by Federal and State law.

9.15 **Privacy Notice**. WHP maintains compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and 164). WHP will store, transmit and communicate protected health information in a way that protects the privacy of individually identifiable health data as required under applicable Federal and State law.

The confidentiality of Member specific data shall be maintained and shall not be released to individuals or entities, unless for treatment, payment and operations as allowed by law as stated in WHP's Notice of Privacy Practices (please refer to Section 18 in this Agreement).

When an Employer or its representative seeks specific confidential information, such information will be released by WHP only after the receipt of written authorization from the Member or Dependents.

9.16 **Non-Discrimination**. No eligible Subscriber or eligible Dependent will be denied membership or benefits based on gender, race, creed, color, religion, handicap status, or national origin, or any other status protected by State or Federal law.

9.17 **Fraud and Abuse**. Fraud increases the cost of health care for everyone. If you suspect that a Physician, pharmacy or Hospital has charged you for services you did not receive, billed you twice for the same service or misrepresented any information, please do the following:
a. Call the Provider and ask for an explanation. There may be an error.
b. If the Provider does not resolve the matter, please notify WHP's Customer Services department at (812) 426-6600 or (800) [illegible] and explain the situation. For the hearing impaired, please call the toll-free Indiana Relay number at (800) 743-3333.
c. If the issue is not resolved you may contact the National Insurance Crime Bureau at (800) 835-6422.

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SECTION 10. TERMINATION

10.1 **Termination (Ending) of Member Benefits and Services**. All rights to benefits and services end on the date of Member termination unless the Member has been covered by the group Agreement, or a group Agreement it replaced for at least three (3) months; and the Member gave notice to WHP of its desire to maintain coverage and has made payment within thirty-one (31) days after notice to maintain coverage has been given. Upon group coverage termination, WHP will promptly provide written notice clearly explaining the notice of cancellation of the Group coverage as well as the Member's right to available conversion or continuation policies. Upon termination, Members will receive a Certificate of Prior Employer Health Plan Coverage. WHP membership may be ended for any of the reasons below:

a. Failure of Employer to pay the WHP premium for a Member. This Agreement can be terminated by WHP if the Employer fails to pay premiums for a Member within the applicable grace period. If so terminated, benefits and services will end at the end of the last prepaid period.

b. Termination of Membership in Association. If Coverage is provided through an Association, this Agreement can be terminated by WHP if the membership of the Subscriber or the employer in the Association ceases for any reason.

c. Death of Subscriber. If the Subscriber dies, benefits and services to Dependent(s) shall end at the conclusion of the current month of which a premium has been paid. The Dependent(s) may have the right to Conversion or Continuation of Coverage as described in Section 11 of this Agreement.

d. Loss of Eligibility. If a Member is no longer eligible for coverage, all benefits and services shall end at midnight on the date of ineligibility.

e. Loss of student child eligibility. Student Child coverage ends in agreement with the provisions of Section 2.2. If benefits are provided after coverage stops, the Subscriber and the Dependent must pay back to WHP an amount equal to the claims paid by WHP for the Dependent and the costs of collection and reasonable legal fees. The Student Child may be eligible for Continuation of Coverage and Conversion rights as described in Section 11 of this Agreement.

f. Failure by Subscriber/Member to pay a required Copayment. The Member is expected to pay all Copayments, Coinsurance, Deductibles and bills for unauthorized or non-Covered services. If the Member fails to make these payments, WHP or a Provider will notify the Member in writing of the failure. WHP will send Member a termination notice if payment is not made within thirty-one (31) days of the failure to pay notice. Coverage for the Member will end at midnight on the last day of the month in which the thirty-one (31) day period expires. A copy of the failure to pay notice will be given to the Employer at this same time.

g. Member wishes to end coverage under the Agreement for any reason. The Employer must properly notify WHP that a Member has elected to end coverage.

h. Lack of satisfactory Physician/patient relationship. If, after reasonable efforts, a Participating Provider is unable to establish or maintain a satisfactory Physician-patient relationship, WHP will send notice of termination. Coverage will end at midnight thirty-one (31) days after written notice of such termination. The ending of coverage may also occur if a Member displays any of the following behaviors toward a Provider or his staff:

   i. Abusive behavior.
   ii. Threatening behavior.
   iii. Disruptive behavior.
   iv. The Member repeatedly refuses to accept a procedure or follow treatment recommended by a Participating Provider.
   v. The Member attempts to secure services in a manner that damages the ability of the Provider to coordinate the Member's care.
   vi. The Member repeatedly makes but fails to keep appointments for health services.

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i. Fraud or intentional misrepresentation. If the Subscriber, Member, or his representative engages in fraudulent conduct relating to an application for Coverage under this Agreement, obtaining services, or filing a claim for benefits, Coverage terminates on the date of the fraudulent conduct.

j. Misuse of ID card. If a Member knowingly permits the use of his or any other Member's ID card by any other person, uses another person's ID card, or defaces the ID card in order to obtain services or a higher level of benefits, WHP may end the Member's coverage upon thirty-one (31) days written notice. The Subscriber shall be liable to WHP for all costs incurred as a result of the misuse of the ID card except when the Member is unaware of the misuse (e.g., a lost or stolen ID card).

k. Failure to cooperate with coordination of benefits or subrogation. If a Member fails to cooperate with WHP's administration of the coordination of benefits as outlined in Section 12 of this Agreement or with WHP's rights to subrogation or reimbursement under Section 12 of this Agreement, the Member's coverage may be ended. Termination may be retroactive to the service date of the claim in question.

l. The Agreement is terminated. If the Agreement is ended by WHP for any reason, the Member's coverage under this Agreement will end as of midnight on the date the Agreement is terminated.

m. The Agreement is terminated if the Subscriber or Member or his representative knowingly misrepresents himself in order to obtain medical services or Coverage under the terms of this Agreement.

10.2 **Member in the Hospital**. If this Agreement is ended by WHP, an extension of benefits is provided for:

a. Hospital confinement until the earlier of one (1) of the following:
   1. Discharge from the hospital confinement or transfer to a lower level of care (i.e., Skilled Nursing, Rehabilitation or Long Term Acute Care).
   2. Until maximum benefits under the Agreement are received; or
   3. At least twelve (12) months.

b. A period of total disability until the earlier of one (1) of the following:
   1. Until coverage for the total disability has been obtained under another group Agreement.
   2. Until the total disability ceases;
   3. Until maximum benefits under the Agreement are received.
   4. At least twelve (12) months.

10.3 **Reinstatement**. WHP may, at its sole discretion, reinstate benefits and services for a Member terminated pursuant to any provision in this Section. To be reinstated, the Member must apply on forms specified by WHP.

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SECTION 11. CONVERSION or CONTINUATION OF COVERAGE

11.1 **COBRA**. A Subscriber and/or the Subscriber's Covered Dependent(s) who lose coverage due to a "qualifying event" may qualify for continuation of Employer coverage under COBRA. This continuation of coverage generally does not apply to employers of less than twenty (20) Eligible Employees. COBRA is an Employer-administered program. The Employer is responsible for administering COBRA (including, but not limited to, distribution of any initial COBRA rights information and election forms). This explanation is a summary of a Member's continuation of coverage rights under COBRA. It is important to note that the Internal Revenue Service may change or amend COBRA rules from time-to-time. Members must contact their Employer about COBRA benefits.

a. Only qualified beneficiaries may elect continuation of coverage. For this purpose, a qualified beneficiary is a person who is Covered through WHP on the day before a qualifying event and is:
   i. A Subscriber.
   ii. A Covered Dependent of a Subscriber (including a child born to or placed for adoption with the Subscriber while the Subscriber is Covered under COBRA continuation of coverage).

   A domestic partner and partner's Dependent are not considered qualified beneficiaries and are not eligible for COBRA coverage.

b. Qualifying events for continuation of coverage include only:
   i. An end of employment of the Subscriber for any reason other than gross misconduct.
   ii. Reduction in the hours worked by the Subscriber that would result in loss of coverage through WHP.
   iii. Death of the Subscriber.
   iv. Divorce or legal separation of the Subscriber from the Subscriber's spouse.
   v. A Covered Dependent reaching the Limiting Age or becoming married.
   vi. The Subscriber becoming eligible for Medicare, making the Dependents eligible for COBRA.

c. In order to obtain COBRA coverage under this Agreement, the Employer must:
   i. Notify all Members of their right to continuation of Employer coverage as required by Federal law.
   ii. Notify WHP as soon as possible and within the standardized timeline established by COBRA regulations when a Member elects to continue coverage. The notice must also state the date the Member's COBRA coverage becomes effective; and
   iii. Collect and forward applicable premiums to WHP on a timely basis.

d. Continuation of coverage under COBRA will be terminated when:
   i. The maximum available period of continuation of coverage has been reached.
   ii. The qualified beneficiary fails to make timely premium payment.
   iii. The qualified beneficiary becomes Covered by another Employer health plan after the date of COBRA election (unless the new plan has exclusions or limitations that apply to preexisting conditions of the qualified beneficiary.
   iv. The qualified beneficiary becomes Covered by Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395- through ggg).
   v. The qualified beneficiary becomes entitled to Medicare (Part A or B) after the date of the COBRA election.
   vi. The Employer ceases to provide any Employer health plan to any Employee.
   vii. The qualified beneficiary ceases to be disabled according the Social Security Administration after the eleven (11) month disability extension has begun.

   Members may elect COBRA coverage by completing an election form supplied by the Employer. This election form must be completed within sixty (60) days from the later of (i) the date the qualified beneficiary's coverage would ordinarily have terminated or (ii) the date the qualified beneficiary is notified of their right to elect the continuation of coverage. Except as otherwise specified, the election by a Subscriber or a spouse

includes an election on behalf of any other qualified beneficiary who would also lose coverage under this Agreement as a result of that particular qualifying event.

f. The Employer may require the qualified beneficiary who elects continuation coverage to pay one hundred and two (102) percent of the premium. Upon election of the continuation of coverage, the qualified beneficiary will have forty-five (45) days from the date of election to pay the premiums for the period between the date the coverage would have been terminated under the Agreement and date of election. Claims during the elective period do not have to be paid until COBRA continuation coverage is elected and any required premium payment is made.

g. Disability extension of eleven (11) months is available after an eighteen (18) month qualifying event when the disability is effective, according to Social Security determination, prior to or within the first sixty (60) days of COBRA coverage. WHP must receive written notice of the Social Security determination within sixty (60) days of issue and prior to the end of the initial eighteen (18) months of COBRA coverage. This extension may not result in more than twenty-nine (29) months of total COBRA eligibility.

h. WHP is permitted to require the payment of any amount that does not exceed one hundred and fifty (150) percent of the applicable premium for any period of COBRA continuation coverage for a disabled qualified beneficiary, whether single or family coverage, if the coverage would not be required to be made available in the absence of a disability extension.

i. WHP will not impose more than one (1) rate increase during any five (12) month period for COBRA continuation coverage.

11.2 **Small Employer Conversion**. This Section applies to Employers with fifty (50) or less employees. Subscribers who are eligible for COBRA coverage must apply for that benefit.

a. Members are eligible for Small Employer conversion if:

i. They were continuous Covered under this Agreement for at least ninety (90) days.

aa. They request the conversion policy from WHP within thirty-one (31) days after loss of coverage.

ii. They cease to be Covered under the Agreement as a result of:

aa. The end of employment of the Subscriber for any reason other than gross misconduct.

bb. Reduction in the hours worked by the Subscriber that would result in a loss of coverage through the Employer.

cc. Death of the Subscriber.

dd. Divorce or legal separation of the Subscriber from the Subscriber's spouse.

ee. A Covered Dependent reaches the limiting age or becomes married.

ff. The Subscriber becomes eligible for Medicare, which allows the Covered Dependents to be eligible for Small Employer conversion privileges.

b. The Subscriber will not be required to furnish evidence of insurability. This conversion will be without regard to health status or requirements for health services. Conversion is not available if the loss of coverage is the result of the termination of this Agreement.

c. If a Member eligible for conversion under this Section elects to exercise his conversion rights, such conversion shall be effective retroactive to the date coverage was terminated, subject to the payment of any applicable enrollment fees or premiums due for the thirty-one (31) day notice period.

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SECTION 12. SUBROGATION AND REIMBURSEMENT

12.1 **General**. If a Member or Dependent's injury or illness is caused by the acts or omissions of another party and WHP has paid expenses for such injury or illness, WHP will have the right to be reimbursed when the Member receives any payment from the other party. WHP is subrogated to all of the Member's rights against any party legally liable to pay for the Member's injury or illness. This right includes but is not limited to liability insurers of the other person and insurers covering the Member through: uninsured automobile coverage, underinsured automobile coverage, medical pay coverage under homeowner's insurance and automobile insurance policies, medical benefits coverage of an Employer, Employer-type and individual "no-fault" and traditional automobile "fault" agreements, and workers compensation recoveries. WHP may decline this right independently of the Member.

12.2 **Expenses**. When used in this section the term Expenses means the costs of all medical, surgical and hospital care furnished to the Member and provided, arranged or paid by WHP, figured on the basis of the usual, customary and reasonable fees charged by health care providers of such services. When medical expenses acquired by WHP have been subject to contractual discounts or capitation agreements, WHP shall be entitled to reimbursement based on the usual and customary fees charged by health care providers of such services, without regard to contractual discounts or capitation agreements.

12.3 **Cooperation**. The Member or anyone acting legally on his behalf must:

a. Fully cooperate with WHP in order to protect WHP's subrogation rights.
b. Give notice of WHP's claim to third parties and their insurers who may be legally responsible.
c. Provide WHP with relevant information, sign, and deliver such documents as WHP reasonably requests to secure WHP's subrogation claims.
d. Obtain WHP's consent before releasing any party from liability for medical expenses or services paid or provided.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice, in any way, WHP's subrogation rights.

12.4 **Reimbursement of WHP**.

12.4.1 When Member receives payment from a third party as described in Section 12.1, Member agrees to hold those funds received for WHP. The Member will pay WHP from any funds received from another party by settlement, judgment, or otherwise, up to the amount of benefits provided by WHP in connection with the loss. Where there is a judgment in favor of the Member and the amount of the recovery is reduced due to fault on the part of the Member, there will be a pro-rata reduction in the amount WHP is to be paid. In such event, the amount WHP is to be paid will equal:

a. The total benefits provided by WHP for the loss.
b. The total benefits provided by WHP for the loss multiplied by the percent that the Member's recovery was reduced due to the Member's fault.

12.4.2 WHP shall have a lien on all funds the Member receives in connection with the loss. This will be in the amount of the benefits given by WHP to the Member.

12.4.3 WHP may give notice of its lien to any person or organization that is legally responsible for the loss and/or any person or organization that may be required to make payment to or for the Member in connection with the loss.

12.4.4 WHP may sue a third-party on behalf of the Member.

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SECTION 13. COORDINATION OF BENEFITS

13.1 **General**. Coordination of benefits (COB) applies when the Member also has health care coverage from Another Plan (defined in Section 13.2). Members should refer first to the rules for order of benefits of the other plan to learn if WHP's benefits are determined before or after those of the other plan. Under the order of benefit rules, WHP benefits are not reduced when WHP determines its benefits before the other plan. WHP benefits may be reduced when, under the order of benefit rules, the other plan determines its benefits first.

13.2 **Definition of Another Plan**. "Another Plan" means any of those on the list below that provide benefits or services for medical, pharmacy, or dental care treatment:

a. Employer insurance or employer coverage, whether insured or self-insured or self-funded. This includes prepayment, employer practice or individual practice coverage and coverage other than school accident-type coverage.
b. Coverage under a government plan or coverage required or provided by law. This does not include a state Medicaid plan or any governmental plan that, by law, provides benefits in excess of any private or non-governmental insurance plan.
c. The medical benefits coverage in group, group-type and individual automobile fault and "no-fault" agreements, and premises medical expense coverage.

Each agreement or other arrangement for coverage under item (a) or (b) above is "Another Plan." If an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2) parts, each of the parts is Another Plan.

13.3 **Primary or Secondary**. The order of benefit determination rules state if WHP is primary or secondary.

13.3.1 When WHP is primary, benefits are determined before those of Another Plan. The benefits of the other plan are not considered.

13.3.2 When WHP is secondary, the benefits may be reduced. WHP may recover from the primary plan, a reasonable cash value for the services provided by WHP.

When more than two (2) plans cover the Member, WHP may be primary as to one (1) or more other plans, and may be secondary as to one (1) or more of the other plans.

13.4 **Eligible Charges**. "Eligible Charges" apply when the cost of the item is Covered at least in part by one (1) or more of the plans that cover the Member. Notwithstanding the foregoing, in a coordination of benefits situation where WHP is the secondary plan, Eligible Charges will not include charges or expenses for health care services which are not Covered Services under this Agreement.

13.4.1 WHP will not cover any charges in excess of what an HMO or network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network Provider, WHP will not consider as an allowable charge any charge that would have been Covered by the HMO or network plan had the Covered Person used the services of an HMO or network Provider.

13.5 **Cash Value of Services**. When a plan provides benefits as services, the fair cash value of each service given will be treated as if an Eligible Charge and a benefit paid or payment made.

13.5.1 A secondary plan that provides benefits as services may recover the fair cash value of services from the primary plan to the extent that benefits for the services are Covered by the primary plan and were not

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already paid or provided by the primary plan. Nothing in this Section shall be interpreted to have WHP pay the Member in cash for the value of services provided by Another Plan that provides benefits as services.

13.6 **Claim Determination Period**. The "claim determination period" is twelve (12) months from the date of service. However, it does not include a part of a year when a person does not have coverage under WHP.

13.7 **Order of Benefit Determination Rules.**

13.7.1 General. When there is a claim under both WHP and Another Plan, WHP is secondary. Its benefits are decided after those of the other plan. The other plan may have rules that require that WHP coordinate its benefits first. In this case, it will be done in that order.

13.7.2 Rules. WHP decides the order of benefits using the first of the following rules to apply:

a. Subscriber. The plan that covers the person as a subscriber (that is, other than as a Dependent) is determined before those of the plan that covers the person as a Dependent. If the person is a Medicare beneficiary, under Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   i. Secondary to the plan covering the person as a Dependent.
   ii. Primary to the plan covering the person (e.g., a retired employee).

b. Dependent child of parents not separated. When WHP and Another Plan cover the same child as a Dependent of different persons ("Parents") who are (i) married, not separated (whether or not they have ever been married); or a court decree gives joint custody without specifications as to which Parent has the responsibility to provide health care coverage:
   i. The plan of the Parent whose birthday falls earlier in a year is determined before those of the plan of the Parent whose birthday falls later in that year.
   ii. If both Parents have the same birthday, the benefits of the WHP that Covered the Parent longer are determined before those that Covered the Parent for a shorter time.
   iii. If the other plan does not have the rule described in item (ii), but instead has a rule based upon the sex of the Parent, and if, as a result, WHP does not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. Dependent child of not married, separated or divorced parents. If two (2) or more plans Cover a Dependent child of not married, divorced or separated Parents, benefits for the child are made in this order:
   i. First, the Parent with custody of the child.
   ii. The current spouse of the Parent with custody of the child.
   iii. The Parent who does not have custody of the child (the other parent shall be secondary).
   iv. The current spouse of the Parent without custody.
   v. If the terms of a court decree state that one (1) of the separated or divorced Parents must take care of the health coverage or medical expenses of the child, and that Parent has actual knowledge of those terms, the benefits of that plan are primary. This does not apply with respect to any claim determination period or contract year in which any benefits are paid or given before the entity has that actual knowledge.

d. Active versus inactive employees. The plan that covers a person as an employee who is neither laid-off nor retired (or is that employee's Dependent) are determined before a plan that covers that person as a laid-off or retired employee or that employee's Dependent (this does not apply if the other plan does not have this rule, and if, as a result, WHP does not agree on the order of benefits).

Length of time Covered. If the rules above do not decide the order of benefits, they shall be as follows:

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i. The plan that has Covered the Subscriber for the longest time is used before the benefits of the plan that Covered the person for the shorter time.
ii. Two (2) consecutive plans are treated as one (1) plan if the person who makes the claim was eligible under the second plan within twenty-four (24) hours after the termination of the first plan.
iii. The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in who provides plan benefits. It does not include a change from one (1) type of plan to another (such as from employer to individual coverage).

13.8 **WHP's Right to Receive and Release Information**. Certain information is needed to apply COB rules. WHP shall decide that information it needs from Members. WHP may obtain that information it needs or may release it to any other insurance carrier for COB purposes. Each person claiming benefits under this Agreement must provide WHP with any facts it needs to apply the rules and determine benefits.

13.9 **Facility of Payment**. When Another Plan pays a claim that should have been paid by WHP, WHP may pay that amount to the organization that made the payment. The amount may be treated as if it were a benefit paid by WHP. WHP will not have to pay that amount again.

13.10 **WHP's Right to Recovery**. If the amount paid by WHP exceeds what should have been paid under this COB provision, it may recover the excess money from:
a. The person to whom it was paid.
b. The insurer.
c. Other organization(s).

13.11 **WHP Makes Whole When Secondary**. WHP conducts COB on a "make whole" basis. This means that when WHP is secondary, it determines what it would have paid if it had been primary. It pays up to that amount toward the balance due after the primary plan is paid. This COB avoids double coverage. At times, this decreases the benefits available under this Agreement. When WHP benefits are reduced as stated above, each benefit is reduced in proportion. It is then charged against any benefit limit of WHP that applies.

13.12 **Excess Coverage**. Services, supplies or other care for injury or sickness for which there is non-group insurance (except individual health insurance policies) providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to this Agreement. If benefits subject to this provision are paid, WHP shall exercise its rights of subrogation or reimbursement as provided in Section 12.

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SECTION 14. WORKER'S COMPENSATION AND EMPLOYER LIABILITY LAWS

WHP provides benefits for care, treatment, supplies, and equipment for an illness, injury, or condition that is job-related, only if the Member is not required to be enrolled in Indiana's Worker's Compensation (or a similar state or federal program), and provided such care, treatment, supplies and equipment is or are otherwise Covered under this Agreement. If the Member is covered by Worker's Compensation, and the Member files a claim with WHP that WHP determines is for a work-related illness, injury or condition, the claim will be denied by WHP and the Member is required to file a claim with Worker's Compensation. If Worker's Compensation denies the claim as not being work-related, WHP will pay benefits under this Agreement, if benefits would otherwise be covered under this Agreement. If WHP, in its sole judgment determines, following the initial denial of the claim by Worker's Compensation, that notwithstanding the denial, the claim is work-related, the Member is required to appeal the initial denial of the claim by Worker's Compensation. If Worker's Compensation pays the claim upon appeal, WHP has the right to reimbursement for the payments WHP made.

It is the Member's responsibility to file claims, fill out forms and provide all necessary information and cooperation required to secure Worker's Compensation benefits. It is the Member's responsibility to file an appeal of the initial Worker's Compensation. WHP benefits will not be paid if the Member is required to be covered by Worker's Compensation but is not, chooses not to file a claim with Worker's Compensation or fails to appeal an initial denial by Worker's Compensation. If WHP has paid a claim that in WHP's sole discretion is for a work-related illness, injury, or condition, and the Member does not file a claim with Worker's Compensation or appeal an initial denial by Worker's Compensation, the Member will be liable to WHP for the payments made by WHP towards the claim. If a Member receives an award from Worker's Compensation or agrees to settle a claim for permanent total or partial disability for a claim that can be settled under Worker's Compensation, the Member is responsible to pay for future medical and diagnostic services and medical equipment for or relating to the injury or condition that caused the disability.

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SECTION 15. CLAIM, APPEAL AND GRIEVANCE PROCEDURES

15.1 **What is a Claim?** A claim may be made by the Member, the Member's treating physician, legal guardian or legal representative, or by someone appointed by the Member to act on the Member's behalf. A claim must be submitted to WHP in writing, and there is a formal procedure that a Member or his representative must follow to make a claim. A claim may either be a pre-service or a post-service claim as further described below. Under WHP, a claim is:

a. A request from a Member:
   i. Seeking approval of a health care service or procedure that requires Prior Authorization by WHP pursuant to Section 8.2 of this Agreement (such as a request for approval by WHP for an elective admission); or
   ii. Seeking approval for services or benefits for which a Participating Provider has declined to provide, authorize or seek Prior Authorization;
b. A request for reimbursement or payment of health care expenses paid or owed by the Member for services or benefits not obtained from Participating Providers (such as reimbursement for out-of-town emergency room expenses); or
c. A request for reimbursement or payment of health care expenses paid or owed by the Member for services or benefits obtained from Participating Providers.

15.2 **Pre-Service Claims for Services or Benefits**. The following procedures are applicable to Pre-service Claims that are: (i) Requests for approval of a health care service or procedure that requires a Prior Authorization request made by a WHP Provider pursuant to Section 8.2 of this Agreement; or (ii) Requests by a Member to WHP for services or benefits that a WHP Provider has declined to provide, authorize or seek Prior Authorization. A Pre-service Claim will be resolved using the following procedures:

15.2.1 Urgent Care and Continuation of Current Treatment Claims. For Claims involving Urgent care services or benefits, WHP will notify the Member of its decision as soon as possible but not later than seventy-two (72) hours after receipt of the Claim. However, if insufficient information has been provided to WHP to determine to what extent the services or benefits are Covered by WHP, the Member will be notified no later than forty-eight (24) hours after receipt of the Claim of the specific information needed to process the Claim. The Member shall have forty-eight (48) hours to provide the missing information. If an Urgent care Claim involves a request that treatment or services be continued beyond the point of time or number of treatments that had been initially authorized, the Member will be notified of the decision within twenty-four (24) hours prior to the time the treatment or services are scheduled to end.

15.2.2 All Other Pre-Service Claims. For non-Urgent care Claims for services or benefits, WHP will notify the Member in writing of its decision no later than fifteen (15) days after the Claim is received by WHP unless an extension is necessary for reasons beyond the control of WHP. If WHP is unable to make a decision within the initial fifteen (15) day period, WHP will notify the Member in writing before the end of the fifteen (15) days of the circumstances requiring the extension and date by which WHP expects to make a decision which will be no later than an additional fifteen (15) days. If the reason for the extension is the failure of the Member to submit necessary information, the Member will be notified as to what information is needed, in which case the Member will have forty-five (45) days within which to submit the necessary information.

15.3 **Post-Service Claims for Reimbursement or Payment**. An initial decision on a Claim for reimbursement or payment of health care expenses paid or owed by the Member for services or benefits obtained from a non-WHP provider will be made within thirty (30) days after the Claim is received unless this time is extended. If WHP is unable to make a decision within the initial thirty (30) day period, WHP will notify the Member in writing before the end of the thirty (30) days of the circumstances requiring the extension and date by which WHP expects to

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make a decision, that will be no later than an additional fifteen (15) days. If the reason for the extension is the failure of the Member to submit necessary information, the Member will be notified as to what information is needed, in which case the Member will have forty-five (45) days within which to submit the necessary information.

15.4 **Appeal**. Claims that are not satisfactorily resolved pursuant to the procedures outlined in Section 15.2 or 15.3 above must be submitted to WHP in writing as a formal Appeal within one hundred and eighty (180) days after the Member receives a determination pursuant to the procedures outlined in Sections 15.2 and 15.3 above. WHP will acknowledge the filing of a formal Appeal within three (3) business days by notifying the Member in writing.

15.4.1 Consideration on an Appeal. On an Appeal, the WHP Appeals Committee will give no weight to the initial decision that is being appealed. The Appeal will not be decided by the person who made the initial decision nor someone working under that person. In an Appeal involving medical judgment, the WHP Appeals Committee will consult with a Health Care Professional who has appropriate training and experience involving the matter being appealed and who was not involved in the initial decision (or works under such a person). All medical experts who were consulted for the initial decision will be identified. The Member may submit written comments, documents, records and other information to be considered on an Appeal. A Member will, upon request and free of charge be provided copies of all documents, records and other information relevant to the Claim. The WHP Appeals Committee will review all available comments, documents, records and other information regarding the Appeal and make a decision.

15.4.2 Emergency/Expedited Appeals. If the Member requests an emergency/Expedited Appeal, all necessary information to decide the Appeal will be exchanged by telephone, fax or other expedited means of communication. The Appeals Committee will render a decision within forty-eight (48) hours from the time the Appeal was filed. The Member will be notified verbally and in writing on the same day the decision is made. If the Member is not satisfied with the decision, the written material will inform the Member of the right to appeal to the Grievance Committee.

15.4.3 Regular Appeals. An Appeal will be resolved no later than fifteen (15) days after the Appeal is filed. The Member will be notified in writing of the decision. The written notice will include the decision reached by WHP, the basis for the decision and a statement that the Member has the right to further appeal the decision through the Grievance Procedure. Also included will be the department, address and telephone number through which the Member may contract a qualified representative to obtain more information about the decision and the right to appeal. All requests to further appeal the matter to the Grievance Procedure must be made in writing and sent to:

Welborn Health Plans
ATTN: Appeals Coordinator
101 S.E. Third Street
Evansville, Indiana 47708

15.5 **Request for Grievance Committee Review**. If the Member is dissatisfied with WHP's Appeal decision, the Member may appeal to the Grievance Committee of WHP by notifying WHP in writing within one hundred and eighty (180) days from the date the Member is notified of the Appeal decision. A Member may designate another person to file an Appeal to the Grievance Committee for the Member and represent the Member before the Grievance Committee. WHP will acknowledge the filing of an Appeal to the Grievance Committee within three (3) business days by notifying the Member in writing. Written Appeals to the Grievance Committee should be sent to

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Welborn Health Plans
ATTN: Grievance Committee
101 S.E. Third Street
Evansville, IN 47708

An emergency expedited appeal filed by telephone may be submitted to Customer Services at (812) 426-6600 or toll-free at (800) 521-0265.

15.5.1 A Grievance Committee will be appointed by WHP for the Appeal. The Grievance Committee will consist of the appropriate number of persons as required by State and Federal legislation, one of whom:
a. Will be knowledgeable in the medical condition, procedure or treatment at issue;
b. Will be licensed in the same profession as the Provider who proposed, delivered, or refused the health care procedure, treatment, or service in question;
c. Will not be involved in the matter giving rise to the Appeal; and
d. Does not have a direct business relationship with the Member or the Provider who proposed, delivered, or refused the health care procedure, treatment, or service involved in the Appeal. WHP's CEO and Medical Director shall be ex-officio and non-voting Grievance Committee members.

15.5.2 A meeting of the Grievance Committee at WHP's office will be scheduled and a decision made within fifteen (15) days after the Grievance Appeal is filed. The Member (or his representative) shall have the right to personally appear at the Grievance meeting where the Claim may be presented. If the Member (or his representative) is unable to appear at the Grievance hearing in person, he will be given the opportunity to communicate directly with the Grievance Committee at the Grievance Committee meeting by other appropriate means. Written notice of WHP's decision with regard to the Grievance Appeal will be sent to the Member within five (5) business days of the completion of its investigation of the Appeal. The notice will also describe the Member's right to further remedies allowed by law, including the right to an external review by an independent review organization (IRO). If the Member elects not to request an external review, the Plan's decision on the Appeal will be considered final.

15.6 **External Review of Grievances**. A Member may file a written request for an external review due to an adverse utilization review determination, an adverse determination of medical necessity, or a determination made by WHP or an agent of WHP that a proposed service by the treating Physician is Experimental/ Investigational. The request for an external review must be filed within forty-five (45) days after the Member is notified of the result of the Grievance. WHP will appoint an IRO approved by the Indiana Department of Insurance. WHP will be responsible for all costs associated with the review except for a $25 filing fee to be paid by the Member. WHP will cooperate with the IRO by promptly providing any information requested by the IRO.

A Member who requests an external review is not subject to retaliation for exercising their right to appeal. A Member may use the assistance of other individuals including physicians, attorneys, friends, and family members throughout the review process and may submit additional information relating to the proposed service throughout the review process. A Member is expected to cooperate with the IRO by providing any requested medical information or authorizing the release of necessary medical information.

Based on information gathered from the Member or the Member's designee, WHP, the treating Physician and any additional information that the organization considers necessary and appropriate, the IRO will make a decision within ten (10) business days from the date the request is filed. If the Grievance is related to an illness, a disease, a condition, an injury or disability that would seriously jeopardize the Member's life, health or ability to reach and maintain maximum function, the IRO will make a decision within seventy-two (72) hours of the time the expedited Appeal is filed. The IRO's decision is binding upon WHP.

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15.7 **Lawsuits and Place of Any Lawsuit**. Any legal action filed against WHP must be filed in the State or Federal Courts located in Vanderburgh County, Indiana.

15.8 **Department of Insurance**. Parties dissatisfied with the nature of a Claim may request a review by the Indiana Department of Insurance, Consumer Services section. WHP shall forward copies of all records concerning the disposition of the Claim to the Department of Insurance within ten (10) days of being notified by the Department. To contact the Department, write or call:

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 3
Indianapolis, IN 46204-278
(317) 232-2395 or (800) 622 61

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SECTION 16. AMENDMENTS TO THIS AGREEMENT

16.1 **General**. This Agreement, including all documents that are a part of this Agreement, may be amended at any time by WHP. This may be done without the permission or agreement of the Subscriber or Members. Any amendment will be effective on the next Anniversary Date by giving the Employer at least sixty (60) days prior notice of the Amendment. All such amendments shall be considered accepted by the Employer unless the Employer gives WHP written notice of non-acceptance within thirty (30) days after receiving the proposed amendments. In such an event, the Agreement shall end on the Anniversary Date.

16.2 **Conformity with State and Federal Statutes**. This Agreement shall be understood, administered and enforced as an Indiana contract according to the internal laws of the State of Indiana. However, it is specifically intended that to the extent ERISA or any other Federal law preempts State law, this Agreement shall be understood, administered and enforced in agreement with such laws that preempt State law. Any provision of this Agreement that is in conflict with statutes of the State of Indiana or the Federal Government is hereby amended to conform to the minimum requirements of such statutes. The Employer will be notified of any adjustments relating to monthly premiums as a result of mandates or State or Federal law.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers.

NHP of Indiana LLC d/b/a
Welborn Health Plans

By: _____

Printed Name: Steven J. Bory

Title: President & Chief Executive Officer

Employer

By: _____

Printed Name: _____

Title: _____

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SECTION 17. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1[illegible]. [illegible](1) of the provisions of this act requires WHP to notify Members of their rights under this law.

What benefits does the law guarantee?
Under the law, health plans that provide medical and surgical benefits in connection with [illegible]stectomy must provide benefits for certain reconstructive surgery. This includes coverage for:

a. Reconstruction of the breast on which a mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appe[illegible]ce; and
c. Prosthesis and physical complications of all stages of mastectomy, includi[illegible]ymp[illegible]demas.

The law also states that the services will be considered "in a manner dete[illegible]ined in consultation with the attending physician and the patient." In other words, you and your physician wi[illegible]determine the most appropriate treatment[illegible] your individual situation.

Coverage of these services may be subject to annual deductibles, copayme[illegible]and c[illegible]nsura[illegible]ce provisions that are consistent with those established for other benefits under this Agreement.

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SECTION 18. NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Protected Health Information ("PHI") is information, including demographic information, that may identify you and that relates to heath care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how we at Welborn Health Plans ("WHP") may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a health plan we are required by Federal law to maintain the privacy of PHI and to provide you with this notice of our legal and privacy practices.

We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to individuals covered under the plan at that time.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations that Do Not Require Your Prior Written Consent
Federal law allows a health plan to use and disclose PHI for the purpose of treatment, payment and health care operations without your consent or authorization. Examples of uses and disclosures that we are allowed to make, as a health plan, are listed below.

Treatment. Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. Although, as a health plan, WHP does not provide treatment, we may provide PHI to health care providers in order to arrange treatment for you.

Payment. Payment refers to the activities of a health plan in collecting premiums and paying claims under the plan for health care services you receive. We use PHI to pay claims and we disclose PHI to companies that pay claims for WHP such as a pharmacy benefit manager or a vision plan manager. Examples of uses and disclosures under this Section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of treatment; sharing PHI with other insurers to determine coordination of benefits; filing and settling subrogation claims and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the plan.

Health Care Operations. Health Care Operations refers to the basic business functions necessary to operate a health plan. Examples of uses and disclosures under this Section include conducting quality assessment studies to evaluate the plan's performance or the performance of a provider or vendor; the use of PHI to provide case and disease management services; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and obtaining reinsurance; the disclosure of PHI to deal with complaints and grievances about your care; the disclosure of PHI to stop-loss or reinsurance carriers to obtain claim reimbursements to the health plan; the disclosure of PHI to plan consultants who provide legal, actuarial and auditing services to WHP; and use of PHI in actuarial data analysis used in the long term management and planning for WHP.

The above examples are not all of the situations when, as permitted by Federal and State law, we may use and disclose PHI for treatment, payment, and operations.

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Other Uses and Disclosures Allowed Without Your Consent
Federal law also allows a health plan to use and disclose PHI, without your consent or authorization in the following ways:

Health Oversight. We may disclose PHI to a health oversight agency or other regulatory agency for purposes authorized by law such as audits, investigations, and inspections.

Legal Proceedings. We may disclose PHI in the course of any judicial or administrative proceeding in response to (i) an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (ii) in response to a subpoena, discovery request or other lawful process (excluding mental health records that, in Indiana, can only be released upon a court order) but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Military Activity and National Security. We may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities and for Veterans Affairs benefits eligibility. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Workers' Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illness.

When Required by Law: We may disclose your PHI otherwise required by law, provided that the disclosure and use complies with and is limited to the relevant requirements of such law.

To the Plan Sponsor: We may disclose your PHI to the Plan Sponsor to conduct plan administration functions only if the Plan Sponsor has adopted certain safeguards to prevent the use of the PHI for employment-related decisions or in connection with any of its other benefit plans.

The examples of permitted disclosures listed above are not provided as an all inclusive list of the ways in which PHI may be disclosed. They are provided to describe in general the types of uses and disclosures that may be made.

All Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

At WHP, we are committed to maintaining the confidentiality of your personal and sensitive information. You and your family trust us to collect and maintain information necessary to administer your benefit plan in a way that protects your privacy. That is why we have policies and processes in place to protect the security and confidentiality of your personal information.

HOW WE PROTECT CONFIDENTIAL INFORMATION

WHP is required by law to keep our members' personal information confidential. Here are things we do to make sure your personal information is protected:

- Whenever possible, we provide information that does not identify any individual. If we do need to share individually identifiable information, we have policies that protect confidentiality.

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- We require a written agreement from companies and organizations who receive confidential information from us. They agree that they will use any individually identifiable information only to administer your benef[illegible]lan in accordance with applicable laws.
- Sometimes we require a member's written authorization before we disclose confidential inform[illegible]ion. For ex[illegible]mple, a request from a research organization or from a member's attorney would require an authori[illegible] signed by the member. Requests for confidential information for a minor or for an adult who is unable[illegible] exerc[illegible] rational judgment or give informed consent require an authorization from the member's paren[illegible]gal guardi[illegible]or health care representative.
- We educate our organization on how to protect the confidentiality and security of your p[illegible]onal informati[illegible] Our employees may not disclose information to other employees except when it i[illegible]ded to co[illegible]act WHP busin[illegible]
- Access to our facility is limited to authorized personnel.
- We have policies and procedures for accessing, labeling and storing co[illegible]dential records.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH[illegible]FORMATION

- You have a right to request restrictions on uses and disclosure[illegible]our personal[illegible]formation with respect to treatment, payment and health care operations. WHP will consider [illegible]r request[illegible]e are not legally required to accept it. You may not limit the uses and disclosures that we are legal[illegible]eq[illegible]d to make.
- You have a right to request in writing that we send information to you at a[illegible]lternate address if you include a statement in your request that the disclosure of all or part of the information [illegible]which the request pertains could endanger you.
- You have the right to inspect and copy your[illegible]for as long as WHP maintains the[illegible]I[illegible]ederal law does prohibit you from having access to the following[illegible]ds: p[illegible]therapy notes; information[illegible]mplied in reasonable anticipation of, or for use in a civil, cr[illegible]inal[illegible]administra[illegible]ction or proceedings, and PHI that is subject to a law that prohibits access to that information. If yo[illegible]request for ac[illegible]denied, you may have a right to have that decision reviewed.
- WHP strives to make sure that information is accu[illegible]te an[illegible]omplete. Yo[illegible]have the right to request that your PHI be amended for as long as the plan maintains the PHI.[illegible]plan may deny your request for amendment if it determines that the PHI was not cre[illegible]the plan, is not infor[illegible]tion that is available for inspection, or that the PHI is accurate and complete. If yo[illegible]equest fo[illegible]mendment is decli[illegible]d, you have the right to have a statement of disagreement included with the[illegible]I and the plan[illegible]as a right to includ[illegible]a re[illegible]tal to your statement, a copy of which will be provided to yo[illegible]
- You have a[illegible]to obtain an acc[illegible]nting of instances in which we have disclosed your personal information after the official complian[illegible]date of Ap[illegible]acc[illegible]ting will be provided within sixty (60) days of receipt of the request and will not[illegible]lude[illegible]es or disclosures that we are allowed to make for treatment, payment or health plan operations.

[illegible]W WE LE[illegible]EMBERS K[illegible]W ABOUT OUR PRIVACY PRACTICES

WHP will provide[illegible]current subsc[illegible]rs[illegible]h a copy of this Notice of Privacy Practices. New subscribers will receive this notice with their p[illegible]n benefit mate[illegible]ls. You can also view this notice on our Web site at www.welbornhealthplan[illegible]com or yo[illegible]can request a copy from our Compliance Department by calling (812) 426-6600 or (800) 521-0265, and cho[illegible]e option #7. For the hearing impaired, please call the toll-free Indiana Relay number at (800) [illegible]-3333.

COM[illegible]AINTS

If you th[illegible]that we[illegible]y have violated your privacy rights, or you disagree with a decision we made about access to your personal in[illegible]mat[illegible], you may file a complaint by calling our Privacy Officer at (812) 426-6600 or (800) 521-0265, and choose option[illegible] For the hearing impaired, please call the toll-free Indiana Relay number at (800) 743-3333. You may also call WH[illegible]for information on how to file a complaint with the Secretary of the Department of Health and Human Services. WHP will take no retaliatory action against you if you file a complaint about our privacy practices.

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This notice became effective April 14, 2003.

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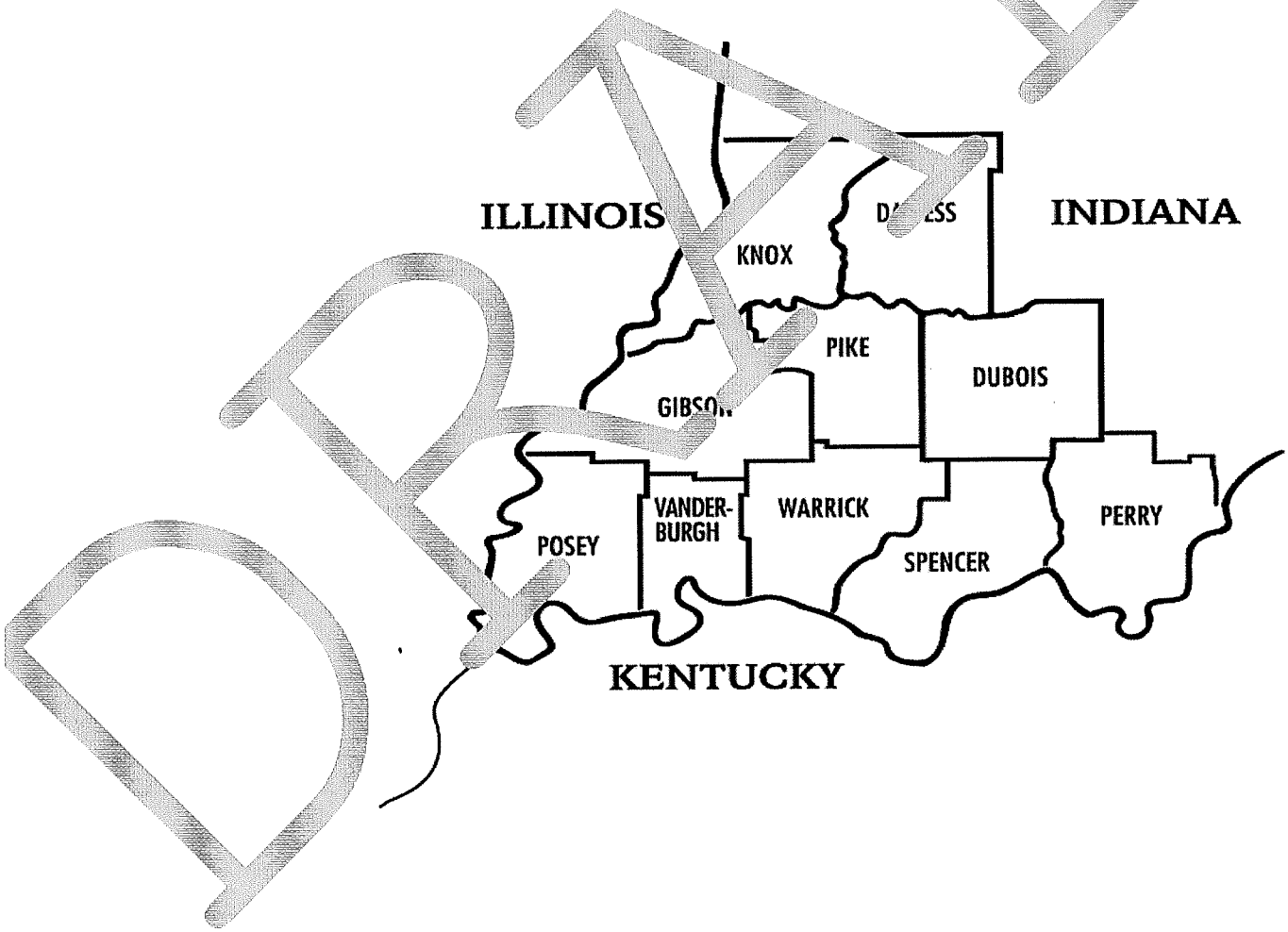
FIGURE 1 – SERVICE AREA

The WHP Service Area includes the counties of:

- **Daviess**
- **Dubois**
- **Gibson**
- **Knox**
- **Perry**
- **Pike**
- **Posey**
- **Spencer**
- **Vanderburgh**
- **Warrick**



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RIDERS

The following are those Riders (additional coverage to the basic Employer and Member Health Service Agreement) available to Employers offering WHP to their employees. **Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package.** *Please refer to your Benefit Summary for a listing of the Riders selected on behalf of WHP Members by the Employer.*

PRESCRIPTION DRUG BENEFITS
RIDER 1

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that Prescription Drug services are Covered to the extent indicated in your Benefit Summary and this Agreement and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer as set forth below. Member Copayments for Prescription Drugs are not applied to the Out-of-Pocket Maximum (i.e., applicable Copayments are still required after the Out-of-Pocket Maximum is satisfied).

Definitions.

a. Maintenance Drug: A drug meant to sustain the health of a patient over a long period of time. This can be over several months or years. Maintenance Drugs should have an established and defined dosage for this long period of time. Regular doses of a Maintenance Drug are needed to avoid the effects of a disease or illness. Drugs that meet this definition may be excluded from the maintenance list at the direction of the WHP Pharmacy and Therapeutics (P&T) Committee. Controlled substances (e.g., Ritalin, Lorcet®, Xanax®) and antibiotics (e.g., Amoxicillin, Septra, Keflex) are not Maintenance Drugs. A first time prescription is not a Maintenance Drug.
b. Prior Authorizations: Certain drugs require the prescriber to obtain Prior Authorization by WHP in order for the prescription to be filled.
c. Quantity Level Limits ("QLL"): Certain drugs may only be dispensed in specified quantities per copayment *usually one (1) month's supply). Quantities prescribed which exceed this limit will require one or more additional

Selected Pharmaceutical List ("SPL"): The list of *Preferred drugs* that is developed by the P&T Committee. The SPL is subject to change at the discretion of the P&T Committee. This Committee periodically reviews drugs, or entire classes of drugs, to determine a drug's status as preferred or non-preferred. This determination is made based on the medication's safety, effectiveness and cost. Non-preferred drugs are Covered (subject to the Limitations and Exclusions Section below), but usually require a higher Copayment.

e. Step-Therapy: Certain drugs require that the member have tried and failed Over-The-Counter ("OTC") medications drugs on the SPL in order for the prescription to be filled.
f. Copayment Levels:
   i. Level 1 Drugs. Preferred generic drugs that are high quality for the lowest cost as determined by the P&T Committee.
   ii. Level 2 Drugs. Preferred brand name drugs or Preferred generic drugs that are high quality for a moderate cost as determined by the P&T Committee.
   iii. Level 3 Drugs. Non-preferred brand name drugs.

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Some benefit options offer additional Copayment levels for the following drug classes:

i. Level 4 Drugs. Drugs that are classified as self-injectable biotechnology products or other self-injectable medications.
ii. Level 5 Drugs. Drugs that are considered to be life enhancing as determined by the P&T Committee.

Covered Medications.

a. Eligible medications and the refills prescribed by a Participating Provider and dispensed through a Participating pharmacy.
b. Eligible medications filled by non-Participating pharmacies when prescribed for Covered Out-of-Area Emergent or Urgent Conditions.
c. Eligible medications when prescribed by non-Participating Providers and approved in advance by WHP.
d. Insulin and insulin syringes.
e. Medications requiring Prior Authorization provided that the Member meets medical criteria for coverage of these medications. The Participating Provider will make arrangements for Prior Authorization. The P&T Committee defines the drugs that require Prior Authorization and the criteria under which they will be Covered. These drugs, and the criteria for coverage, are subject to change based on the P&T Committee's drug literature reviews.

General Conditions. WHP maintains a list of drugs subject to Prior Authorization, Quantity Level Limits, and Step Therapy which is available to members and prescribers upon request. This list is subject to change periodically, however, notice will be given to Members currently receiving these drugs at least thirty (30) days prior to the effective date. All Members are eligible for Covered Prescription Drugs under this Rider provided that the Member presents his ID card at a Participating pharmacy each time a prescription needs to be filled. (Failure to present the ID card may result in a reduction of benefits.)

Exclusions.

a. Any chemical means of abortion, such as RU486 or methotrexate used in combination with misoprostil.
b. Medications for Cosmetic purposes (e.g., Propecia or Retin-A®).
c. Drugs prescribed by a dentist or an oral surgeon that are intended for the treatment of dental related illnesses.
d. Experimental drugs and drugs labeled "Caution - Limited by Federal Law to Investigational Use."
e. Medicines prescribed or administered for purposes other than those approved by the Federal Food and Drug Administration unless one of the following conditions is met:
   i. The drug is recognized for treatment of the off-label indication in at least one (1) standard reference compendium.
   ii. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
f. Food supplements, substitutes, formulas, etc.
g. Charges exceeding generic drug costs for name brand medications when a generic equivalent is available.
h. Lost, stolen or destroyed medications.
i. OTC (over-the-counter) drugs and non-diabetic supplies, that do not require a prescription by Federal law.
j. Prescription Drugs that have an OTC equivalent available.
k. Drugs requiring Prior Authorization, if Prior Authorization is not obtained.
l. Drug charges that exceed the cost for the same drug in conventional packaging.
m. The quantity exceeding the limited amount based on the recommendation of WHP's P&T Committee.
n. Smoking cessation medications (e.g., nicotine gum/patches), unless participating in the Finally Beat Smoking SM* program.
o. Take Home medication from a hospital or other facility.
p. Medications needed for travel such as medications to prevent malaria or travelers' diarrhea.
q. Weight-loss medications.

r. Infertility drugs unless Covered by a valid Infertility Rider.
s. Campral®, ReVia®, Vivitrol® and Antabuse® unless the member is actively participating in a 12-step program and for a period not to exceed 12 continuous months.

Limitations.
a. Dispensing quantities for Covered Prescription Drugs are limited to the amount prescribed by the participating Provider, not to exceed thirty (30) day supply except for selected Maintenance Drugs that may not exceed a ninety (90) day supply.
b. Members who are Covered at the same time by more than one (1) Agreement or Rider are entitled to the maximum limit of the Agreement or Rider with the higher benefit. WHP does not coordinate prescription drug benefits between WHP Agreements or between other agreements and/or riders.
c. WHP does not apply prescription drug charges to the medical deductible amount.
d. Early refills of prescriptions may be authorized if the Member must travel outside the service area for a period beyond the usual refill date of the prescriptions. Many chain pharmacies will refill a prescription at any location nationwide. Please ask your pharmacist if this service is available.
e. Coordination of benefits for prescription copayments is not available.

Payment. All Covered Prescription Drug Benefits pursuant to this Rider are subject to Copayment, Coinsurance and/ or Deductible amounts (if any) as specified in your Benefit Summary. If generic is available and Member or Physician requests brand, the Member pays the applicable brand Copay plus the difference in cost between the brand and generic drug.

Interpretation of this Agreement. Except as expressly provided in this Rider, or by other Riders, that shall be made part of this Agreement, the terms and conditions of the Agreement continue and remain the same and are in full force and effect.

* The Finally Beat Smoking program is a registered service mark of WHP.

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ROUTINE VISION SERVICES
RIDER 2

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that routine vision benefits are Covered at the level indicated in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer, as set forth below:

Covered Services.

a. Standard eye examination, including:
   i. Intermediate Examination - brief or limited routine check-up or vision survey.
   ii. Vision Analysis - various tests for prescription lenses.
   iii. Tonometry - measurement of eye tension for glaucoma.
   iv. Biomicroscopy - examination of the living eye tissue.
   v. Central Field Study - measurement of visual acuity in the central field of vision.
   vi. Peripheral Field Study - measurement of visual acuity in the peripheral field of vision.
   vii. Treatment of the following conditions:
      aa. Eye discomfort or pain.
      bb. Recent loss of eye muscle control.
      cc. Temporary loss of vision.
      dd. Foreign body sensation in the eye.
      ee. Flashes of floaters.
      ff. Pain in or around the eye.
      gg. Eye injury.
      hh. Double vision.
      ii. Red eyes.

General.

a. Spectacle Lenses and Frames. When a Participating Provider prescribes a correction, Members can obtain materials and professional services associated with the ordering, fitting and adjusting of those materials at a discount from the Participating Provider's usual and customary fees, which includes prescription glasses and spectacle lens options.
b. Contact Lenses - Professional Services Only. An additional discount will apply on the Participating Provider's professional services associated with prescription contact lenses (materials at Physician's usual and customary fees).

These vision care benefits are only available through a Participating Provider, Members may use these discounts for prescription glasses and professional services for contact lenses anytime during the twelve (12) month period following the covered eye examination and only offered through the Participating Provider who last provided the Covered eye examination.

Exclusions.

a. Securing materials such as lenses and frames.
b. Orthoptics or vision training.
c. Medical or surgical treatment of the eyes.

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d. Any eye examination, or any corrective eyewear, required by an Employer as a condition of employment.
e. Services by a non-Participating Provider.

Limitations. Routine vision services Covered under this Rider are subject to the limits of one (1) routine eye examination per Member per contract year under this Rider.

Payment. All Covered routine vision services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary. The Member Coinsurance for Routine Vision services does not apply to the Out-of-Pocket Maximum.

Interpretation of this Agreement. Except as expressly provided by this Rider, or by other Riders, that shall be made part of this Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

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ROUTINE VISION & EYEWEAR SERVICES
RIDER 3

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that routine vision and eyewear benefits are Covered at the level indicated in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer, as set forth below:

Covered Services.

a. Eye examination.
b. Spectacle lenses.
c. Frames (within the allotted allowance); and
d. Contact lenses:
   i. Elective contact lenses. Frequency for elective lenses is the same as spectacle lenses. If Members elect contact lenses, they will be eligible for a frame twenty-four (24) months after the last date of obtaining the contact lenses.

      This Rider includes a discount on the participating provider's professional services when Members purchase prescription contact lenses. Materials are provided at usual and customary fees. This benefit is available in conjunction with the contact lens allowance specified in your Benefit Summary, or Members can use it to purchase contacts in addition to glasses.
      These discounts are Covered for twelve (12) months following the date of the Covered eye examination and are only offered through a Participating Provider who provided the last Covered eye examination.

   ii. Medically necessary contact lenses, when prescribed by a Participating Provider for one (1) of the following conditions:
      aa. Following cataract surgery.
      bb. To correct extreme visual problems that cannot be corrected with spectacle lenses.
      cc. With certain conditions of anisometropia.
      dd. With certain conditions of keratoconus.
e. Treatment of the following conditions:
   i. Ocular discomfort or pain.
   ii. Recent loss of eye muscle control.
   iii. Temporary loss of vision.
   iv. Foreign body sensation in the eye.
   v. Flashes of floaters.
   vi. Pain in or around the eyes.
   vii. Eye injury.
   viii. Double vision.
   ix. Red eyes.

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General. Additional charges will apply for the following:
a. Blended lenses.
b. Contact lenses (except as noted elsewhere herein).
c. Oversize lenses. Progressive multifocal lenses.
d. Photochromic or tinted lenses other than Pink 1 or 2.
f. Coated or laminated lenses.
g. A frame that exceeds the WHP allowances.
h. Certain limitations on low vision care.
i. Cosmetic lenses.
j. Optional cosmetic processes.
k. UV protected lenses.

Exclusions.
a. Orthoptics or vision training and any associate supplemental testi
b. Plano lenses (non-prescription).
c. Two (2) pair of glasses in lieu of bifocals.
d. Lenses and frames furnished under this Rider that are lost or broken w not h eplaced except at the normal intervals when services are otherwise available.
e. Medical or surgical treatment of the eyes.
f. Any eye examination, or any corrective eyewear, required by an Employer as a ndition of nployment.
g. Corrective vision services, treatments, and m rials of an experimental nature.
h. Services by a Non-Participating Provider.

Limitations. Routine vision and eyewea services re Covered an vided under this Rider may be limited per Member to a maximum benefit as specified in your nefit Sumr y.

Payment. All Covered routine vision and eyewear se ces rovided purs t to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as spec d in your Benefit Summary. The Member Coinsurance for Routine Vision and Eyew servic does not apply to t Out-of-Pocket Maximum.

Interpretation is Agreement. E cept as expressly pr ed above by this Rider, or by other Riders that shall be made part of t Ag ment, the ter nditions of the Agreement control and remain the same and are in full force and effect.

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ORGAN AND TISSUE TRANSPLANT SERVICES
RIDER 4

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that Organ and Tissue Transplant benefits are Covered at the level indicated in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer, as set forth below:

Definitions.

a. Donor: A live or cadaveric person donating an organ for the sole purpose of reinfusing, transfusing or transplanting into a recipient.
b. Recipient: A Member who receives an organ from a Donor. In the case of an autologous bone marrow transplant, the recipient and the Donor will be the same person.
c. Allogenic Bone Marrow Transplant: An infusion of a related or unrelated Donor's peripheral stem cells, bone marrow or cord blood to re-establish hematopoietic cell function after ablative therapy.
d. Autologous Bone Marrow Transplant: An infusion of the patient's own bone marrow, peripheral stem cells or cord blood to re-establish hematopoietic cell function after ablative therapy.
e. Designated Transplant Facility: A Provider which is under contract to provide transplant services to Members pursuant to this Agreement.

Covered Services.

a. The Recipient Member's medical, surgical and hospital services and costs associated with organ/tissue procurement required to perform any of the following approved human organ or tissue transplants:
   i. Heart;
   ii. Liver;
   iii. Pancreas;
   iv. Lung/Heart/Lung;
   v. Kidney;
   vi. Bone Marrow;
   vii. Kidney/Pancreas;
   viii. Intestine (Small Bowel)
b. Reasonable travel expenses, including transportation, lodging and meals for the Member and one significant other as listed in your Benefit Summary, subject to the approval of the Medical Director and limited to a maximum expense of $10,000 per transplant. Transportation shall mean the lesser of round trip coach airfare via the most direct route or mileage at IRS rates. Lodging shall mean accommodations at the closest available hotel to the transplant facility. Meals shall mean up to $30 per person per day per diem for meals, receipts required.
c. Immunosuppressive/antirejection medications including but not limited to Imuran and Sandimmune, for approved transplants, subject to a Coinsurance as defined in your Benefit Summary.
d. Replacement transplants and services related to a repeat transplant after initial failure.
e. Health services for a Donor when the recipient of the organ/tissue is a Member.

General Conditions. In order to be considered for Covered Services for human organ and tissue transplants, a Member must meet the following criteria:

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a. The Member's PCP and the Medical Director must have approved, in writing, the rendering of Covered organ and tissue transplant services to the Member.
b. The Member must obtain the required approval in advance of receiving any transplant-related services. Failure to obtain preauthorization for any transplant-related services will result in non-payment of these services.
c. The Member is eligible for coverage for transplant health services listed as Covered benefits in the Agreement if such transplant health services are Medically Necessary and are provided by a Designated Transplant Facility.

Exclusions.
a. Services unrelated to the Covered Services defined in this Rider except as specified in the Agreement, or services unrelated to the diagnosis or treatment of an illness resulting directly from such transplants;
b. Drugs determined to be Experimental/Investigational;

Limitations. Organ and tissue transplant services Covered and provided under this Rider may be limited per Member to a maximum benefit if specified in your Benefit Summary.

Payment. All Covered organ and tissue transplant services provided pursuant to this Rider are subject to Copayment, Coinsurance or Deductible amounts (if any) as specified in your Benefit Summary.

Interpretation of this Agreement. Except as expressly provided by this Rider, or by other Riders, that shall be made part of this Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

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MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES
RIDER 5

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood that mental health and chemical dependency benefits are Covered at the level listed in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer, as set forth below:

Covered Services.

a. Acute inpatient services, including:
   i. Structured programs of medical and psychotherapeutic services delivered to a person confined to a participating hospital's acute mental health or chemical dependency unit.
   ii. Services are delivered in a group and individual format by behavioral health professional staff and under the supervision of a licensed Physician.
   iii. Crisis assessment and brief stabilization for psychiatric conditions.
   iv. Short-term establishment of rehabilitative treatment plans. Acute inpatient services do not refer to residential services or those services primarily custodial in nature. Services must be ordered by the Member's PCP, authorized in advance, and provided by a Participating Provider.

b. Partial hospitalization or day treatment services including:
   i. Treatment in a structured outpatient program of psychotherapeutic services for the purposes of psychiatric assessment, crisis stabilization, and short-term treatment.
   v. Meetings occurring at least three (3) to five (5) times a week for no less than four (4) hours and no more than twelve (12) hours per day.
   iii. Services are delivered in-group and individual format by behavioral health professional staff and are under the supervision of a licensed Physician.
   vi. The facility where services are delivered is not a Residential Treatment Facility.
   v. Services must be ordered by the Member's PCP, authorized in advance, and provided by a Participating Provider.

c. Intensive outpatient programs services including:
   i. Structured outpatient programs of psychotherapeutic services for the purposes of psychiatric assessment, crisis stabilization, and short-term treatment.
   ii. Meetings occurring at least two (2) to three (3) times per week for not less than three (3) hours and no more than six (6) hours per day.
   iii. Services are delivered in a group format by behavioral by behavioral health staff.
   iv. The location facility where services are delivered is not a Residential Treatment Facility.

d. Individual psychotherapy services including services provided on a one-to-one basis between the Member and a licensed Physician or appropriately licensed/certified behavioral health professional, usually occurring in an office setting.

e. Group or family psychotherapy services including services provided by a licensed Physician or appropriately licensed/certified behavioral health professional in a structured format, treatment to two (2) or more participants or family members, and usually in an office setting.

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f. Services for substance abuse and chemical dependency, when required in the treatment of a mental illness, will be provided at the same benefit level as other medical or surgical conditions.

Exclusions.
a. Gender identity disorders including any process, service or supply required for a sex change, deviation or disorder.

b. Residential care and all associated services and/or supplies.

Limitations. Mental Health and Chemical Dependency services Covered and provided under this Rider may be limited per Member to a maximum benefit if specified in your Benefit Summary.

Payment. All Covered Mental Health and Chemical Dependency services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary.

Interpretation of this Agreement. Except as expressly provided above by this Rider or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

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ORAL SURGERY SERVICES
RIDER 6

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that Oral Surgery benefits are Covered at the level indicated in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer, as set forth below:

Covered Services.
a. Excision of teeth not completely erupted.
b. Excision of a tooth root within extraction of the entire tooth.
c. Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction.
d. Surgical excision of erupted teeth.

Exclusions.
a. Services do not include root canal therapy and procedures.
b. Dental cleaning, root scaling, planning or other scrapping procedures.
c. Dental implants.

Limitations. Oral Surgery services Covered and provided under this Rider may be limited per Member to a maximum benefit as specified in your Benefit Summary.

Payment. All Covered Oral Surgery services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary. The Member Coinsurance for Oral Surgery services does not apply to the Out-of-Pocket Maximum.

Interpretation of this Agreement. Except as expressly provided above by this Rider, or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same, are in full force and effect.

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INFERTILITY SERVICES
RIDER 7

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood that Infertility Services benefits are Covered at the level indicated in your Benefit Summary and shall be defined and provided under this Agreement in accordance with the terms and conditions of this Rider and in conjunction with the Maternity Services Rider, when selected by the Employer, as set forth below:

Definitions. Infertility: Infertility services are medical/surgical services performed to investigate and treat the causes of Infertility, which include the inability to conceive (get pregnant), cause pregnancy, maintain pregnancy until full term, or maintain or improve desired fertility.

Covered Services. To be Covered, all Infertility services must be requested by a PCP and approved by the Medical Director. Covered Services will only be provided for Members. Partners/spouses who are not Members are not eligible for Covered Infertility diagnostic and treatment services.

a. Diagnostic services for the Member partner to establish cause or reason for infertility.
b. Pathology and laboratory services.
c. Surgical services.
d. Drugs prescribed for Covered Infertility treatment subject to applicable coinsurance.
e. Invitro fertilization.
f. Gamete or zygote intrafallopian transfer (GIFT or ZYFT).
g. Embryo transplantation.
h. Artificial insemination.
i. Drugs, testing, surgical procedures and services associated with these Covered Services.
j. Cryopreservation of eggs, sperm or embryos will be covered provided that both donor and recipient are members and only for the period of eligibility stated under the Limitations Section of this Rider.

General Conditions. In order to be considered for Covered Services related to the evaluation and treatment of Infertility, a Member must meet the following criteria:

a. The Member must be married and the Member and the Member's spouse must have had unprotected intercourse for conception for at least one (1) year; and
b. The male partner must have had a sperm analysis performed:
   i. If the male partner is a Member, the sperm analysis must have been performed by a Participating Provider.
   ii. If the male partner is not a Member, the sperm analysis must have been performed with the results being sent to the Member's PCP.
c. The female partner must have been unable to achieve and sustain two (2) successful pregnancies in her lifetime.

Exclusions.

a. Reversal of voluntary sterilization.
b. Experimental services.
c. New technology not defined under the Covered Services Section of this Rider unless authorized by the Medical Director.

Limitations. Infertility services Covered under this Rider are subject to the following limitations:

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a. Benefits for Covered Infertility evaluation and treatment services are not extended beyond two consecutive (2) years. These services are Covered only if the current Agreement or Rider covering Infertility is still in force and the Member is still an eligible Member.
b. All Covered Services and equipment for Infertility are subject to Coinsurance charges for the services or equipment.
c. If pregnancy is achieved, but terminated through spontaneous abortion or premature birth, Covered Infertility benefits will be extended for a one (1) year period following the fetal loss.
d. In no circumstance will services for Infertility be Covered beyond two (2) successful pregnancies resulting in live birth.
e. Services for Infertility evaluation and treatment will only be Covered so long as the treated person is a Member.

Infertility Services Covered and provided under this Rider may be limited per Member to a maximum benefit if specified in your Benefit Summary.

Payment. All Covered Infertility Services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary. The Member Coinsurance for Infertility services does not apply to the Out-of-Pocket Maximum.

Interpretation of this Agreement. Except as expressly provided by this Rider, or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

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SURGICAL TREATMENT OF MORBID OBESITY
RIDER 8

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that morbid obesity benefits are Covered at the level indicated in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer, as set forth below:

Definitions.

a. Morbid Obesity: (Ind. Code §§ 27-8-14.4 and 27-13-7-14.5):
   i. A body mass index of at least thirty-five (35) kilograms per meter squared with co-morbidity or co-existing medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
   ii. A body mass index of at least forty (40) kilograms per meter squared without co-morbidity.
b. Non-surgical treatment of Morbid Obesity:
   i. Medical documentation of participation and compliance with a diet program, supervised by a PCP, for at least six (6) months; and
   ii. Medical documentation of participation and compliance with an exercise program for at least six (6) months supervised by a PCP; and
   iii. Documented attempt of at least six (6) months of pharmacological such as Xenical® treatment supervised by a PCP; and
   iv. Evaluation by a Participating mental health professional.

Covered Services. These services are limited to those procedures deemed most appropriate for the specific Morbid Obesity condition, as determined by the WHP Medical Director and by the Participating Provider. This includes office consultations and follow-up visits by the bariatric surgeons and Consulting Providers as well as the surgery, facility fees and any other services or consultations. Complications from the surgery will also be subject to the limitations of this Rider. Obesity surgery includes but is not limited to the following procedures:

a. Gastric banding.
b. Adjustable gastric banding.
c. Gastric bypass.
d. Restrictive procedure with gastric bypass and Roux-en-Y.
   *Partial or total gastrectomy combined with either or both of the following:
   i. Biliary diversion
   ii. Intestinal malabsorptive procedure
   *Also known as "Duodenal Switch Procedure"

General Conditions. The Member's PCP and the WHP Medical Director must have approved, in writing, the request for the services for surgical treatment of Morbid Obesity.

Exclusions.

a. Failure to meet any above criteria for diagnosis of Morbid Obesity or non-surgical treatments.
b. Use of a Non-Participating Provider.
c. Unwillingness to comply with diet and/or other treatment recommendations.

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d. Services incurred without receiving prior approval from WHP.
e. Weight-loss medications.
f. New technology not defined under the Covered Services Section of this Rider unless authorized in advance by the WHP Medical Director.
g. Removal of excess skin as a result of weight loss.

Limitations. Surgical treatment of Morbid Obesity is limited to one (1) surgical procedure per Member per lifetime and must be performed by a Participating Provider and authorized in advance by WHP. Services for and related to surgical treatment of Morbid Obesity will only be Covered as long as the treated person is a Member.

The Member must be at least 21 years old to have Morbid Obesity surgically treated. A Member less than 21 years of age will only be eligible for surgical treatment of Morbid Obesity if two (2) physicians licensed under Ind. Code § 25-22.5 et seq. determine the surgery is necessary to save the life of the Member or to restore the Member's ability to maintain a major life activity as defined in Ind. Code § 4-23-29-6. Each physician must document in the Member's medical record the reason for the physician's determination.

The Morbid Obesity must have persisted for at least five (5) years and non-surgical treatment that was supervised by a Physician has been unsuccessful for at least eighteen (18) consecutive months.

Payment. All Covered Morbid Obesity services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary. The Member Coinsurance for Morbid Obesity services does not apply to the Out-of-Pocket Maximum.

Interpretation of this Agreement. Except as expressly provided in this Rider, or by other Riders, that shall be made part of this Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

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MATERNITY SERVICES
RIDER 9

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that Maternity benefits are Covered at the level indicated on your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by Employer, as set forth below:

Definitions. Maternity Services: Obstetrical services rendered to a woman from the time the pregnancy is established by a Participating Provider until delivery or termination of pregnancy and discharge from the hospital or other facility for rehabilitation services.

Covered Services. Covered services includes when pregnancy is confirmed by a Participating Provider:

i. Office visits by a Participating Provider;
ii. Ultrasound examinations;
iii. Laboratory, pathology and other diagnostic tests;
iv. X-ray services;
v. Drugs, medications and biologicals;
vi. Anesthesia and oxygen services;
vii. Medical and surgical supplies;
viii. Administration of whole blood and blood products;
ix. General inpatient nursing care;
x. Inpatient meals;
xi. Operating room and related services;
xii. Labor and delivery room, and related services;
xiii. Intensive care unit and related services;
xiv. Semi-private rooms or private rooms when Medically Necessary and when consistent with written Hospital rules for isolation;
xv. Short-term rehabilitative services and physical therapy when provided on an inpatient basis;
xvi. Rehabilitation Facility, as subject to the benefit limitations listed in your Benefit Summary;
xvii. Medical and surgical services performed by interns and residents-in-training, as defined in Section 1861(b) of Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.;*
xviii. Special duty nursing when Medically Necessary;
xix. Obstetric services for labor, delivery and post-partum care to the Member only. The minimum length of stay for a vaginal delivery is forty-eight (48) hours. The minimum length of stay for a cesarean section is ninety-six (96) hours. However, a shorter length of stay can be arranged if:
    a. The Member and attending Physician agree the mother does not need further inpatient care;
    b. In the attending Physician's opinion, the newborn meets the criteria for medical stability under the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines; and
    c. One (1) at-home post-delivery care visit is provided.

Exclusions. Non-Participating Provider services unless Emergency/Urgent maternity situation.

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Limitations. Maximum benefit as specified in your Benefit Summary.

Payment. All Covered Maternity/Obstetrical Services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary.

Interpretation of this Agreement. Except as expressly provided above by this Rider, or any other Rider that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same, are in full force and effect.

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POINT-OF-SERVICE (POS) BENEFITS
(WELBORN HEALTH OPTIONS ~ SELECT)
RIDER 10

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that Point-of-Service (POS) benefits provided through the Welborn Health Options product are Covered at the level indicated in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider if selected by the Employer, as set forth below:

Eligibility. All Members who have a POS benefit plan are eligible for Out-of-Plan health care benefits.

Definitions.
Excess Charges: Plan payment for Out-of-Plan Covered Services applies to WHP's Usual and Customary (U&C) fee schedule, and WHP Members are responsible for applicable Copays, Coinsurance and Deductible *plus* any charges exceeding WHP's U&C fee schedule.

Penalty: Failure to obtain Prior Authorization for Medically Necessary services results in a penalty per occurrence as defined in your Benefit Summary.

General. Welborn Health Options~Select (POS) Covers both In-Plan and Out-of-Plan Covered Services:

a. In-Plan benefits apply to Covered Services provided by the PCP or services provided by a Participating Provider when a referral from the PCP exists. Referrals must be approved in advance by WHP. In-Plan benefits may also apply to Covered Services for Emergency and Out-of-Area Urgent Conditions. In-Plan benefits for pharmacy coverage require the use of a Participating pharmacy.
b. Out-of-Plan benefits apply to Covered Services not provided or Referred by the Member's PCP, i.e., self-Referral to a Provider for a non-Emergency condition. Out-of-Plan benefits also apply to Referred services that are not approved in advance by WHP. When using Out-of-Plan benefits, the Member is responsible for Prior Authorizations, submitting claims to WHP and for any applicable Copayments, Deductibles, and Excess Charges.
c. All Covered Services listed in the basic Agreement provided by Non-Participating Providers.

Limitations. Services limited in the basic Agreement.

Exclusions.

a. Experimental/Investigational services or devices.
b. Medically unnecessary services.
c. Normally Covered Services rendered for Non-Covered conditions.
d. Normally Covered Services that exceed benefit limits.
e. Services excluded in the basic Agreement.
f. Out-of-plan benefit claims that are submitted to WHP after ninety (90) days are considered the Member's financial responsibility.

Payment. All health care services and items Covered pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary and any excess charges.

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Interpretation of this Agreement. Except as expressly provided above by this Rider, or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same, are in full force and effect.

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HIGH DEDUCTIBLE HEALTH PLAN (HDHP) with HEALTH SAVINGS ACCOUNTS (HSA)
RIDER 11

Please note that the inclusion of the following Rider language in this Agreement does not necessarily mean that these Riders are included in your particular benefits package. Please refer to your Benefit Summary for applicable Covered Riders.

It is understood and agreed that High Deductible Health Plan (HDHP) benefits are Covered at the level indicated in your Benefit Summary and shall be defined and provided under the Agreement in accordance with the terms and conditions this Rider if selected by the Employer, as set forth below.

Definitions and the Basics.
A High Deductible Health Plan (HDHP) is a form of health coverage with a higher annual deductible than a typical health plan. In addition, there is a maximum limit on the sum of the annual deductible and out of pocket medical costs that you must pay for covered expenses. Other than these monetary differences, an HDHP functions the same as a traditional health plan. A HDHP is used in conjunction with a Health Savings Account (HSA).

Depending on the HDHP you elect, you may have the choice of using either in-network and out-of-network providers. Using in-network providers will save you money with the exception of Preventive Care. The annual deductible must be met before the plan benefits are paid. Preventive care services are paid as first dollar coverage, as a Copayment.

A Health Savings Account (HSA) is an account that you set up with a qualified HSA administrator, usually a bank, to pay or reimburse certain medical expenses you incur. An HSA is portable, meaning that you can maintain the same account, even if you leave your current place of employment or no longer remain a member of WHP. HSA balances accrue, without limit, from year to year, meaning that if you do not use all of your available funds in one calendar year, your remaining balance remains available for next year.

General Conditions
A "Covered Service" is a medical expense that is specifically allowed under the HDHP health plan, and payment toward a Covered Service counts toward the HDHP deductible.

A "Qualified Medical Expense" is a medical expense that is reimbursable from an HSA. This means that you may deduct funds from your Health Savings Account to pay the costs of any Qualified Medical Expense.

The list of Qualified Medical Expenses allowed to be paid from an HSA includes items that are not Covered under the HDHP. Because the definition of "Qualified Medical Expense" is broader than the definition of Covered Service, not all Qualified Medical Expenses will count toward the HDHP deductible. Only Qualified Medical Expenses that are included in the list of HDHP Covered Services will count toward the HDHP deductible. For questions on Qualified Medical Expenses, please contact your Human Resources department or your HSA administrator.

HDHP members must receive Covered Services in order for payments for those services to count towards the HDHP deductible. The provider will submit claims to WHP, and the member will be issued an Explanation of Benefits statement. The member will be responsible for paying the provider directly until the deductible is met.

Any payments for Qualified Medical Expenses that are not Covered Services must be paid directly by the member. Payments for these Qualified Medical Expenses will not count towards the HDHP deductible.

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Prescription Drugs.
HDHP members will pay the entire cost of the prescription drugs until their annual deductible has been m During the period of time that the member is paying full price for prescription drugs, these payments will count t rds h their annual deductible and their annual maximum out-of-pocket amount. Once the annual deductible ha een met, HDHP will begin to pay part of the prescription cost, with the member paying a co-payment or co-insur amount. This co-payment or co-insurance amount will continue to be applied to the member's annual maximu out-o ocket amount. Once the member reaches their annual maximum out-of-pocket amount, 100% of the pres tion costs l be covered by the HDHP.

Customer Services.
- For questions on services under the HDHP plan, please contact the Welbo Heal Plans Member Service Department at (812) 426-6600 or (800) 521-0265.
- For questions about services covered as a Qualified Medical Expens nder the HSA or if you have inquiries ab your HSA account, please contact your Human Resources depart t or your HSA Administrator.

Payment. All health care services and items Covered pursuant t his r er are sub Copayment, Coinsurance and/or Deductible amounts (if any) as specified in your Benefit Summary d an cess charges.

Interpretation of this Agreement. Except as expressly provided above by this der, or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and main the ne, are in full force and effect.

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101 S.E. Third Street ♦ Evansville, Indiana 47708
Call (812) 426-6600, (800) 521-0265 or toll free Indiana Relay (800) 743-3333 with questions.