

**ATHENS AREA HEALTH PLAN SELECT, INC.
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GROUP EVIDENCE OF COVERAGE
PREFERRED PROVIDER (PPO)
HEALTH BENEFIT PLAN**

This EVIDENCE OF COVERAGE, which contains the Schedule of Benefits and applicable riders, explains your Group Preferred Provider Organization (PPO) health benefits coverage. This coverage is based upon the Group Healthcare Contract (the "Contract") between Athens Area Health Plan Select, Inc. ("HPS") and your Employer (the "Policyholder"). The Plan selected by your Employer is set out in the Benefit Summary which is attached hereto as Appendix A. The Benefit Summary describes the Copayments, Coinsurance, and Deductibles and sets out the limitations and Exclusions of this Plan.

NOTICE: THIS HEALTH BENEFIT PLAN CONTAINS A PPO BENEFIT. YOU WILL PAY LESS FOR YOUR HEALTHCARE IF YOU GO TO AN IN-NETWORK PROVIDER FOR TREATMENT. IF YOU RECEIVE TREATMENT FROM AN OUT-OF-NETWORK PROVIDER YOU WILL PAY SUBSTANTIALLY MORE OF YOUR HEALTHCARE COSTS.

THIS PLAN REQUIRES THAT ALL INPATIENT MEDICAL TREATMENT AND CERTAIN OUTPATIENT MEDICAL TREATMENT OR SERVICES BE PREAPPROVED. IF PRIOR AUTHORIZATION IS NOT OBTAINED THOSE TREATMENTS OR SERVICES WILL NOT BE COVERED IF DETERMINED TO NOT BE MEDICALLY NECESSARY. IT IS YOUR RESPONSIBILITY TO READ AND UNDERSTAND THIS EVIDENCE OF COVERAGE PRIOR TO RECEIVING NON-EMERGENCY MEDICAL TREATMENT.

Defined Terms: Certain words used in this Evidence of Coverage are capitalized. These words as used herein have specific meanings. Please refer to "Definitions", Section II, as you read this document.

Plan Administrator: Athens Area Health Plan Select, Inc. is not the "Plan Administrator" or named fiduciary as defined by ERISA of your Employer's welfare benefit plan. You should contact your Employer to determine who is the "Plan Administrator" of your employee welfare benefit plan.

Drug Rebates: This notice only applies if the Prescription Drug Rider has been purchased and is attached to this Evidence of Coverage: HPS may receive rebates for certain prescription drugs included in the optional Prescription Drug Rider benefit. These rebates are not deducted from the price of the drug when the coinsurance amount, if any, is calculated nor or these rebates refunded to you. The rebates do not apply to the Deductible or to any applicable Copayments.

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SECTION I INTRODUCTION

Your employer has contracted with HPS to provide you the health benefits coverage described in this Evidence of Coverage. This Evidence of Coverage replaces any previous Evidences of Coverage issued to you by HPS. You should carefully review this Evidence of Coverage, the Schedule of Benefits, the Benefit Summary, and any attached Riders, which will help you understand your HPS Health Benefit Plan.

IMPORTANT INFORMATION

- A. Selection of Your Physician.** You may select any In-Network physician to be your personal physician. If you choose an Out-of-Network physician you will pay more for your healthcare. Your physician may refer you for any treatment or services he or she feels is appropriate for your condition, however, for benefits to be paid such services must be Medically Necessary and covered by this Plan, and subject to the limitations and exclusions of this Evidence of Coverage. It is your responsibility to assure that your Physician obtains any necessary pre-approval on your behalf.
- B. Care Management by your Physician.** The relationship between your physician and you is that of a physician and patient. The physician, hospital or other medical provider is responsible for the medical services they provide to you. If you receive treatment from an In-Network Physician, most types of outpatient care, including routine lab work and X-rays done in the Physician's office, will be covered after payment of the Copayment, Deductible (if applicable), and Coinsurance indicated in the Benefit Summary. Please refer to Section IV of this Evidence of Coverage for a description of the treatments or services that require Prior Authorization to be covered. For most types of outpatient care received from an Out-of-Network Physician, you will be responsible for payment of the Deductible and Coinsurance at the level set out in the Benefit Summary. The Benefit Summary also contains limitations on certain benefits and services. Inpatient hospital services which have received Prior Authorization are covered at the level set out in the Benefit Summary after your Copayment (if In-Network), Deductible (if applicable), and Coinsurance. **Non-emergency inpatient treatment will not be covered if no Prior Authorization is obtained.** You should refer to the Benefit Summary for a full description of the Copayments, Coinsurance, and Deductibles for your Plan. Some plans do not require an In-Network Deductible. Please refer to the Benefit Summary. In most cases you do not have to fill out claim forms. Your physician usually submits claims for you.
- C. When your Physician Is Not Available.** Your physician is responsible for providing twenty-four (24) hour coverage including weekends and holidays. Should you require medical attention, contact your physician's office and identify yourself as a Member of HPS. If your usual physician is unavailable, his or her office staff may refer you to an on-call physician. The on-call physician will give you further instructions. It is a good idea to check with your physician to find out his or her particular method of handling after hours calls.
- D. Scheduling and Canceling Appointments.** Call your PCP's office when you need to schedule an appointment. Always identify yourself as an HPS Member. **In no event will HPS pay for missed or cancelled appointments.**
- E. If Care Is Not Received from an In-Network Provider.** If you choose to receive Covered Healthcare Services from an Out-of-Network Provider, except in the event of an emergency, Medically Necessary services will be covered as described in the Benefit Summary for Out-of-Network benefits (including Coinsurance and the applicable Deductible) if any required Prior Authorization is obtained. Please refer to Section IV of this Evidence of Coverage for a description of the Prior Authorization requirements. **HPS will pay a percentage of the Usual, Customary, and Reasonable (UCR) charge for those services. Members are responsible for payment of any portion of the charge for Covered Services received from Out-of-Network Providers that exceeds UCR.** Please follow the instructions in Section VII regarding filing claims for services provided by Out-of-Network Providers.

F. Emergency Care. If you require emergency care for an unforeseen illness or injury, you or someone acting on your behalf must notify HPS of the treatment within forty-eight (48) hours by calling the appropriate number listed on your Membership Card. You will be required to pay the Copayment, Deductible, and/or Coinsurance for emergency services specified in the Benefit Summary for all emergency care. **In all cases, if you feel your life or health is threatened, seek treatment from the nearest emergency facility.**

G. Prior Notification and Authorization. Providers of service must inform HPS of proposed Non-Emergency services not less than three business days prior to the date of service for the determination of eligibility, benefit coverage, and medical necessity. Prior Authorization is required for all In-Network and Out-of-Network Non-Emergency inpatient medical or surgical admissions, outpatient services and procedures (except for EKGs, lab, plain film radiology, non-obstetric ultrasounds and mammograms), Rehabilitation Services and Durable Medical Equipment. In addition, the following services provided by an In-Network or Out-of-Network Specialty Physician must receive Prior Authorization from HPS:

- Cancer treatment. A treatment plan will be required after one (1) initial consultation visit.
- All pain management services;
- Services performed by an oral surgeon will require a treatment plan after one (1) initial consultation visit;
- Services performed by a plastic surgeon will require a treatment plan after one (1) consultation initial visit; and
- All mental health services and substance use disorder treatment.

This notification does not guarantee the services provided Out-of-Network will receive In-Network benefits. If the proposed Covered Services are available In-Network, Out-of-Network services will be covered subject to the Deductible and Coinsurance described in the Benefit Summary for Out-of-Network services. In all cases the services must be Medically Necessary Covered Services for benefits to be paid. **It is the Member's responsibility to make sure that all Out-of Network treatment meets the prior notification and prior approval requirements. Failure to do so will result in a reduction or denial of benefits.**

Please note: Prior Authorization does not guarantee payment. Benefits and eligibility will be determined at the time the claim is received.

I. Case Management. Your Physician will manage the development of your treatment plan and review it, your expected length of stay in the hospital (if a hospital admission is required), and other significant aspects of your care. HPS provides Case Management Services for high risk and complex medical conditions.

HPS may, at its discretion, provide Case Management Services for high risk and complex medical conditions.

J. Copayments. The Copayments required for In-Network services or benefits under this Plan are set out in the Benefit Summary. You will be required to pay the Copayment at the time you receive covered healthcare services or benefits. Copayments do not count towards the Annual Out-of-Pocket Maximum.

K. Important Notices:

1. Family Violence: The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

2. **Newborn and Maternity Health Protection Act:** No pre-approval or authorization is required for hospital stays of up to 48 hours following a vaginal delivery or up to 96 hours following a cesarean section. However, the treating physician, after consultation with the mother, may discharge the mother or her newborn earlier than the 48 hours for a vaginal birth or 96 hours for a cesarean section.
3. **Direct Access to Certain Specialists:** No referral is necessary from your Physician for treatment from a Participating Provider such as a Dermatologist, Ophthalmologist/Optomist, or OB/GYN physician.
4. **Mastectomy and Lymph Node Coverage:** Coverage for Inpatient care following a mastectomy or lymph node dissection shall be provided until the completion of the appropriate period of stay for such Inpatient care as determined by the attending physician in consultation with the patient. Coverage shall also be provided for such number of follow-up visits at home or in the physician's office as determined to be appropriate by the attending physician after consultation with the patient.
5. **Women's Health and Cancer Rights Act:** The Women's Health and Cancer Rights act of 1998 requires that Athens Area Health Plan Select, Inc. provide you with notice of the coverage that this law requires our plan to provide.
 The HPS health plan provides coverage for medically necessary mastectomies. This coverage is subject to the same deductibles, coinsurance, and copayments as other surgical or medical treatments. Please refer to your Benefit Summary for more information.
 The following benefits relating to mastectomies are provided:
 - a. Coverage for all stages of reconstruction of the breast on which the mastectomy is performed.
 - b. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
 - c. Coverage for prostheses (implants, special bras, etc.) and physical complications resulting from any stage of the mastectomy, including lymphedemas.
6. **Statement of Rights under the Newborns' and Mothers' Health Protection Act:**
 Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
 Also under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
 In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48-hours (or 96-hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.
7. **Mental Health and Substance Use Disorder Parity Notice:** Medically Necessary Inpatient and Outpatient treatment for mental health and substance use disorders are covered on the same basis as any other physical illness or injury and are subject to the same Copayments, Coinsurance, and Deductibles as set out in the Benefit Summary.

If you have any questions, please call Member Services at (706) 549-0549 for more information.

SECTION II DEFINITIONS

The following definitions apply to this Evidence of Coverage:

Accidental Injury: Any unforeseen and unintended injury.

Allowable Charge/Allowable Expense: Any medically necessary expense that does not exceed the Usual, Customary, and Reasonable (UCR) or the amount of the negotiated charge with that Provider for that service, and that is covered, at least in part, by the provisions of this healthcare plan.

Allowable Charge Limitation: The Plan will not pay any amount that is in excess of the Allowable Charge as defined above for Out-of-Network charges. In no event will HPS pay more than the billed amount.

Ancillary Provider: An individual or healthcare facility, which provides those Healthcare Services not provided by physicians or hospitals, such as home health, physical therapy and durable medical equipment.

Annual Maximum: The maximum amount the Plan will pay for eligible expenses or services incurred by a covered person during the calendar year.

Annual Out-of-Pocket Maximum: The Annual Out-of-Pocket Maximum is the amount paid for all Covered Services received by a Member or for a family. There may be a different Annual Out-of-Pocket Maximum for In-Network benefits and for Out-of-Network benefits. The Annual Out-of-Pocket Maximum for this Plan is set out in the Benefits Summary. After the Member or family has satisfied this amount for the calendar year, the Member or family is not responsible for any additional Coinsurance or Deductible for the remainder of the same calendar year. Amounts in excess of the UCR charges or for non-Covered services do not count toward the Annual Out-of-Pocket Maximum.

Appeals Committee: Second level appeals for review of non-medical issues that concerns exclusions or limitations of treatments or services, eligibility issues, and other matters that do not involve medical judgments will be decided by a non-medical Appeals Committee composed of the Executive Director, Chief Operating Officer, and Chief Financial Officer, any two of which constitute a quorum.

Appeal or Medical Appeal: A request that a decision of HPS be reviewed from a Member, their provider, or their authorized representative acting on their behalf regarding medical treatment, Prior Authorization, Medical Necessity, length of stay, etc. Please see the Complaint and Appeal Section

Calendar Year: A period which begins January 1st and ends December 31st. For purposes of Deductibles, Out-of-Pockets and Annual Maximums, the Calendar Year period will apply.

Claim Form: The standard forms utilized by physicians and hospitals and other providers to file for services provided or a customized form provided by HPS to its members for the purpose of filing directly for services received. See also Section VII for additional filing information.

Coinsurance: The Member will be responsible for the Coinsurance percentage set out in the Benefits Summary for Covered Services, after paying the applicable Deductible. However, any Out-of-Network charges in excess of UCR are not eligible expenses and are the Member's responsibility. In addition, charges in excess of UCR do not apply to nor can they satisfy the Annual Out-of-Pocket Maximum.

Complaint: A written expression of concern by an enrollee regarding the provisions of health care services or a condition in the operation of HPS. A Complaint or Administrative Appeal concerns exclusions or limitations of treatments or services, eligibility issues, and other matters which do not involve medical judgments, or a condition in the operation of HPS. Please see Complaint and Appeal Procedures, section XIV.

Complications of Pregnancy: Conditions requiring hospital confinement when the pregnancy is not terminated

and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as ectopic pregnancy which is terminated, acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; but the term shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Continuation of Coverage: Plan coverage may be continued, after the date which Coverage would otherwise end, by a Member at the Member's election upon meeting the requirements set out in Section X.

Contract: The Contract consists of the Group Healthcare Contract between HPS and Policyholder, this Evidence of Coverage, any applicable riders, and the application for coverage form completed by the Member.

Contract Years and Contract Months: Are determined from the Effective Date of the Contract.

Convalescent or Custodial: Care primarily intended to assist with the activities of daily living. For example, help in walking, getting in or out of bed, dressing, eating, or taking medications, etc. The guidelines used by Medicare will be used to determine if care is custodial in nature.

Copayment: A charge, expressed as a fixed dollar amount which the Member is required to pay for certain Healthcare Services provided under the Contract. The Member is responsible for the payment of any Copayment directly to the Provider when Healthcare Services are received. Copayments do not count towards the Annual Out-of-Pocket Maximum.

Covered: Being eligible for and enrolled in the Group Health Benefit Plan.

Covered Services: The Healthcare Services provided to Members under the terms of the Contract and this Evidence of Coverage.

Crisis Intervention and Evaluation: Those Healthcare Services that are Medically Necessary to provide immediate treatment for acute Mental Health Conditions on a short-term basis.

Days Per Confinement: Consecutive days of services received as an Inpatient in a Hospital; or successive confinements when discharge from and readmission to a Hospital occurs within a period of time of not more than three (3) days.

Deductible: The amount that an individual Member or family must pay for Covered Non-Emergency treatment or services each calendar year before benefits for such services are paid. Any portion of the Deductible which is met within the last three months of the Calendar Year that applies to that Calendar Year's Deductible will carry-over and also apply to the Deductible for the next Calendar Year. The Deductible does count towards the Annual Out-of-Pocket Maximum.

Dependent: A person listed on the Subscriber's Enrollment/Change Form who is:

1. the Subscriber's legal spouse; or
2. an unmarried Dependent Child, as defined below, of either the Subscriber or the Subscriber's spouse, who is:
 - a. less than nineteen (19) years of age;
 - b. whose principal residence is with the Subscriber (unless the Dependent resides with the other spouse according to a qualified medical child support order);
 - c. is primarily dependent upon the Subscriber or the Subscriber's spouse for support and maintenance;
 - d. is claimed as a dependent on the Subscriber's or the Subscriber's spouse's income tax return; and

- e. subject to the following conditions and limitations:
- (1) The term "Dependent Child" as used herein shall include any stepchild, legally adopted child or child placed in the Subscriber's home prior to adoption, or a child for whom the Subscriber is legal guardian. NOTE: Newborns and adopted children are automatically covered for thirty-one (31) days after birth or adoption or placement in the home prior to adoption. To continue coverage beyond thirty-one (31) days, unless the Subscriber is already enrolled under the Family Membership Plan, the Subscriber must apply for coverage by submitting an Enrollment/Change form to the Policyholder within the thirty-one (31) day period.
 - (2) An unmarried dependent child, regardless of age, who is incapable of self-support and became so incapacitated before attaining age nineteen (19) because of mental illness, mental retardation, developmental disability, or physical handicap, will be covered and when coverage of such child would normally terminate upon the child's (nineteenth) 19th birthday, will continue to be covered as a Dependent, subject to the provision for extended coverage in Section XI. To be eligible for coverage as an incapacitated dependent child the dependent child must have been covered under this Plan or a plan it replaces prior to reaching age nineteen (19).
 - (3) Any unmarried dependent child who is between nineteen (19) and up to and including twenty-five (25) years of age, provided the child is a full-time student at a Post Secondary Educational Institution for at least five (5) calendar months or more in the calendar year or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury. Full-time means a minimum of twelve (12) credit hours per semester or quarter. Full-time student status ends on the last day of the month in which the student graduates or ceases to be enrolled as a full-time student in the Post Secondary Education Institute. It is the responsibility of the Subscriber to provide proof of full-time student status on a semi-annual basis on a form furnished by HPS and completed by the registrar or similar official of the Post Secondary Educational Institution. The Subscriber must notify HPS when a Dependent is no longer a full-time student. If a dependent child was prevented from being enrolled due to illness or injury, and is eligible to be claimed as a dependent on the Subscriber's federal income tax return, the child will be considered eligible until he or she is able to enroll as a full-time student or reaches up to and including the age of twenty-five (25) years. Medical documentation in the form of a physician's certification of the medical condition of the dependent child will be required to extend this coverage.
 - (4) In no event shall the term "Dependent" include: (a) any spouse or child who is eligible for Medicare, by reason of age (except, when the Subscriber remains employed on a full-time basis, the spouse may be entitled to remain covered as a Dependent); or (b) any spouse or child on active duty in the armed forces of any country except persons serving in the United States military for thirty-one (31) days or less.
- f. Those dependents for which You are ordered to provide coverage through a Qualified Medical Child Support Order.

The Subscriber must reimburse HPS for any benefits paid on behalf of a child for any period when the child did not meet the definition of a Dependent and was not eligible for coverage under this Plan.

Disease Management Programs: Educational programs designed for individuals with chronic diseases designed to help maintain high quality of life and prevent future need for medical resources by using an integrated, comprehensive approach to health care coordinated with the individual's treating physician.

Durable Medical Equipment: Equipment that is appropriate for use in the home, is able to withstand repeated use, is Medically Necessary, is not of use to a person in the absence of illness or injury and is approved for coverage under Medicare as of January of the year immediately preceding the year coverage under this Plan became effective or was last renewed. Such equipment includes, but is not limited to infant apnea monitors, blood glucose monitors, hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicare.

Effective Date: The date from which eligible Group Members are approved by HPS to receive Healthcare Services, also called Eligibility Date.

Eligibility Date: The date on which a particular Member is approved by HPS to receive Healthcare Services.

Eligibility Period: The thirty-one (31) day period following completion of any Policyholder probationary period after the initial date of employment.

Eligible Employee: An active full-time employee, including an owner, sole proprietor, or partner, who works a minimum of thirty (30) hours on average per week for the Policyholder in the Policyholder's business and who has completed any probationary period for employees and for whom the Policyholder deducts FICA taxes from his or her pay.

Eligible Expenses: The reasonable charges defined as Covered Charges herein and not excluded by this Evidence of Coverage or the Contract. Out-of-Network Emergency services are subject to Usual, Customary, and Reasonable (UCR) Charge allowances. All amounts that exceed UCR are not covered by the Plan.

Emergency: A medical condition of a recent onset and severity, including but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in (1) placing the patient's health in serious jeopardy, or (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part, or (4) with respect to a pregnant Member who is having contractions, that there is inadequate time to safely transfer her prior to delivery or that such transfer may pose a threat to the health or safety of the Member or her unborn child.

Enrollment/Change Form: The form completed by Subscribers requesting coverage from HPS which lists all Family Dependents to be covered on the Eligibility Date and provided by HPS to the Policyholder for distribution to Members who wish to add or delete a Family Dependent, or revise information contained in the enrollment record.

Evidence of Coverage: This document which describes Plan policies, services, benefits, exclusions and limitations. In some cases this may be referred to as the Certificate of Coverage. No change in this Evidence of Coverage shall be valid until approved by an executive officer of HPS and unless such amendment is attached hereto. No agent has authority to change this Evidence of Coverage or to waive any of its provisions.

Exclusions: Specific conditions, circumstances, or treatments, devices, or medications listed herein that are not covered and for which this Plan will not provide benefit payments.

Experimental or Investigative: Drugs, treatments, diagnostic tests, devices and/or procedures that are not approved by the United States Food and Drug Administration (FDA) and are not generally accepted forms of treatment according to national medical standards as reflected in published reports or articles in nationally recognized authoritative medical and scientific journals or literature. All determinations of experimental or investigative treatments will be reviewed by HPS's Medical Director. A treatment or service that is determined to be Experimental or Investigative is not a Covered Benefit.

Explanation of Benefits (EOB): A form sent to the covered Member after a claim for payment has been processed by HPS that explains the action taken on that claim. The explanation will include the amount that has

been paid, the benefit available, the reason for denying payment in whole or in part, and, if appropriate, the claims appeal process.

External Review: A review of non-certification decisions by an external Independent Review Organization (IRO).

Genetic Testing: Means any test that might reveal information about an individual's DNA, RNA, chromosomes, proteins, or metabolites, or chromosomal changes. Genetic testing does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

Grievance: A written complaint submitted by Members or other authorized representatives acting on behalf of the Member about any of the following:

- HPS's decisions, policies, or actions related to availability, delivery, or quality of health care services.
- Claims payment or handling or reimbursement for services.
- The contractual relationship between a Member and HPS.
- The outcome of an appeal of a non-certification.

Group: The Policyholder's Employees and Dependents who are eligible to enroll in the Health Benefit Plan. The Group may be subdivided into classes to the extent permissible under federal and state law.

Group Application Form: The form completed by the Group requesting coverage from HPS.

Group Health Benefit Plan: The HPS health benefit plan that provides coverage to Subscribers and their Dependents pursuant to the applicable Contract between the Policyholder and HPS.

Group Healthcare Contract: The Contract between HPS and the Policyholder.

Healthcare Services: Services and supplies Medically Necessary to treat Accidental Injuries, Sickness, Mental Health Conditions, and Preventive Care as outlined in the Schedule of Benefits in Section V.

Health Insurance Portability and Accountability Act (HIPAA): A federal health benefits law which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; and which restricts the use and disclosure of protected health information.

Home Healthcare: A program of care provided by a duly licensed or certified agency engaged in providing Home Healthcare Services, including, but not limited to skilled nursing services; and having a valid, existing agreement with HPS to provide said services to Members.

Hospital: An acute general care facility operated pursuant to a law which:

1. is primarily engaged in providing, for compensation from its patients, diagnostic therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by, or under the supervision of, a staff of physicians; and
2. has twenty-four (24) hour nursing services by registered professional nurses; and
3. is not a federal hospital other than a Veterans Administration Hospital or a Department of Defense Hospital;
4. is not, other than incidentally, a place for rest, custodial care for the aged, or a nursing home, a convalescent home, or similar institution, or
5. is licensed as a hospital by the state licensing authority or an agency of the federal

government.

HPS reserves the right to determine whether a facility is a hospital based on the above factors.

HPS: Athens Area Health Plan Select, Inc.

Identification Card: See Membership Card.

Initial Enrollment Period: The period of time when an employee or Dependent first becomes eligible for coverage on either the effective date of the Plan or within thirty-one (31) days of the first date of employment, excluding the Waiting Period.

Injury: Bodily harm resulting from a non-occupational Accident.

In-Network Benefits: Payments made for In-Network treatment or services in accordance with the Benefit Summary. Services will be subject to Co-payments, and, if set out in the Benefit Summary, Deductibles and Coinsurance.

In-Network Provider: See Participating Provider.

Individual Conversion Policy: A policy issued in accordance with the conversion privilege described in Section X-D; or for any other reason which requires the Member to pay the premium directly for individual coverage.

Inpatient: A person admitted to a hospital as a bed patient for treatment or testing but not merely for observation for a period of time which usually includes an overnight stay.

Lifetime Maximum Benefit: The Lifetime Maximum Benefit includes the total of all payments made under this HPS plan, including prescription drug benefits and benefits paid pursuant to any other rider. The Lifetime Maximum Benefit is the maximum of all benefits one individual can receive and once an individual has reached his or her Lifetime Maximum Benefit no further benefits are payable under this Contract or plan.

Long Term: Lasting more than sixty (60) days.

Maximum Annual Out-of-Pocket: The Maximum Annual Out-of-Pocket refers to the Annual Out-of-Pocket Maximum expenses defined herein and set out in the Benefit Summary.

Medical Audit: The retrospective examination and evaluation of the documentation of clinical application of medical knowledge as revealed in patient health records for the purposes of education, accountability, and quality assurance.

Medical Director (or Associate Medical Director): The medical professional employed by HPS who is designated as the person who directs the clinical component of HPS.

Medically Necessary or Medical Necessity: Any Healthcare Service or supply which, based upon generally accepted medical practices in light of conditions at the time of the treatment, is: (a) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the Member's condition; (b) compatible with the standards of acceptable medical practice in the United States; (c) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms; (d) not provided solely for the convenience of the Member or the convenience of the health care provider or hospital; and which is not primarily custodial care, unless custodial care is a Covered Service or benefit under the Member's Evidence of Coverage. HPS reserves the right to make the final determination of whether a service is Medically Necessary, for purposes of Plan coverage only, and not for the purpose of practicing medicine or superseding Physician's independent medical judgment.

Member: A Subscriber, or Dependent, who is covered by the HPS Health Benefit Plan described in this Evidence of Coverage.

Membership Card: The identification card that HPS issues to its Members showing that they are entitled to receive Healthcare Services. Possession of a Membership Card does not guarantee eligibility for medical coverage. Benefits and eligibility will be determined at the time claims are received. Verification of coverage prior to receiving services can be obtained through contacting the Member Services Department at HPS. Members whose coverage under this Plan terminates must not use their Membership Card after the termination of their coverage to obtain benefits or services. They must reimburse HPS for any claims paid by HPS for services or benefits received after coverage terminates except for claims paid pursuant to an Extension of Benefits. See Section XI.

Membership Type: There are five (5) types of memberships offered to HPS Policyholders:

1. Single
2. Employee and Spouse
3. Employee and one dependent (spouse or one child)
4. Employee and dependent child or children
5. Family

Mental Health Condition: Mental, nervous, or emotional disorders, subject to significant clinical improvement through Short-Term treatment. Certain Mental Healthcare Services are excluded from coverage, see “Exclusions” in Section VIII.

Network: The hospitals, physicians and other healthcare professionals that have contracted with HPS to provide treatment and services to Members. These medical providers make up the HPS Network of Participating Providers.

Non-certification: A determination by HPS (or a Utilization Management Delegated Entity) that an admission, availability of care, continued stay, or other health care service, after review of information provided, does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services and the requested service is therefore denied, reduced, or terminated. A non-certification includes any situation in which an insurer or its designated agent makes a decision about a covered person’s condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision. A denial based on excluded services does not constitute a non-certification.

Non-Emergency Care: All health care that does not meet the definition of “Emergency Care” contained herein.

Non-Participating Provider: See Out-of-Network Provider below.

Open Enrollment Period: The annual period during which HPS and the Policyholder agree that Subscribers and eligible Dependents may apply for coverage. Subscribers and Dependents may also be able to enroll during special enrollment periods.

Out-of- Area: The area outside of the geographical area defined by HPS as the Service Area.

Out-of-Network: Any Hospital, Physician, home health agency, ambulance service, laboratory, pharmacy or other healthcare provider that is not under contract with HPS to provide services to Members or has not been authorized in advance by HPS to provide specific Healthcare Services to Plan Members, or any healthcare treatment or services received from an Out-of-Network Provider.

Pain Management: The attempt to relieve or control chronic or severe pain through the use of medications, therapy, and other treatments recognized in the general medical community of the United States as being appropriate and effective and which do not pose an undue risk of causing addiction or dependence on controlled

substances.

Participating Physician: An In-Network Physician.

Participating Provider: Any Participating Hospital, Physician, Home Health Agency, Ambulance Service, Laboratory, pharmacy, or other health care provider that is listed in HPS's Provider Directory and has a direct contract with HPS to provide services to Members or has been authorized, in advance, by HPS to provide specific Healthcare Services to Members. Unless otherwise specified, all Participating Providers have independent professional businesses, exercise independent judgment and are independent contractors with HPS. Participating Provider does not include medical providers that participate in a Preferred Provider Organization with which HPS has a contract to provide Out-of-Network services to Members.

Physician: Any practitioner of medicine, osteopathy or other practitioner providing medical services who is duly licensed by the State of Georgia.

Plan: This healthcare benefit plan underwritten by Athens Area Health Plan Select, Inc. (HPS).

Policyholder: The employer or other entity with whom the Contract is made and who agrees to collect and pay the applicable premium to HPS on behalf of all of its Subscribers and Dependents.

Post Secondary Education Institution: An institution of higher learning having an organized curriculum and requiring class attendance for a minimum number of hours per quarter or semester, and which is accredited by a government agency or nationally or regionally recognized accreditation association, or which is approved for educational benefits by either the Georgia Department of Education, the United States Veteran's Administration, or other state or federal agency. This term includes, but is not limited to, colleges, universities, vocational or technical schools, professional or graduate schools. This term does not include cosmetology school, barber school, equestrian school, sports school, bartender school, cooking school, or other similar training.

Premium: The amount charged for coverage under this healthcare Plan by HPS. The Employer or Policyholder is responsible for paying this amount to HPS each month.

Premium Contribution: The premium that the Policyholder pays on behalf of, or collects from, Subscribers and submits to HPS.

Prescription: A written order or refill notice issued by a licensed medical professional for drugs, which are only available through a pharmacy

Preventive Care: Proactive health care designed to keep people from getting sick or hurt. It includes immunizations and screenings. A key part of preventive medicine is making sure patients know how to improve their health by altering their lifestyles.

Prior Authorization: A determination made by HPS before a treatment or service is received to approve the treatment or service for coverage by the Plan based on eligibility, benefit plan coverage, and medical necessity. Prior Authorization is required for all Non-Emergency Inpatient medical or surgical admissions, outpatient services, all Out-of-Network referrals, Rehabilitation Services and Durable Medical Equipment. Please see Section IV of this Evidence of Coverage for a full description of the requirements for Prior Authorization.

Prior Notification: A process for providers of service to inform HPS of proposed Non-Emergency services not less than three (3) business days prior to the date of service for the determination of eligibility, benefit coverage and medical necessity. Prior Authorization is required for all Non-Emergency Inpatient medical or surgical admissions, outpatient services, all Out-of-Network referrals, Rehabilitation Services and Durable Medical Equipment.

This notification does not guarantee that services that are provided Out-of-Network will receive In-Network

benefits. If the proposed services are available In-Network, as determined by HPS, Out-of-Network services will be covered subject to the Deductible, Coinsurance, and Usual, Customary, and Reasonable (UCR) rate.

Qualified Medical Child Support Order: An order by a court or government agency that requires a non-custodial parent to provide health care coverage to a child who does not usually reside with the parent being ordered to provide such coverage.

Review Panel: Requests for review of medical issues (medical treatment, Prior Authorization, Medical Necessity, length of stay, etc.) will be determined by a physician or other licensed medical professional of like specialty to the requesting provider or Member in accordance with the Complaint and Appeal Policies and Procedures adopted by HPS. Requirement for these health professionals are:

- That they were not involved in the original determination;
- Must be a clinical peer;
- Must hold an active, unrestricted license to practice medicine or a health profession;
- Must be board certified (if applicable);
- Must be in the same or similar specialty that typically treats or manages the medical condition, procedure, or treatment requested.

If the review is a Level-2 Appeal for non-certification or involves a clinical issue the committee members must be composed of a panel of not less than three persons, at least one member of which shall be a physician other than the medical director of the plan and at least one member of which shall be a health care provider competent by reason of training and licensure in the treatment or procedure which has been denied.

Rider: An agreement with the Policyholder, which amends the Contract.

Semi-Private Room: A room with two (2) or more beds in a Hospital; Skilled Nursing Facility; or other Participating Provider facility.

Service Area: The geographic area in which HPS has arranged to provide Healthcare Services to Members.

Short-Term Therapy and/or Rehabilitation Services: A plan of treatment, or any portion of such plan for an Accidental Injury or Sickness which is subject to significant clinical improvement within sixty (60) days or less, not to exceed the benefit plan maximums as stated in the Member's current Benefits Summary.

Sickness: Physical illness.

Skilled Nursing Facility: A facility legally operated to provide therapeutic services to Inpatients requiring medical and skilled nursing care or which is qualified to participate as an extended care facility under Medicare. This does not include an institution or part of one that is used mainly as a place of rest or as a place for the aged.

Sound Natural Tooth or Teeth: Means a tooth or teeth which: has no fillings or cavities; or has fillings or cavities which do not undermine the tooth cusp; and has healthy and intact pulpal tissues; and has periodontal tissues showing no sign of active or chronic inflammation. HPS reserves the right to determine what is a sound natural tooth. HPS will evaluate each tooth separately.

Special Enrollment Period: The period during which a Subscriber and/or Dependent may elect to enroll as described in Section III-C.2 (b) and, in the case of a new Dependent, as described in Section III-C.3(c).

Specialty Care Physician: A Physician who is qualified by education, training and applicable credentialing criteria to provide Specialty Care, which are Physician-delivered Healthcare Services other than those provided by a primary care physician.

Spouse: A person of the opposite sex who is legally married to the Subscriber.

Subscriber: An Eligible Employee of the Policyholder who is entitled to participate in healthcare benefits through the Policyholder and who meets such eligibility requirements (such as length of service, active employment, etc.) as may be imposed by the Policyholder, subject to any Continuation of Coverage that may be available.

Subscriber Premium Contribution: The amount paid or payable periodically by a Subscriber to pay any part of the premium.

Substance Use Disorder: Means the improper or overuse of a legal or illegal drug or substance such as alcohol or prescription drugs such that the physical or mental wellbeing of the individual is adversely affected.

Temporomandibular Joint Dysfunction (TMJ): Disease or deformity of the temporomandibular joint.

Totally Disabled or Total Disability: In the case of an adult Member, Totally Disabled means that he or she, as a result of illness or injury, is unable to perform the usual tasks required of his or her employment and is not able to be employed for wages or profit. A Dependent child is considered Totally Disabled when, as a result of injury or illness, he or she is wholly unable to engage in the normal activities of a person of the same sex and age.

Transition of Care: If a Member is being treated by a Medical Provider under the terms of this Plan for a serious medical condition or chronic disease when the Medical Provider's contract with HPS terminates, the Member will be allowed to continue treatment by that Medical Provider for that condition for up to sixty (60) days under the terms of this Plan. Members who are pregnant will be allowed to continue treatment with their treating physician until delivery and for six weeks of postdelivery care. Members who are experiencing an ongoing medical condition that meets HPS's predetermined clinical criteria to continue with their established practitioner (even though that practitioner may not be in the HPS network), until the episode of care is completed or the time frame allowed for transition has elapsed, whichever is less. The goals of the transition of care program are to: provide a seamless transition for health plan Members from their prior health plan; or from one medical provider to another; improve access to health services; improve Member satisfaction; and enhance health status and quality of life.

Examples of medical conditions likely to qualify for TOC benefits include treatment for unstable or serious conditions that require a limited course of treatment or follow-up care, such as recent acute heart attack, newly diagnosed cancer requiring surgery, chemotherapy or radiation therapy, total joint replacement requiring physical therapy, acute trauma such as a bone fracture, certain psychiatric treatment or substance abuse programs, and/or recent surgical procedures with complications.

Conditions limited or excluded from coverage are not eligible for TOC benefits. You should not apply for TOC benefits if the treating physician is in the HPS network.

Urgent Care: Healthcare Services required for the examination and treatment of medical conditions or injuries which are not life threatening or potentially disabling but which require prompt medical attention.

Usual, Customary, and Reasonable (UCR) as Determined by HPS: An amount that is within the reasonable range of charges in the Athens, Georgia Metropolitan Area for the same service or treatment by medical providers with similar training and experience that is within the scope of the law, in conformity with industry standards, and not exceeding the appropriate limits based on standard industry methodology for the service or treatment provided. For hospital services HPS uses the published Medicare Cost Data to calculate UCR rates.

Waiting Period: The period of time chosen by the employer after the initial date of employment before the employee becomes eligible for group healthcare coverage under the Plan.

We, Us, Our and Ours: Athens Area Health Plan Select, Inc.

You or Your: The Member receiving Healthcare Services under this Evidence of Coverage. For ease of reading these words are not capitalized in the text of this Evidence of Coverage.

SECTION III ELIGIBILITY, ENROLLMENT AND CONDITION OF COVERAGE

A. Eligibility.

1. You are eligible for enrollment when you are:
 - a. A Subscriber who is employed full-time (30 hours or more on average per week) and have completed any probationary period for employees and for whom the Policyholder deducts FICA taxes from your pay or you are an owner, sole proprietor, or partner who works 30 or more hours on average per week, in the Employer's business. .
 - b. A Dependent and you reside in the United States.
2. Except as otherwise provided herein, persons not entitled to coverage include:
 - a. Persons who are in the armed forces of any government (except persons serving in the United States military for thirty-one (31) days or less).
 - b. Any child born to a Subscriber's Dependent child.
3. HPS has the right to request and be furnished with such proof as may be needed to determine eligibility status of a Member.
4. HPS may examine a Group's records including payroll records and an individual's employment, or Membership records in determining eligibility status for Membership.

B. General Enrollment.

1. You may enroll yourself and your Dependents within thirty-one (31) days of your first day of employment and completion of any Policyholder required Waiting Period by completing an Enrollment/Change Form, available from either the Policyholder or HPS. The Policyholder shall give all newly hired Employees or Members of the Group HPS's Enrollment/Change Form and descriptive literature as soon as they become eligible for coverage. If Subscribers do not apply within thirty-one (31) days of the date they become eligible, they must wait until the next Open Enrollment Period or a Special Enrollment Period as provided in Paragraph C below to become Covered.
2. Changes to the original Enrollment/Change Form must be made by completing a Change of Status Form, which will be made available by HPS to the Policyholder for distribution to you. The Policyholder agrees to promptly send HPS all Enrollment/Change Forms and to notify HPS if there is any change in any Subscriber's eligibility for coverage from HPS. **HPS is not responsible for errors due to the failure of the Policyholder or the Subscriber to give timely notice of changes.**
3. Unless otherwise agreed to by HPS and the Policyholder, your coverage shall take effect on the Effective Date of the Contract, provided that you have satisfied the requirements of this Section. Subscribers and their Dependents eligible to enroll in the Group Health Benefit Plan after the Effective Date shall be enrolled in the Group Health Benefit Plan on the Eligibility Date agreed upon by both the Policyholder and HPS and if the first month's premium is paid on behalf of the Subscriber and the Dependents.
4. You may enroll in the Group Benefit Plan by applying for coverage during the Open Enrollment Period, which is the thirty (30) day period preceding the anniversary date of the Contract (except for Special Enrollment) upon meeting the eligibility requirements imposed by the Policyholder, or during special Open Enrollment Periods agreed upon by both the policyholder and HPS.

C. Special Enrollment

The Health Insurance Portability and Accountability Act (HIPAA) requires that group health plans must offer certain individuals the right to enroll for group health coverage when specified events occur. If you did not apply for coverage under the group health plan when first eligible you have the right to apply for and be accepted for coverage when any of the following events occur:

1. If the reason you failed to enroll was because you were covered under a different health plan at the time you were first eligible, such as your spouse's plan or COBRA coverage under your prior plan, and (a) that coverage terminates, (b) you reach the lifetime limit on benefits for that plan, (c) if you were covered under an HMO plan and you moved out of the HMO's service area, (d) the employer contribution to that plan ended, (e) the other plan does not offer dependent coverage, or (f) the other plan ceases to cover the class of employees to which you belong you may apply for coverage under this Plan if you meet the eligibility requirements.
2. If you marry or have a child, either by birth or adoption, you and your dependents are eligible for Special Enrollment. You and your eligible dependents are eligible to enroll in any benefit package offered to other eligible employees and dependents offered by your employer. **You and/or your dependents must apply for Special Enrollment under this Plan within thirty-one (31) days after the other coverage terminates or you obtain the new dependent (marriage or the birth or adoption of a child).** Please contact Member Services at (706) 549-0549 or write to:

Member Services Department
Athens Area Health Plan Select, Inc.
295 West Clayton Street
Athens, Georgia 30601

The Effective Date of Special Enrollment is:

- (1) In the case of marriage, the first day of the first calendar month beginning after the date the Enrollment Form is received by HPS or the date of marriage if allowed by the Policyholder and approved by HPS and if the enrollment form is received by HPS within thirty (30) days of the marriage;
 - (2) In the case of the Dependent's birth, the date of such birth;
 - (3) In the case of the Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.
3. SPECIAL ENROLLMENT DUE TO MEDICAID AND STATE CHILD HEALTH INSURANCE:

(a) Special Enrollment for Employees and Dependents Due to Termination of Medicaid or SCHIP Eligibility. Any Employee or Dependent who is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and coverage of the employee or dependent under such plan is terminated as a result of loss of eligibility for such coverage will be allowed to enroll for coverage under the Plan if they request coverage under the Plan not later than sixty (60) days after the date of termination of the Medicaid or State child health plan coverage and otherwise meet the eligibility requirements of the Plan.

(b) Special Enrollment for Employees and Dependents Due to Eligibility for Medicaid or SCHIP Assistance. Any Employee or Dependent who becomes eligible for premium assistance with respect to coverage under the Plan under such Medicaid plan or State child health plan shall be allowed to enroll for coverage under the Plan if they request coverage under the Plan not later than sixty (60) days after the date the Employee or Dependent is determined to be eligible for such premium assistance and if they otherwise meet the eligibility requirements of the Plan.

In all cases of a change in eligibility or dependent status the Policyholder must notify HPS within ten business days from receipt of such information from the Employee or Dependent.

D. Condition of Coverage.

Submission of an Enrollment Application and payment of premiums shall constitute your acceptance of the terms of the Contract; including the obligations, benefits, limitations and exclusions herein.

HPS shall make reasonable efforts to maintain a Participating Provider network that can reasonably meet the Medically Necessary health service needs of HPS's Members. HPS does not guarantee the ongoing availability of any specific Participating Provider. The relationship between HPS and a Participating Provider is an independent contractor relationship and the Contract contains provisions whereby either party can terminate the contract with written notice. In the event that either party terminates a Participating Provider's contract, HPS shall assist you if you are affected by the termination of such contract(s) and want to secure the services of another Participating Provider.

Notice for Initial Enrollees: If you or one of your Dependents were totally disabled on the date coverage under your prior plan ended and are now covered under an extension of benefits by that plan in accordance with state law, you will be enrolled for coverage under this HPS plan. However the prior plan remains liable for coverage for the disabling condition for the period of the extension of benefits.

SECTION IV PRIOR AUTHORIZATION REQUIREMENTS AND CHARGES FOR SERVICES

A. Prior Authorization.

Prior Authorization is required for coverage for non-Emergency Inpatient medical or surgical admissions, outpatient services or procedures, rehabilitation services and Durable Medical Equipment.

1. In addition Prior Authorization is required for the following services:

- **Cancer treatment. A treatment plan will be required after one (1) initial consultation visit.**
 - **All pain management services;**
 - **Services performed by an oral surgeon will require a treatment plan after one (1) initial consultation visit;**
 - **Services performed by a plastic surgeon will require a treatment plan after one (1) initial consultation visit; and**
 - **All mental health services and substance use disorders treatment.**
2. If you are under the ongoing care of an In-Network or Out-of-Network Provider on the Effective Date of coverage under this Plan and this Plan replaces coverage under a prior group health plan, the prior group health plan will be responsible for coverage of on-going care for a disabling condition in accordance with the prior plan's Extension of Benefits provision
 3. HPS will be responsible for payment of Covered, Medically Necessary Inpatient facility services, home health, and outpatient mental health services and substance use disorders only when those services have the Prior Authorization of HPS.
 4. HPS and Participating Providers work together to efficiently manage the Healthcare Services required by Members. HPS shall not be responsible for paying for Healthcare Services at levels of care that are not Medically Necessary to treat your medical condition or for modes of treatment or therapy that are not demonstrably superior to alternative treatments or therapies as determined by HPS.

B. Out-of Network Facility Admissions.

HPS must receive prior notification of non-Emergency Out-of-Network hospital admissions and outpatient surgeries. If you are admitted inpatient to an Out-of-Network hospital following emergency care, HPS will coordinate with the facility to determine the feasibility of transfer to an In-Network facility. If it is determined that transfer is feasible but you elect to remain in the Out-of-Network facility, expenses other than those for Emergency Services will be subject to Out-of-Network benefits.

C. Membership Card.

When you receive Covered Healthcare Services, you must show the provider your Membership Card to verify coverage by HPS.

D. Charges for Services.

Out-of-Network Member Charges. Members who choose to receive Covered Non-Emergency Services from Out-of-Network Providers are responsible for the Out-of-Network Member Charges described below. Emergency Services are covered as specified in Section V, Paragraph H.

E. Annual Deductible.

If the Benefit Summary indicates that this Plan includes a Deductible, the Member or Family Unit (the Subscriber and his/her Dependents) is responsible for the Deductible amount set out in the Benefits Summary each Calendar Year before the Plan will pay any portion of the charges for Covered Services received from Providers during such Calendar Year. As shown on the Benefits Summary, there is a maximum Deductible amount per Member or Family Unit each Calendar Year. The annual Deductible does not apply to child wellness services or to certain preventive care services or treatments as set out in the Schedule of Benefits, Section V of this Evidence of Coverage. Any portion of the Deductible which is met within the last three months of the Calendar Year that applies to that Calendar Year's Deductible will carry-over and also apply to the Deductible for the next Calendar Year. The Deductible does count toward the Annual Out-of-Pocket Maximum.

F. Coinsurance.

The Member will be responsible for the coinsurance percentage set out in the Benefits Summary for all UCR charges for covered Non-Emergency Services received Out-of-Network, or In-Network if so indicated on the Benefit Summary, after paying the applicable Deductible. Any charges in excess of UCR are not eligible expenses and are the Member's responsibility. Charges in excess of UCR do not apply to and do not satisfy the Annual Out-of-Pocket Maximum defined below.

G. Annual Out-of-Pocket Maximum.

The amount of Deductible and Coinsurance charges the Member is responsible for in a calendar year. There is an individual and a family Coinsurance Maximum which applies as set out in the Benefit Summary. Annual Out-of-Pocket Maximum for all covered Non-Emergency Services received Out-of-Network for an individual Member or for a family is identified on the Benefits Summary. After a Member or family has satisfied this maximum for the calendar year, the Member or family is not responsible for any additional Deductible and Coinsurance for the remainder of the same calendar year. However, Members are responsible for payment of any portion of the billed charges for Covered Non-Emergency Services received from Non-Participating Providers that exceeds HPS's determination of UCR charges for such services. **Copayments do not count towards the Annual Out-of-Pocket Maximum.**

H Percentage Payments of Out-of-Network Charges.

After application of the Deductible, the Plan will pay a percentage of UCR for Covered Services or

supplies provided Out-of-Network or by a Non-Participating Provider. Please refer to the Benefit Summary.

I. Excess Charges.

Members are responsible for payment of any portion of the billed charges for Covered Non-Emergency Services received from Non-Participating Providers that exceeds HPS's determination of UCR charges for such services. All amounts in excess of UCR charges are not Eligible Charges and do not count towards the Coinsurance Maximums.

J. Copayment.

For Covered Services received from Participating Providers, a Copayment is due and payable at the time Covered Services are provided. The Copayment is the responsibility of the Member and must be paid as a condition of continued eligibility for coverage under this Plan. **Copayments do not count towards the Annual Out-of-Pocket Maximum.**

**SECTION V
SCHEDULE OF BENEFITS**

The Healthcare Services set forth below in this section are Covered Services, provided that Prior Authorization from HPS is obtained where required. Only Medically Necessary services as determined by HPS are covered.

A. Outpatient Healthcare Services.

1. Office Visits.
2. Routine diagnostic (EKG, chest and extremity x-rays), laboratory (complete hemoglobin, urine analysis, hematocrit, serum glucose stick, strep screens, CBC (or any portion thereof), occult blood, gram stains and pregnancy tests), and treatment services. The tests include all specimen collection, interpretation and transportation.
3. Adult Health Examinations.
To include examinations as follows:
 - a. For Women.
 - (1) One (1) routine gynecological examination per year, which will not require the referral by the Member's PCP.
 - (2) One (1) routine pap smear per year, or more often if ordered by a Physician.
 - (3) Mammograms as follows.
 - (a) A baseline mammogram for women age thirty-five (35) through thirty-nine (39);
 - (b) A mammogram every year for women age forty (40) and over; and
 - (c) When ordered by a Physician for "at risk" Members who:
 - i. have a personal history of breast cancer;
 - ii. have a grandmother, mother, sister or daughter who has had breast cancer; or
 - iii. have not given birth by at least age thirty (30).
 - b. For Men.
One (1) routine Prostate specific antigen test per one (1) year period for males age forty (40) or older.
 - c. Adult immunizations and tuberculosis skin testing in accordance with accepted medical practices.
4. Pediatric Health Examinations
Child Wellness Services are covered through age five and include the periodic review of a Covered child's physical and emotional status conducted by a physician or pursuant to a

physician's supervision. The review includes a medical history, complete physical exam, developmental assessment, appropriate immunizations, anticipatory guidance for the parents, and lab testing in keeping with the standards outlined in the prevailing Recommendations for Preventive Pediatric Health Care as established by the American Academy of Pediatrics. These benefits are not subject to the Deductible.

Coverage also includes examinations as follows:

- a. Pediatric immunizations and tuberculosis skin testing in accordance with accepted medical practices.
 - b. Routine Eye and Hearing Examinations.
One (1) routine exam or one (1) visit to determine the need for correction annually for children through age seventeen (17).
5. Maternity Care for Subscribers and Eligible Spouses. Services include prenatal, intrapartum, and postnatal care. This includes both complications of pregnancy of the mother and care with respect to the newborn child from the moment of birth, as well as necessary care and treatment of illness, injury, and congenital defects of the infant.
 6. Outpatient surgery, including physician services, is covered unless otherwise noted in Section VIII.
 7. Coverage is provided for the formulation and administration of allergy injections, including injectibles for which a separate charge is not routinely made.
 8. Bone Mass Measurement: Coverage is provided for "qualified individuals" for bone mass measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis. "Qualified individual" means an estrogen-deficient woman or individual at clinical risk of osteoporosis, an individual with osteoporotic vertebral abnormalities, an individual receiving long-term glucocorticoid therapy, an individual with primary hyperparathyroidism, or an individual being monitored by a physician to assess the response to or efficacy of approved osteoporosis drug therapies.
 9. Chlamydia Screening Test: Coverage is provided for one annual chlamydia screening test for Covered females.
 10. Diabetic Coverage: Medically Necessary equipment, supplies, pharmacological agents, and outpatient self-management training and education including medical nutrition therapy, are covered for Members with diabetes. All training must be provided by certified, registered or licensed healthcare providers with expertise in diabetes.
 11. Children in Clinical Trial Programs for the Treatment of Cancer: Coverage is provided for routine patient care costs incurred in connection with the provision of goods, services, and benefits to children in connection with approved clinical trial programs for the treatment of cancer for those Covered children that have been diagnosed with cancer prior to their 19th birthday, and are enrolled in an approved clinical trial program for treatment of children's cancer, and are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.
 12. Ovarian Cancer Testing: Surveillance tests are covered for Covered women age 35 and over who are 'at risk' for ovarian cancer. "At risk" for ovarian cancer means: having a family history with one or more first or second degree women relatives with breast cancer, having clusters of women relatives with breast cancer, of nonpolyposis colorectal cancer, or testing positive for BRCA1 or BRCA2 mutations. "Surveillance tests" means annual screening using CA-125 serum marker testing, transvaginal ultrasound, and pelvic examination.
 13. Autism Treatment: Treatment for autism shall be covered on the same basis as other diagnosed neurological disorders.
 14. Colorectal Cancer Screening: Benefits will be provided for such colorectal cancer screenings, examinations, and tests that are specified in current American Cancer Society guidelines for colorectal cancer screening of asymptomatic individuals who are 50 years of age or older or who are less than 50 years of age and at high risk for colorectal cancer according to current colorectal cancer screening guidelines of the American Cancer Society. This coverage shall be provided on the same basis as any other illness or injury.
 15. Observation Services: The use of a bed and periodic monitoring by a facilities' nursing or other staff. These services are considered reasonable and customary to assess an

outpatient's condition to determine the need for Inpatient admission or discharge. Observation status implies a diagnosis is not known.

B. Inpatient Services.

The following hospital accommodations and services shall be made available to HPS's Members when these accommodations and services are in the Hospital or part of its system, are deemed Medically Necessary by the attending Physician and are approved by HPS in accordance with Section IV, Prior Authorization Requirements:

1. Semi-private room and board accommodations including staff nursing care. Private room and board shall be provided when authorized as Medically Necessary by the attending Physician and approved in writing by HPS, or if no semi-private room is available.
2. Nursery accommodations including general duty nursing care.
3. In-hospital diagnostic, therapeutic, rehabilitative and support care, services and appliances.
4. Dressing, casts, and special equipment when supplied by Hospital for inpatient use.
5. Special diets when authorized as Medically Necessary by attending Physician or consultants.
6. Administration of blood and blood plasma components.
7. End stage renal disease services on an inpatient or outpatient basis when authorized by either the Primary Care Physician or nephrologist, and the HPS Medical Director or designee.
8. Inpatient and outpatient utilization of the operating room and recovery room services which include, but are not limited to, anesthesia, administration of fluids and injections, special procedures, and other diagnostic and therapeutic procedures.
9. Special Care Unit Services including but not limited to:
 - a. Intensive Care Unit.
 - b. Cardiac Care Unit.
 - c. Neonatal Intensive Care Unit.
 - d. Burn Unit.
 - e. Oncology Unit.
 - f. Perinatal Intensive Care Unit.
 - g. Neurological Unit.
 - h. Neurosurgery Unit.
 - i. Spinal Cord Unit.
10. Emergency medical services including medications, equipment, and supplies.
11. Diagnostic, rehabilitative, and therapeutic services, to be provided on an inpatient basis include:
 - a. Pharmaceutical services.
 - b. X-ray therapy.
 - c. Cobalt therapy.
 - d. Radiation therapy.
 - e. Nuclear medicine services.
 - f. Laboratory services.
 - g. Blood bank services.
 - h. Electroencephalography (EEG services).
 - i. Cardio-pulmonary therapy services including electrocardiogram (EKG).
 - j. Physical therapy.
 - k. Occupational therapy.
 - l. Speech and hearing therapy.
 - m. Rehabilitative services.
 - n. Medical social services.
 - o. Diagnostic radiological services.

C. Rehabilitation Services - Outpatient.

Rehabilitation Services, including physical, occupational, or speech therapy are covered subject to HPS guidelines up to the total number of approved visits specified in the Benefits Summary for all combined rehabilitation visits only if, in the judgment of HPS and the Participating Physician, that service will result in significant improvement to the Member's acute condition. Maintenance therapy is not a covered benefit.

D. Cardiac Rehabilitation.

Cardiac Rehabilitation Services that are determined to be Medically Necessary are covered up to the maximum number of approved visits specified in the Benefits Summary.

E. Prosthetics.

Coverage is limited to the standard prosthetic devices that adequately meet the medical needs of the Member. Only Prosthetic devices intended to return an individual to the same functional level as before the injury or illness are covered. Prosthetic devices intended to raise the functional level or to enhance athletic ability are not covered. Cosmetic, convenience or luxury items and features are not covered.

1. Prosthetic devices are those rigid or semi-rigid external devices, which are required to replace all or any part of a body organ or extremity.
2. When prescribed by a Participating Physician and obtained from sources designated by HPS, Medically Necessary prosthetic devices are covered in accordance with the Benefit Summary. Necessary repairs and adjustments, other than those necessitated by misuse, approved by a Participating Physician and obtained from a source designated by HPS, will be covered in accordance with the Benefit Summary.
3. Mastectomy supplies are limited to one (1) prosthesis every other year and four (4) bras per year.
4. Exclusions. The following are not covered:
 - (a) Corrective shoes and supports. However, therapeutic shoes for Members with diabetes, which are approved for coverage under Medicare, are covered.
 - (b) More than one (1) prosthetic device for the same part of the body; upgrades, enhancements, or spare devices or alternate use devices are excluded.
 - (c) Replacement of lost prosthetic devices.
 - (d) Repairs, adjustments, or replacements necessitated by misuse.
 - (e) Dental prostheses, devices, and appliances except as specified herein.

F. Durable Medical Equipment.

The maximum annual and lifetime benefits for Durable Medical Equipment are set out in the Benefits Summary.

1. Durable medical equipment (DME) is equipment that is: appropriate for use in the home; able to withstand repeated use; Medically Necessary; not of use to a person in the absence of illness or injury; and approved for coverage under Medicare as of January of the year immediately preceding the year the Contract became effective or last renewed; Such equipment includes, but is not limited to: infant apnea monitors; blood glucose monitors; hospital beds; oxygen equipment; wheelchairs; TMJ Splints, and oral appliances for Sleep Apnea. Orthotic Devices are covered on the same basis

as Durable Medical Equipment.

2. **Prior Authorization is required for all Durable Medical Equipment.** Durable Medical equipment will be covered as set out in the Benefit Summary if Medically Necessary, and prescribed by a Physician and obtained on either a purchase or rental basis, as determined by HPS. Repair and replacements other than those necessitated by misuse or loss, is also provided. Oxygen for use in conjunction with durable medical equipment prescribed by a Physician is provided without charge. Letters of Medical Necessity from the prescribing Physician must be included with all requests for Prior Authorization for Durable Medical Equipment (DME).
3. Exclusions. The following are not covered:
 - (a) Electronic monitors of bodily functions, except infant apnea monitors.
 - (b) Devices to perform medical testing of body fluids, excretions or substances, except diabetic blood glucose monitors. The Glucowatch™ is considered a non-covered blood glucose monitor.
 - (c) Devices not medical in nature such as whirlpools, saunas and elevators.
 - (d) Convenience or comfort items. See Exclusion 24 in Section VIII.
 - (e) Disposable supplies.
 - (f) Replacement of lost equipment.
 - (g) Repair, adjustments or replacements necessitated by misuse.
 - (h) More than one (1) piece of durable medical equipment serving essentially the same function, except for replacements as specified in Section “F, 2” above.
 - (i) Spare equipment or alternate use equipment.
 - (j) Modifications to homes or motor vehicles are not covered.
 - (k) Scooters.
 - (l) Electric wheelchairs, electric beds, or other deluxe equipment when standard equipment is available and appropriate

G. Permanently Implanted Devices.

Medically Necessary permanently implanted devices, which are approved for general use by the Federal Food and Drug Administration (FDA), and are customarily available in the Service Area, such as pacemakers and hip joints, are covered.

H. Emergency Services.

1. Emergency services in or out of service area are covered (emergency room Copay will be waived if the Member is admitted to the hospital). However, if care is received in an Out-of-Network hospital and an In-Network hospital was also reasonably available in the same area such that there was no medical necessity to receive treatment from the non-Network hospital, the UCR limits for such Out-of-Network treatment will be imposed.
2. Ambulance services.
In the event of an Emergency, essential ambulance service is covered when it is deemed Medically Necessary subject to the limitations in Section VI. Upon review by HPS, coverage may be denied unless previously authorized, where ambulance service was provided in a non-Emergency situation.
3. Dental Services.
Services are limited to Medically Necessary treatments required as a result of accidental injury to Sound Natural Teeth provided within twelve (12) months of an accidental injury and removal of impacted third molars (wisdom teeth) subject to the limitations in Section VI.

4. **Psychiatric Emergency Care.**
In the event of an Emergency, psychiatric care in the hospital emergency room is covered when it is deemed Medically Necessary, subject to Exclusions # 7, 8, and 9 in Section VIII.
5. **Alcohol and Drug Abuse.**
Services are limited to immediate medical evaluation and Medically Necessary care, which includes medical management of intoxicated persons until no longer incapacitated by the effects of the alcohol or drugs and/or initiation of appropriate Healthcare Services needed for continuity of care.

I. Inpatient Skilled Nursing Facility.

Limited to the number of days per calendar year indicated in the Benefits Summary commencing with the first day of admission to a Skilled Nursing Facility. HPS covers care provided in an Inpatient Skilled Nursing Facility only when the facility is an alternative to acute Inpatient hospital care. HPS does not cover custodial confinements.

J. Urgent Care.

Limited to services rendered by a designated Urgent Care facility or the Urgent Care unit or service of an acute care Hospital as designated by HPS.

K. Home Healthcare.

Up to the number of visits per calendar year indicated in the Benefits Summary, limited to Medically Necessary services provided by a participating Home Healthcare agency and with a referral by the attending Physician or Specialty Care Physician.

L. Mental Healthcare Services and Substance Use Disorder Treatment Services.

NOTE: Medically Necessary Inpatient and Outpatient treatment for mental health and substance use disorders are covered on the same basis as any other physical illness or injury and are subject to the same Copayments, Coinsurance, and Deductibles as set out in the Benefit Summary. Prior Authorization is required for all non-emergency mental health and substance use disorder treatment.

Mental Healthcare Services are those necessary for the diagnosis, rehabilitation, and treatment of acute psychiatric conditions, which, in the judgment of Member's HPS Participating Physician are deemed appropriate for Crisis Intervention and Evaluation and therefore, are subject to significant improvement through short-term therapy (both inpatient and outpatient). This includes the treatment of eating disorders. Certain Mental Healthcare Services are excluded from coverage, see Exclusions 7, 8, and 9 in Section VIII.

M. Infertility Treatment.

Medical and Hospital services for diagnosis and treatment of involuntary infertility are provided at medical offices, outpatient facilities and Hospitals. Benefits for treatment of infertility are limited to the calendar year maximum and lifetime maximum specified in the Benefits Summary. Infertility medication is excluded.

N. Health Education Services.

HPS will offer programs in health education that are conducted by Participating Providers for the benefit of all Members. A nominal charge may be made for these services. New Member sessions will be conducted to educate Members in appropriate use of the Plan and preventive health services, and newsletters and other informational materials addressing health education will be provided at no charge.

Nutritional counseling is a covered benefit for Members who are diagnosed with diabetes and when ordered by their treating physician.

O. Family Planning Services.

Family planning services shall be available to the Members on a voluntary basis. Family planning counseling includes, but is not limited to, abortion counseling and information on birth control. Birth control medications are covered through an optional Prescription Plan Rider if purchased by the Policyholder.

P. Hospice Care.

Members who are diagnosed as having a terminal illness with a life expectancy of six (6) months or less may elect home-based hospice care for such illness instead of the traditional services covered under the Contract. Care is provided by licensed hospices approved in writing by a Participating Physician. While a hospice election is in effect, care for the terminal illness is provided without charge. Such covered care includes the following services and other benefits when ordered by a Participating Physician and the hospice care team:

1. nursing care;
2. physical, respiratory, occupational or speech-language pathology therapy;
3. medical social services;
4. Chaplain services;
5. Medical supplies, drugs and appliances;
6. physician services;
7. short-term inpatient care, including respite care and care for pain control and acute and chronic symptom management;
8. counseling and bereavement services;
9. Durable Medical Equipment (DME) as defined herein.

Members who elect hospice care under this provision are not entitled to any other benefits under the Contract for the terminal illness while the hospice election is in effect, unless so specified by the Medical Director or designee, in exceptional cases.

Q. Breast Reconstruction.

Members who have undergone a mastectomy may elect breast reconstruction. The coverage will be provided in a manner determined in consultation with the attending physician and the Member for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce symmetrical appearance;
3. Prosthesis;
4. Treatment of any physical complication at all stages of the mastectomy.

Breast reduction, not related to mastectomy, is only covered if it meets HPS's criteria for Medical Necessity and is reviewed and approved by HPS.

R. Preventive Services.

HPS may offer the following preventive services (including family planning services and the detection of asymptomatic diseases) on a periodic basis.

1. The full range of family planning services;
2. Services for infertility;

3. Preventive eye/ear examinations by a physician, optometrist, or other qualified health professional to determine the need for correction for children through age seventeen;
4. Pediatric and adult immunizations in accordance with the Immunization Program of the Georgia Department of Human Resources for pediatric enrollees, and for adults, one (1) tetanus immunization will be offered every ten (10) years. Flu shots will be offered seasonally;
5. Periodic health examinations with appropriate protocols for specific age and sex groups; and
6. Health education activities (described at Section V “P.” above).

S. Plastic Surgery.

Except for breast reconstruction as set out above, only Medically Necessary plastic or reconstructive surgery is covered following surgery, trauma, infection or disease, or when it is Medically Necessary to correct a functional defect that is a result of congenital disease or anomaly of a covered Dependent child. All plastic or reconstructive surgery must be reviewed and approved by HPS prior to treatment.

T. Genetic Testing.

Coverage will be provided for Medically Necessary Genetic Testing, which consists of medical and scientific testing of human genes and hereditary factors to diagnose, or to determine an individual’s probability or susceptibility to develop, certain diseases or medical conditions. Other Covered Expenses include consultations with Specialist Physicians, and laboratory charges.

This coverage is subject to the Deductible and Coinsurance applicable to any other medical testing or laboratory charges. All testing and office visits shall be subject to the specialist Copay as outlined in the attached Benefit Summary in Appendix A. Each test shall be limited to no more than one per calendar year and the maximum coverage amount of \$2,500 per calendar year. The Prior Authorization requirement applies to each test. ALL TESTS MUST BE APPROVED IN ADVANCE BY HPS.

Coverage for Genetic Testing is limited to the following:

- Preconceptional or Prenatal Genetic Testing of Parent or Prospective Parent for cystic fibrosis and a limited number of other specific diseases;
- Genetic Testing for Breast and Ovarian Cancer (BRCA 1 and BRCA 2);
- Gene Expression Profiling for Breast Cancer Management;
- Genetic Testing for Cancer Susceptibility as follows:
 1. Hereditary Non-Polyposis Colorectal Cancer (HNPCC);
 2. Familial Adenomatous Polyposis (FAP);
 3. Medullary Thyroid Cancer;
 4. Multiple Endocrine Neoplasia Type 2 (MEN2); MYH-associated Polyposis (MAP); and
 5. Aplastic anemias.

There is a \$2500 Calendar Year limit on coverage for genetic testing.

Genetic testing shall only be conducted at the request of and with the written authorization of the person being tested. HPS shall not release any information derived from genetic testing to any third party except as required by law or with the explicit authorization of the person tested. HPS shall not use information derived from genetic testing for any nontherapeutic purpose.

SECTION VI LIMITATIONS OF COVERAGE

The rights of Members and obligations of HPS are subject to the following limitations:

A. Ambulance Services.

Transportation by ambulance will only be covered when it is determined to be an Emergency or when Medically Necessary as determined by HPS. Transportation other than by ambulance is not covered by HPS. Coverage for air ambulance services is limited to a \$10,000.00 calendar year maximum benefit. Coverage for transportation by fixed wing aircraft must receive Prior Authorization.

B. Dental or Oral Surgical Care.

Benefits are limited to (1) Medically Necessary treatment of Sound Natural Teeth injured as a result of a Covered accident which is received within twelve (12) months of the accident and only if such treatment has been reviewed and approved by HPS. Medically Necessary surgical or non-surgical treatment for the correction of Temporomandibular Joint Dysfunction or correction of functional deformities of the maxilla and mandible are covered. Coverage is provided for the removal of impacted third molars (wisdom teeth) subject to the maximum benefit specified in the Benefits Summary. The oral surgeon must submit a treatment plan and estimate of charges at least ten (10) days before treatment is to begin for review and only the maximum per tooth benefit will be covered.

No coverage is provided for orthodontic treatment, dentures, preparation for dental implants, or dental implants even if Medically Necessary or the result of an injury or illness. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects and such injuries are not covered unless the Dental Rider has been purchased by the Policyholder as indicated in the Benefit Summary.

Inpatient or outpatient hospital services, physician services and other costs shall not be covered by HPS for any non-Covered Dental Services. If the Member has a concurrent hazardous medical condition that makes the service of a hospital and physician Medically Necessary as determined by HPS, the hospital, physician and related hospital services shall be covered. The services of the dentist or oral surgeon shall be considered non-Covered Services. The age, mental status, physical impairment or comparable conditions of the Member shall be considered concurrent hazardous medical conditions for purposes of this benefit limitation. Coverage for outpatient services and general anesthesia in connection with dental services for children age seven (7) years and younger, and for the developmentally disabled will be provided with prior approval from HPS.

Other dental services not specifically set out herein are not covered unless coverage is provided under a Rider elected by the Policyholder as indicated in the Benefit Summary.

C. Emergency Healthcare Services.

HPS will pay eligible expenses for Emergency Covered Services. The Member must pay the applicable Copayment and Coinsurance for Emergency Covered Services rendered in a Hospital Emergency Room. The Copayment will be waived if the Member is admitted to a Hospital for treatment of the same Accidental Injury or Sickness within twenty-four (24) hours. Once admitted to the Hospital and/or for any follow-up Covered Services, the Member will be responsible for any applicable Copayments for Covered Services. Inpatient treatment in an Out-of-Network hospital or by a Out-of-Network Provider may be subject to the UCR limitations. See Section V, "H".

Members must notify HPS within forty-eight (48) hours of seeking Emergency Covered Services, or as soon thereafter as is reasonably possible.

For those Members who do not receive approval for Emergency Covered Services, HPS reserves the right to review the medical records of Members receiving such services to determine whether the medical condition for which the Member sought care was an Emergency. If HPS, in its sole determination, concludes that the Covered Services provided to the Member were not Emergency services, HPS shall not be responsible for payment.

HPS will not provide coverage for repeated use of Emergency Room facilities for Non-Emergency care instead of obtaining treatment from your Physician in accordance with the provisions of this Plan.

D. Major Disaster or Epidemic.

In the event of a major disaster, epidemic, war, terrorist attack, or other circumstances beyond HPS's control, HPS will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

E. Organ Transplants.

Human organ transplants not otherwise listed in the Exclusions Section of this Evidence of Coverage, including human heart, stem cell, and Bone Marrow transplants for breast cancer or Hodgkin's disease, that are not deemed to be Experimental or Investigative; which offer significant long-term survival clearly superior to conventional treatments, therapy or procedures; and are conducted in accordance with criteria adopted by HPS are covered subject to the specific limitations herein:

1. The transplant must be performed in an accredited transplant center.
 2. HPS's Medical Director must review and make a determination of the Medical Necessity for the transplant for purposes of Plan coverage only and not to interfere with the doctor-patient relationship between the patient and the treating physician.
 3. HPS shall cover Medically Necessary costs related to acquisition, transportation, or donation of a human heart.
 4. Donor charges are covered only when the transplant recipient is a HPS Member and are subject to the following restrictions:

Only Medically Necessary donor costs, which are restricted to the medical services necessary to remove the donated organ or tissue, to preserve it during transportation, and to transport the organ or tissue to the medical facility where the transplant is performed, are covered.

Donor search, testing and related acquisition and identification services, that are not included in the standard fee charged by the transplant center, are not covered for any type of transplant other than a human heart transplant. The standard (or "global") fee is that amount charged by the transplant center for all routine services connected with the organ transplant.

Complications suffered by the Donor that occur more than 60 days after the donation of the organ or tissue are not covered.
- If the organ or tissue is obtained from a living donor the following rules apply:
- a) If the donor and recipient are both Members of an HPS plan, payment will be made pursuant to each Member's benefit plan.
 - b) If the donor is not a Member of an HPS plan and the donor has no health coverage or the donor's health coverage does not cover donor costs, HPS will pay the donor charges. However, if the donor has health care coverage that will pay benefits for the donor's charges, HPS will pay donor costs as the secondary payer to the donor's health care coverage.
4. Travel expenses relating solely to the transportation of the organ or tissue are covered. Other travel expenses including, but not limited to airline fare, mileage, lodging, meals, etc. are not covered for the Member, donor, or support person.
 5. Artificial or mechanical organs or non-human organs are not covered.
 6. A second evaluation and work-up for determining if a transplant is appropriate for a Member will be covered only if approved in advance by HPS and if done in a Transplant Network facility.

F. Growth Hormones.

Human growth hormones are covered only for children seventeen years of age or younger with an absolute deficiency in growth hormone production who meet guidelines established by HPS and when approved in advance by HPS.

G. Home Nocturnal Hemodialysis.

Coverage is provided for Home Nocturnal Hemodialysis (HNMD) for authorized dialysis procedures and supplies received in a Member's home as billed by an approved dialysis provider. No coverage is provided for modifications or renovations to the home, or for additional equipment that may be required in an individual situation.

H. Other Limitations.

HPS reserves the right to limit coverage under the Contract to those services, treatments, procedures and drugs which are generally accepted in the authoritative medical literature to have demonstrably superior therapeutic value as compared to alternative services, treatments, procedures and drugs that are available and commonly used to treat a specified medical condition.

**SECTION VII
CLAIMS FOR TREATMENT
FOR COVERED SERVICES BY NON-PARTICIPATING PROVIDERS**

A. Claim Form.

HPS will provide you with a Claim Form within ten (10) days of your request. You should request a Claim Form within sixty (60) days after the date you incur Eligible Expenses for treatment of Accidental Injury or Illness.

You must submit the Claim Form to HPS at its office within ninety (90) days after the date you incur Eligible Expenses for treatment of Accidental Injury or Sickness. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim provided such notice and Claim Form is furnished as soon as reasonably possible. However, a claim must be submitted within twelve (12) months from the date the service or treatment is received or the claim will not be payable under any circumstances.

B. Payment of Claim.

Subject to the Prior Authorization requirements and payment of the Deductible and Coinsurance HPS will pay Out-of-Network Eligible Expenses incurred during treatment by an Out-of-Network Provider upon receipt of the Claim Form. Benefits under the Contract may be paid to you. All or a portion of any benefits that become payable may be paid directly to the Hospital, person, or entity rendering the services upon your written assignment.

Payments will be mailed within fifteen (15) working days of receipt of due written proof of loss. If payment is not made within such fifteen (15) working days, HPS will mail a notice stating the reason for failure to pay and which includes an itemized list of documents or other information needed to process the claim. Upon receipt of such requested information, HPS will either make payment within fifteen (15) working days or will provide, in writing, the reasons for denying such claim or any portion thereof. If HPS fails to provide such notice or payment as required, HPS will pay interest at the statutory rate equal to eighteen percent (18%) per annum on the proceeds or benefits due under the terms of the policy.

C. Claims for Treatment While Outside the United States.

If you receive medical care while temporarily outside the United States you must pay for the care and file the claim with HPS. You must provide, at your expense, an English translation of the claim and all required medical records when submitting the claim. Payment of such claims will be made to you at the then current rate of exchange and you will be responsible for payment to the medical provider. Please see Exclusion # 45 in Section VIII.

**SECTION VIII
EXCLUSIONS**

The following services are not covered and no benefits will be provided for the following: (Please note that these Exclusions apply even if the treatment or service is prescribed by your Physician and is considered Medically Necessary or is the only treatment or service available for your medical condition):

1. Treatment or services that are not Medically Necessary as determined by HPS unless specifically described herein as Covered Services. If you receive services or treatments that are determined not to be Medically Necessary HPS will not pay benefits for those services or

treatments and the charges will not count towards the Deductible or Annual Out-of-Pocket Maximum limit. If you receive services or treatments that are determined not to be Medically Necessary HPS will not pay benefits for those services or treatments and the charges will not count towards the Deductible or Annual Out-of-Pocket Maximum limit.

2. Charges for hospital confinement or inpatient treatment in excess of the approved length of stay as determined by HPS.
3. Any illness or injury resulting from or relating to:
 - (a) War or an act of war, whether declared or not;
 - (b) Service in the armed forces of any country (except service in the United States military for thirty-one (31) days or less);
 - (c) Injuries received while committing a crime including, but not limited to, driving under the influence of alcohol, driving under the influence of drugs, assault, battery, theft, criminal trespass, or violation of motor vehicle laws involving speed or recklessness;
 - (d) The participation in an organized motor vehicle race of any kind, sky diving, piloting an experimental aircraft, ultra light aircraft, home built aircraft, or an aircraft built from a kit or engaging in exhibition or air show flying, aerial races, aerial photography, or acrobatic flying of any kind, or piloting or crewing a commercial flight for hire, or other extraordinarily dangerous activity;
 - (e) A Member's instigation of or participation in a riot or insurrection; or
 - (f) Any release of nuclear energy.
4. Travel costs such as non-Emergency transportation other than Medically Necessary ambulance transportation from one hospital to another hospital, mileage, taxi fare, airline travel, lodging, meals or other expenses relating to travel to obtain treatment or services.
5. Personal convenience or comfort items including, but not limited to hospital admission kit or any other service or supply intended for the personal comfort, hygiene or convenience of the patient.
6. Treatment or services, and any resulting charges, received from an immediate family member including spouse, parent, brother or sister, child, or other closely related person residing in the same household.
7. Psychological testing, neuropsychological testing, testing for aptitude, intelligence or interest and mental health therapies that are not part of medically necessary treatment for Mental Health Conditions or that are not generally accepted as effective in treating mental disorders.
8. Treatment of Mental Health Conditions or substance use disorder that has not approved by HPS or its designee, except for Emergency Care.
9. Court ordered treatment for Mental Health Conditions, except where treatment would otherwise be a Covered Service as set out in this Evidence of Coverage.
10. Marriage counseling, sex counseling, or other counseling that is intended for social adjustment or personality development.
11. Acupuncture, care or treatment by hypnosis, thermography or thermograms, sleep therapy, biofeedback therapy or training in the use of biofeedback, primal therapy, light box therapy, or nutrition therapy not otherwise described in this Evidence of Coverage.

12. Outpatient prescription drugs and medications, unless a prescription drug Rider is purchased by the Policyholder and indicated in the Benefits Summary. Drugs obtained outside the United States, drugs used for cosmetic purposes, over the counter drugs and medicines including prescription drugs with a non-prescription chemical and dose equivalent, and blood pressure cuffs are not covered under any circumstances. No coverage is provided for drugs or supplies obtained without a prescription. No coverage is provided for lost or stolen prescription drugs in any event.

13. Dental care or treatment, except for treatment of TMJ as described in the Schedule of Benefits, except for treatment of injury to sound natural teeth (primary or adult teeth including any fillings, but not including crowns or cosmetic appliances) or for removal of impacted third molars. An optional Rider may be available for this benefit. If your Employer purchased this optional coverage it will be attached to this Evidence of Coverage.

14. Custodial care, convalescent care or rest cures including any stay in a skilled nursing facility or other nursing facility unless described specifically herein as a Covered Service or if approved by HPS as an alternative to inpatient stay in a hospital.

15. Cosmetic services or surgery to change the appearance of the body except for Medically Necessary reconstructive surgery following surgery, trauma, infection or disease or when it is Medically Necessary to correct a functional defect that is the result of a congenital disease or anomaly of a covered Dependent Child. See the Schedule of Benefits for a description of Covered Services following Mastectomy.

16. Physical examinations or immunizations except as specifically set out in the Schedule of Benefits. Physical, psychiatric or psychological examinations or testing, and vaccinations, immunizations, treatments, or testing for purposes of:
 - Obtaining or maintaining employment;
 - Premarital and pre-adoptive purposes by court order;
 - Obtaining or maintaining insurance;
 - Otherwise relating to education, training, employment or insurance;
 - Obtaining or maintaining license of any type;
 - Relating to any judicial or administrative proceeding;
 - Medical research;
 - Physicals required for participation in sports activities; or
 - School related physicals.

17. Services, treatments or supplies from any governmental program or agency (except Medicaid) including the United States, and any state or local government unless there is a requirement to pay such charges in the absence of healthcare coverage or insurance.

18. Treatment or care for any sickness or injury or complications of any such sickness or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease, or similar laws, or that arises out of or in the course of, any employment for wages or profit.

19. Physical, occupational, or speech therapy unless specifically described in the Schedule of Benefits for Short Term or Emergency treatment.

20. Rehabilitation therapy or services primarily intended to improve physical functioning for purposes of enhanced job, athletic or recreational performance

and which are not Medically Necessary to recover from an illness or injury.

21. Care or treatment of learning disabilities, dyslexia or developmental delays or disorders.
22. Services or treatment for the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation of or in the vertebral column or any complications resulting from such treatment.
23. Services or treatment for the reversal of sterilization including, but not limited to, vasectomies and tubal ligations. Artificial insemination, in vitro fertilization, Gamete Intro-Fallopian Transfer (GIFT), surrogate parenting or any other similar techniques or procedures are not covered. Infertility medications are not covered.
24. Equipment or machines such as air conditioners, air filters or purifiers, humidifiers, dehumidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, rubber gloves, electric stair climbing devices, electric chair lifts, exercise equipment, ultraviolet or tanning equipment, emergency alert equipment, scooters, whirlpools, saunas, swimming pools or other personal comfort items, even if ordered by a Participating Physician.
25. Foot care for corns or calluses, flat feet, fallen arches, metatarsal, hallux flexus, rigidus, valgus, bunions, weak feet, chronic foot strain, symptomatic complaints of the feet, shoes of any kind, prosthesis, orthotics or other supportive devices for feet, trimming of toenails, or other cosmetic care of feet unless specifically described as a Covered Service in this Evidence of Coverage.
26. Elective abortions or drugs intended to induce non-spontaneous abortions.
27. Eye refractions, vision therapy or training, surgery or other procedures for correction of vision, eyeglasses, contact lenses, lens implantation, or the examination or the fitting or wearing of any of these, or for treatment of ptosis (drooping of upper eyelid) regardless of medical necessity unless coverage is provided under a Rider as set out in the Benefits Summary. However, coverage is provided for cataract surgery including removal and lens implantation for the correction of cataracts.
28. Hearing aids, hearing devices, and related or routine testing, examination, fitting charges, or services regardless of medical necessity unless coverage is provided under a Rider as set out in the Benefits Summary.
29. Services or treatment relating to conditions or complications resulting from or closely relating to a Member's refusal to accept or undergo Medically Necessary treatment or medication recommended or prescribed by a Participating Physician.
30. Complications of non-covered treatment or services are not covered.
31. Services or surgical or non-surgical treatment of any type for weight control, obesity or morbid obesity, or any complications resulting from such treatment. Food supplements or augmentation, exercise programs, or other treatment or services for the reduction of weight are not covered. Enteral nutrition is covered only if it meets HPS guidelines for Medical Necessity.
32. Sex changes or transformations, sex therapy, penile implants and other devices to

treat impotency, and all related procedures, studies, services or supplies. Impotency medications are not covered. Penile implants may be covered if Medically Necessary, as determined by the Medical Director, to restore some degree of normal sexual function if other medically recognized treatments have failed to provide improvement.

33. Sperm or human egg (whether fertilized or not) preservation by any means.
34. Implantation of artificial organs not approved or available for general medical use by appropriate governmental agencies or which are experimental or investigative in nature as determined by HPS using appropriate medical guidelines and criteria.
35. Ventricular Assist Devices are not covered for destination therapy.
36. Court ordered Healthcare Services that would not otherwise be Covered Services.
37. Maternity care for a Dependent Child. However, services or treatment for Complications of Pregnancy are Covered.
38. Treatment of involuntary infertility that exceeds the allowable Plan limits and that has not been ordered by a Participating Physician and approved by HPS.
39. Charges for missed appointments or fees for completion of forms, filing for benefits, or copies of records.
40. Services or treatments which are considered Experimental or Investigative as defined herein even if no other treatment or service is available for your condition.
41. Inoculations and immunizations required for overseas travel.
42. The removal of skin tags is not covered unless determined to be Medically Necessary.
43. Services or treatment relating to genetic testing, by whatever means known, except as set out in this Evidence of Coverage in the Schedule of Benefits.
44. Services and treatment by unlicensed practitioners.
45. Services or treatment received outside the United States except for emergency treatment while on temporary visits of thirty (30) days or less. Medical evacuation or the return of human remains are not covered.
46. Services or treatment for the cessation of smoking or to eliminate or reduce the dependency on or addiction to tobacco, except for such programs as may be sponsored by or approved by HPS.
47. Wigs or cranial prostheses. Treatment of hair loss is considered cosmetic in nature.
48. Charges for paternity testing, laboratory services for marriage licenses, or laboratory services for insurance purposes.
49. Charges for the drawing of or storage of blood or blood products or other bodily fluids. Harvesting and Storage of Umbilical Cord Blood Derived Stem Cells is

not a covered service.

50. Charges that are in excess of the Usual, Customary, and Reasonable (UCR) as defined herein.
51. Charges that are not described herein as Covered Services.
52. Charges for treatment or services provided before the Member's Effective Date or after coverage ends unless coverage is extended as set out in this Evidence of Coverage.
53. Any charge or portion of a charge that is waived by a provider such as a Copayment or Coinsurance. If a provider routinely waives a portion of the charges, that provider's charges for those services will be reduced by that amount before payment by this Plan.
54. Any treatment or services received from your employer, such as treatment from an employer health clinic or medical department.
55. Daily room charges while the Plan is paying for Intensive Care, Cardiac Care, or other higher level of care charges.
56. Care or treatment not given or supervised by a physician or other licensed medical provider acting within the scope of their license.
57. Charges for treatment or services for which you have no legal obligation to pay or for which no charge would be made if you had no health insurance or health benefit plan coverage.
58. The cost or charges for copies of medical reports or medical records.
59. Charges for medical treatment or drug therapy for hyperhydrosis.

SECTION IX TERMINATION OF COVERAGE

A. Termination of Group Healthcare Contract.

Subject to Section X, Continuation of Coverage, and Section XI, A, Extension of Coverage, HPS may terminate the Group Healthcare Contract (the "Contract") on the earliest of the following dates.

1. Nonpayment. If Policyholder fails to make past due payment within 31 days after the date the premium was due HPS may terminate the Contract effective upon written notice to the Policyholder. Upon such a termination the Policyholder is liable for all unpaid Premium Contributions.
2. Discontinuance of a Product or All Products Within a Market. AAHP may terminate a particular product or all products offered in a small or large group market as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If HPS discontinues offering a particular product, HPS may terminate the Contract upon ninety (90) days written

notice to the Policyholder and Members, provided that HPS shall offer the Policyholder another product then offered to groups in its respective market. If HPS discontinues offering all products to small and/or large group markets, HPS may terminate this coverage upon one hundred eighty (180) days written notice to the Policyholder and Members and no other product will be offered to the Policyholder. After the effective date of termination, neither HPS, Policyholder, nor any Participating Provider shall have any further liability or responsibility under this Agreement for services after the date of termination except for totally disabled Members referred to in Section XI, A. For purposes of this Section, a product is a combination of healthcare benefits and services provided to Members, each such product being defined by an Evidence of Coverage.

3. Fraud: Noncompliance or Intentionally Furnishing Incorrect or Incomplete Information. HPS may terminate the Contract upon thirty (30) days written notice to Policyholder, if Policyholder has performed an act that constitutes fraud or intentionally misrepresents a material fact in applying for or procuring coverage under the terms of this group plan or Contract.
4. Violation of Contribution or Participation Requirements. If the Policyholder fails to adhere to HPS' contribution or participation requirements, HPS may terminate this Agreement upon sixty (60) days written notice to the Policyholder.

B. Termination of Membership.

Subject to Section X, Continuation of Coverage, and Section XI, A, Extension of Coverage, which may be available, HPS may terminate Membership in the following circumstances. When HPS terminates the membership of a Member under this Section B, neither HPS, the Policyholder nor any Participating Provider has any further liability or responsibility under the Contract with respect to such terminated Member, except as provided under Section XI, A, Extension of Coverage.

1. Fraud: Furnishing Incorrect or Incomplete Information. HPS relies upon the information contained in all documents submitted by Members and such information must be true and complete. Members must advise HPS of any change in family status or Medicare coverage status that affects eligibility or benefits. If a Member fraudulently and intentionally furnishes incorrect or incomplete material information when applying for or procuring coverage or fraudulently fails to inform HPS of a material change in family or Medicare coverage status, HPS may terminate the Membership of the Member upon written notice to the Subscriber. HPS may terminate the Membership of the Member and all such Member's Dependents upon 30 days written notice to the Subscriber. Such termination may be effective as of (a) the date the Member fraudulently furnished incorrect or incomplete information, or (b) the date of the family or the Medicare coverage status change that the Member did not report.

C. Return of Portion of Monthly Payment in Certain Cases.

If HPS terminates the Membership of a Member under Section IX, B, within thirty (30) days HPS will refund to the Policyholder any payments made by the Policyholder on account of the terminated Member applicable to periods after the effective date of termination. The amount of any claims paid on behalf of the terminated Member after the date of termination will be deducted from such refunds of premium.

D. Notification of Termination of Member by Policyholder.

The Policyholder must provide notice of the termination of coverage of any Member who is no longer employed as a full-time employee by notifying HPS in accordance with the terms of the Group Healthcare Contract within thirty (30) days of the date the Member ceases to be an Eligible Employee. If the Policyholder fails to give timely notice, in no case will coverage be retroactively terminated if the Member or his or her Dependents have incurred any claims prior to the requested date of termination. An Employer requested termination cannot be retroactive to a date more than ten (10)

days prior to the date such request is received by HPS. In no case will retroactive termination be allowed for a Member who is Totally Disabled and eligible for benefits under Section XI, A, Extension of Coverage.

E. Termination of Eligibility Prior to End of Month.

If eligibility for coverage ends because you no longer meet the eligibility requirements of the Plan (due to loss of employment or reduction in hours, divorce, or loss of Dependent status, etc.) your coverage shall continue until the last day of that month if the premium for that month has been paid.

**SECTION X
CONTINUATION OF COVERAGE AND CONVERSION PRIVILEGE**

A. Continuation of Coverage Under Georgia Law.

1. A Covered Member whose coverage has been terminated and who has been continuously covered under this Plan and any plan providing similar benefits which it replaces for at least six (6) months, may continue coverage for the Employee and Dependents, subject to the following terms. Each Dependent has an individual right to continue coverage under this provision. The exercise of this Continuation of Coverage will not affect the conversion rights defined in Sections B and C below. Continuation of Coverage will not be available for:
 - a. Any person who is, becomes, or could be covered under Medicare; or
 - b. Any person who is, becomes, or could be covered as an employee, Member, or Dependent by any similar group coverage; or
 - c. Any person whose employment was terminated with cause; or
 - d. Any person whose coverage was terminated for failure to pay any required premium contribution; or
 - e. Any person whose coverage was terminated as a result of the Group Health Benefit Plan or a portion of the Group Health Benefit Plan being terminated.
2. If you want Continuation of Coverage you must request such continuation by notifying the Policyholder and HPS in writing, within the thirty-one (31) day period following the later of:
 - a. The date of such termination; or
 - b. The date the Group gives you. In no event, however, may you elect continuation more than thirty-one (31) days after the date of such termination.
3. Continuation of Coverage must be requested in writing and you must pay the first month's premium and any retroactive premium charges for Continuation of Coverage to the Policyholder within thirty-one (31) days after the date the coverage ends. Such premium shall be at the same rate as for Members whose coverage has not been terminated and shall include both the Subscribers' Premium Contribution and the Policyholder's Premium Contribution. Future monthly premium payments must be made in advance to the Policyholder.
4. Continuation of Coverage will end on the earlier of :
 - a. The expiration of the fractional policy month remaining and three (3) months after the end of employment or Membership; or
 - b. The end of the period for which premium payments were made. This will apply if premiums are not paid on time; or
 - c. The date on which the Contract with the Policyholder ceases.
5. The Conversion Privilege described in D below is available when any period of Continuation of Coverage under this paragraph ends. However, it will not be available if it ends due to nonpayment of premiums.

B. Continuation of Coverage for Those 60 and Over

1. A Member who is sixty (60) years of age or more on the date his or her continuation coverage

under Paragraph A above or COBRA continuation coverage described in Paragraph C below commences and who has been covered under this Plan and any plan providing similar benefits which it replaces for at least six (6) months, may elect to continue his or her coverage under this Plan if coverage terminates after the continuation period described in Paragraph A above or the COBRA continuation period described in Paragraph C. below. To be eligible the Member must elect to continue and to exhaust their continuation benefits under COBRA.

2. A Member will not be entitled to continue coverage if:
 - a. Termination of employment is voluntary for other than health reasons;
 - b. Termination of coverage occurred because the employment of the Member was terminated for reasons, which cause a forfeiture of unemployment compensation under Chapter 8 of Title 34, the "Employment Security Law";
 - c. Termination of coverage occurred because the Member failed to pay any required contribution;
 - d. Any discontinued coverage is immediately replaced by similar coverage; or
 - e. The Group Healthcare Contract or group Plan was terminated in its entirety or was terminated with respect to a class to which the group Member belonged.
3. The surviving spouse or divorced spouse, if age sixty (60) or over, of a Covered Employee may continue coverage under this provision under the same terms and conditions as a Member.
4. Election of continuation of coverage under Paragraph A or C of this Section shall act as an election to continue coverage under this Paragraph for those age sixty (60) or over.
5. The premium for this continuation coverage shall be One Hundred Twenty (120%) percent of the amount that would be charged if the individual was a current Member.
6. This right to continue coverage shall terminate upon the earliest of the following:
 - a. The failure to pay premium or any required premium contributions, when due, including any grace period;
 - b. The date the Group Plan is terminated for all Members, except that if a different plan is offered to current Members, it must also be offered to the individual whose coverage is being continued under this Paragraph;
 - c. The date the individual whose coverage is being continued becomes covered under any other group health plan; or
 - d. The date the individual whose coverage is being continued becomes eligible for Medicare coverage.
7. This provision (Continuation of Coverage for Those 60 Years or Age and Over) shall only apply to Employers whose plan covers twenty (20) or more Employees.

C. Continuation of Coverage Under Federal Law.

1. **COBRA**
Continuation coverage may also be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This law applies to employers that had at least twenty (20) or more employees on fifty (50%) percent of its typical business days during the preceding calendar year. COBRA is available to "Qualified Beneficiaries" (individuals who were covered under the group health plan on the day preceding the "Qualifying Event" as an Employee or Dependent) if any of the following "Qualifying Events" occur:
 - a. Voluntary or involuntary termination;
 - b. Reduction in hours that would result in loss of group health coverage;
 - c. Death of the Employee;
 - d. Employee becoming entitled to Medicare coverage;
 - e. Divorce or legal separation;
 - f. Dependent child ceasing to be a Dependent

The Employee or Qualified Beneficiary must give the Employer or Plan Administrator notice within sixty (60) days of a divorce or legal separation (the sixty (60) days begins

on the date of the entry of the divorce decree or legal separation by the court), a child reaching the limiting age, or the Employee becoming entitled to Medicare. Failure to give timely notice of these Qualifying Events will result in a loss of eligibility for COBRA continuation coverage.

Continuation coverage for up to eighteen (18) months is available for the Employee in the case of termination of employment or reduction of hours. Continuation coverage for up to thirty-six (36) months is available for the Spouse or Dependent in the case of entitlement to Medicare, divorce or legal separation, or for the child ceasing to be a Dependent. Each Qualified Beneficiary has the same rights under the group health plan as a similarly situated active Employee including the right to add an eligible Dependent such as a newly adopted child to their coverage. COBRA continuation coverage may not be available to an Employee or Dependents if the Employee was terminated for gross misconduct. The Employer or Plan Administrator determines what constitutes gross misconduct. HPS does not determine what constitutes gross misconduct.

COBRA continuation coverage ends:

- a. At the end of the eighteen (18) month period for voluntary or involuntary termination or reduction of hours;
- b. At the end of twenty-nine (29) months for voluntary or involuntary termination or reduction of hours and the individual is determined to be eligible for Social Security disability benefits;
- c. At the end of thirty six (36) months for individuals whose coverage ended because of the death of the Employee, divorce or legal separation, a child ceasing to be a Dependent, or the Employee's entitlement to Medicare;
- d. If premium is not timely paid coverage will end at the expiration of the grace period for making premium payments to the Plan;
- e. The date on which the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to a pre-existing condition;
- f. On the date the Qualified Beneficiary becomes entitled to Medicare;
- g. On the date the Employer ceases to maintain any group health plan;
- h. In the case of an individual who is receiving the eleven (11)-month Disability Extension, coverage may terminate the month that begins more than thirty (30) days after the date the final determination is made by Social Security that the individual is no longer disabled.

Premium for COBRA continuation coverage is One Hundred Two (102%) percent of the premium that would be applicable if the individual was still covered under the Plan as an employee or dependent. If only a Spouse or Dependent child is covered under COBRA they will be charged 102% of the premium applicable to an active employee of the same age and gender. For individuals who are determined to be eligible for Social Security disability benefits and receive the additional eleven (11) months of coverage the premium is One Hundred Fifty (150%) percent of the applicable premium. Non-disabled family Members can also be charged 150% of applicable premium if the disabled individual is covered under COBRA.

Once an individual has elected COBRA continuation, the initial premium payment must be paid within forty five (45) days after the date that the COBRA enrollment form was signed. All premiums back to the termination date are due at that time. The employee or dependent on COBRA continuation coverage is responsible for paying the premium in a timely manner each month. After the initial payment is made, each subsequent payment is generally due on the first day of each month. The COBRA enrollee has a thirty (30) day grace period to pay the monthly premium. The payment must be postmarked within the thirty (30) day grace period. The premiums must be paid within the grace period or coverage will be terminated. Eligibility for coverage with the health plan will not be updated until payment is received.

Notice must be given by the Employer or the Plan Administrator of an individual's right to COBRA continuation coverage upon the occurrence of a Qualifying Event. HPS is not the Plan Administrator under COBRA. Refer to your Employer or Group administrator regarding whether COBRA applies. If requested to extend coverage, HPS will cooperate to the full extent required by law.

2. **Assistance Eligible Individuals.**
Pursuant to the American Recovery and Reinvestment Act (P.L. 111-5) any Employee who was involuntarily terminated from employment between September 1, 2008 and December 31, 2009 may be eligible for a premium subsidy for up to nine months of COBRA continuation coverage. The Employee must have been covered by the health plan on the day before the qualifying event, been eligible for COBRA continuation, at the time of termination, must elect COBRA continuation coverage, and must pay the premium as set out above. The premium for Assistance Eligible Individuals will be thirty-five (35%) percent of the normal COBRA premium. Dependents of Employees who are involuntarily terminated during this period of time, who were covered by the health plan on the day before the qualifying event may also be eligible for the premium subsidy. The premium subsidy can last for up to nine months, after which, the COBRA participant must pay the full cost of the COBRA continuation premium.
3. **Family Medical Leave Act (FMLA).**
If your Employer is subject to the FMLA you have the right, at your option, to Continuation of Coverage under the Group Health Benefit Plan if you take leave under FMLA. Refer to your Group administrator regarding the terms of continuation.

D. Conversion Privilege - Direct Payment.

NOTE: You must have exhausted any applicable continuation rights as set out above before being eligible for Conversion coverage. Two types of conversion coverage are available to "Qualifying Eligible Individuals" who live in Georgia and have eighteen (18) months or more of credible coverage, and are not eligible for coverage under Medicare or Medicaid, or for continuation of coverage under COBRA or state continuation laws. Qualifying Eligible Individuals whose coverage has terminated for any reason other than fraud or failure of the Qualifying Individual to pay a required premium contribution may elect either the Enhanced Conversion Option or the Basic Conversion Option. Individuals who are not Qualifying Eligible Individuals and whose coverage has been terminated for any reason other than eligibility for Medicare or failure of the Member to pay a required premium contribution and who have been covered under this Plan or the plan it replaces for at least six (6) months may elect only the Basic Conversion Option as described below.

Enhanced Conversion Option: The Enhanced Conversion option is comparable to the coverage offered under comprehensive health insurance coverage offered in the individual market in Georgia or comparable to the standard option of coverage available under the group or individual health insurance laws of Georgia. Qualifying Eligible Individuals must exercise their right to elect their conversion right within sixty-three (63) days of receiving notice of such right.

Basic Conversion Option: Both Qualifying Eligible Individuals and other Members are eligible to convert to a Basic Conversion Option. This is a more limited benefit plan which offers the same benefits provided by the most common Individual Conversion Agreement being offered by HPS, effective as of the date of termination of the Group coverage (which includes the period of Continuation of Coverage, if any), upon submitting a timely application for such coverage within thirty (30) days of receiving notice of their right to exercise their conversion right.

A full description of the benefits and premium for each type of conversion plan will be provided with the notice concerning your conversion rights. The initial premium for the converted policy for the first

month must be paid at the time the conversion right is elected. The premium and subsequent renewal premium shall be determined in accordance with Georgia law.

You shall be eligible to continue your Individual Conversion Agreement coverage only as long as you are not covered by, or eligible for coverage by another substantially similar insurance policy, prepaid plan, or other health benefit plan, or program offered by any party, including the federal, state or local government, which together with the Individual Conversion Agreement, would result in overinsurance or duplication of benefits according to standards on file with the Department of Insurance. The Individual Conversion Agreement coverage will terminate when you become eligible for Medicare coverage by reason of age.

SECTION XI EXTENSION OF COVERAGE

A. Extended Coverage Upon Total Disability.

If you are hospital confined when your coverage under the Contract terminates, your coverage will be continued until discharge from that confinement. If you are Totally Disabled on the date your coverage under the Contract terminates, coverage for the disabling condition only will be extended for the lesser of the period for which you are determined to be Totally Disabled or for twelve (12) months from the date that your coverage terminated.

B. Extended Coverage for Handicapped Children.

The coverage of an unmarried Dependent child will be continued past the age limitation for such coverage if the child is:

1. Incapable of self-support because of mental illness, mental retardation, or developmental disability, as determined by the Department of Human Resources or because of physical handicap; and
2. Dependent upon the Subscriber for support and maintenance;
3. Incapacitated prior to age nineteen (19);
4. The child must have been covered under this Plan or a plan it replaces prior to reaching age nineteen (19).

To be eligible for extended coverage, proof of the child's incapacity and dependency must be furnished to HPS within thirty-one (31) days of the date of the child's nineteenth (19th) birthday. Coverage will be continued so long as the Contract remains in force and the Subscriber remains eligible and covered under the Contract between Policyholder and HPS and all required premiums have been paid. HPS may require proof that the child remains eligible for extended coverage on each renewal of the Contract. The handicapped child is eligible for conversion coverage as a Dependent as explained in Section X.

SECTION XII COORDINATION OF BENEFITS (COB)

A. Coordination Process.

If you are eligible for services or benefits under two (2) or more Group Health Benefit Plans providing or paying for Healthcare Services rendered to you, the coverage under those Group Health Benefit Plans will be coordinated so that up to, but no more than, One Hundred (100%) percent of any of HPS's Eligible Expenses will be paid for or provided by all the Group Health Benefit Plans less any

applicable Copayments or coinsurance. Plans include: group insurance and group subscriber contracts; uninsured arrangements of group or group type coverage; group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; group type contracts (group contracts not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group); medical benefits coverage in automobile insurance contracts; and Medicare or other government benefits (but not Medicaid). HPS will be responsible, as either a primary or secondary payor, for Healthcare Services rendered by Participating Providers, for Emergency care, or for the services of Non-Participating Providers, if approved in advance by HPS. These services or benefits will be determined in the following order:

1. The benefits of a plan that does not have a COB provision or has a COB provision, which does not comply with Georgia Insurance Department regulations, will be primary.
2. The benefits of a plan which covers the person as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before those of a plan which covers the person as a Dependent or retiree.
3. When two or more different plans cover the child as a Dependent of different persons called "parents":
 - a. The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but
 - b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a short period of time;
 - c. If the other plan does not have the rule described above, but instead, has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
 - d. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.
4. If two (2) or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the plan of the parent with custody of the child is primary;
 - b. Then, the plan of the spouse of the parent with custody of the child; and
 - c. Finally, the plan of the parent not having custody of the child.
 - d. If the specific terms of a court decree or separation agreement state that one (1) of the parents is responsible for the health care expenses of a child, any entity obligated to pay or to provide the benefits of the plan of such parent that has actual knowledge of those terms, shall have benefits determined first. This paragraph shall not apply with respect to any claim determination period of a plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
5. If none of the above rules determines the order of benefits, the benefits of the plan, which covered an employee or Member longer, are determined before those of the plan which covered that person for the shorter period of time.

B. Order of Responsibility.

HPS shall be entitled to:

1. Determine whether and to what extent a Member has indemnity or other coverage for the Covered Services provided under the Contract;
2. Establish priorities for primary responsibility among the health benefit plans obligated to provide Covered Services or indemnity benefits;
3. Release to or obtain from any other health benefit plan any information needed to

- implement this provision; and
4. Recover the value of Covered Services rendered to the Member under the Contract to the extent that such Covered Services are covered by any other health benefit plan with primary responsibility for paying for such Covered Services.

C. Plan as Primary Coverage.

When HPS's coverage is primary coverage, it will provide all necessary Covered Services in accordance with this Evidence of Coverage. The secondary health benefit plan may be obligated to pay any Deductible, Coinsurance, Copayment, or other charges not covered by HPS if you file a claim with that Group Health Benefit Plan.

D. Plan as Secondary Coverage.

In no event will benefits be paid for non-Covered services or treatment. When this Plan is a secondary payor as determined by the rules set out above as to one or more other plans the benefits of this Plan will be reduced so that the sum of the amount paid by the primary plan or plans and the amount paid by this Plan will not exceed the amount of Allowable Expenses as determined by this Plan. When HPS's coverage is secondary, it reserves the right to require that you submit claims to the other plan(s), recover any claim payment that you receive from the other plan(s) and provide HPS with a copy of the Explanation of Benefit forms for the benefits paid by the other plan(s). If there is more than one secondary plan the order of priority will be determined by the rules set out above and any benefits paid by any other plan that is primary to this Plan will be considered when determining the benefits of this Plan. In all cases the Member is responsible for the Copay as set out in the Benefit Summary.

You must cooperate with HPS in providing any required information concerning any other insurance coverage you or your Dependents may have in order that HPS can properly process claims. Failure to provide such information may result in delay or a reduction in benefits.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

**SECTION XIII
RIGHT OF RECOVERY**

If you or your Covered Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this Plan, HPS may have a right of recovery. Our right of recovery shall be limited to the recovery of the reasonable cash value of any services provided or benefits paid for identical covered medical services or expenses under this Plan, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. HPS's right of recovery may include compromise settlements. You or your attorney must inform HPS of any legal action or settlement agreement at least ten days prior to settlement or trial. HPS will then notify you of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of your attorney's fees and expenses of litigation.

**SECTION XIV
COMPLAINT AND APPEAL PROCEDURES**

Complaints about HPS Service: As a Health Plan Select HMO, POS, or PPO member, you have a right to express dissatisfaction and expect unbiased resolution of issues. The following explains the process established to ensure that HPS gives its full attention to your concerns. Please use these procedures to tell us your concerns when you are not satisfied with any aspect of services you receive.

IMPORTANT NOTICE: For purposes of this Section XIV a Medical Appeal concerns questions of medical treatment, Prior Authorization, Medical Necessity, length of stay, and other issues involving medical judgment. All Medical Appeals will be reviewed by a medical doctor(s) or other licensed medical professional who was not involved in the non-certification (including his or her subordinates), who is board certified (if applicable), and is of the same or similar specialty as typically manages or treats the medical condition in question. All second level Appeals will be decided by the Review Panel .

Complaints are any expression of dissatisfaction with the health plan and include Administrative Appeals which concerns exclusions or limitations of treatments or services, eligibility issues, and other matters which do not involve medical judgments. All Complaints and Administrative Appeals will be decided by a non-medical Appeals Committee.

Please contact the Member Services Department at (706) 549-0549, extension 2301 or toll free, 1-800-293-6260 and tell us your problem. We will work to resolve it for you as quickly as possible. Please be prepared to provide us the following information:

- Member's identification number;
- Member's name and address;
- Date(s) of Service; and
- Provider's name.

- A. **MEDICAL APPEALS:** If you are not satisfied with our answer concerning a medical issue, you may file a formal Appeal. We prefer this Appeal be in writing, however, you may submit your Appeal verbally or via Email. Your formal Appeal for further review of your concerns should be forwarded to the address below:

Attention: Appeal Coordinator
Athens Area Health Plan Select, Inc.
295 W. Clayton Street
Athens, GA 30601

E-mail: memberservices@aaahps.com

1. You should receive a written acknowledgement from the Appeal Coordinator within five (5) working days following receipt of your request. You or your physician can request an expedited Appeal if it reasonably appears that failure to receive the proposed care or treatment would seriously jeopardize the life or health of a Member, jeopardize the Member's ability to regain maximum function, or subject the Member to severe pain that cannot be adequately managed without the proposed care or treatment. At the conclusion of this formalized review of your concern, a final written response will be sent to you, which will hopefully resolve your issue.
2. Any Complaint regarding care issues will be referred to the Quality Department for immediate investigation and resolution, with communication of the status to the Complaint Coordinator prior to the fifteenth (15th) working day after the appeal was acknowledged.
3. If you remain dissatisfied upon the completion of the first Appeal level, you may again request an Appeal of your decision. At the second Appeal level, you have the opportunity to represent yourself in a formal Review Panel setting to present your position.
4. The Appeals Coordinator will issue a written decision to you following the Review Panel meeting and, if applicable, to your provider, within five (5) days. The decision will include:
 - a) The professional qualifications and licensure of the members of the review panel.
 - b) A statement of the review panel's understanding of the nature of the Appeal and all pertinent facts.

- c) The review panel's recommendation to HPS and the rationale behind that recommendation.
- d) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
- e) In the review of a non-certification or other clinical matter, the medical doctor(s) or other healthcare professionals will provide a written statement of the clinical rationale, including the clinical review criteria, that was used by the medical doctor(s) to make the recommendation. See the "Important Notice" above.
- f) The rationale for HPS' decision if it differs from the review panel's recommendation.
- g) A statement that the decision is HPS' final determination in the matter.
- h) A statement advising the Member of the right to request an external review.
- i) A statement that the member may appeal to the Georgia Department of Insurance and/or the Georgia Department of Human Resources at the following addresses:

Office of Insurance and Safety Fire Commissioner
 Consumer Services Division
 Seventh Floor, West Tower
 Floyd Building
 2 Martin Luther King Jr. Drive
 Atlanta, Georgia 30334

Georgia Department of Human Resources
 Complaint Intake Unit
 2 Peachtree Street, NW
 32nd Floor
 Atlanta, GA 30303

B. COMPLAINTS AND ADMINISTRATIVE APPEALS: If you are not satisfied with our answer concerning a non-medical issue, you may file a formal Administrative Appeal. We prefer this Administrative Appeal be in writing, however, you may submit your Administrative Appeal verbally or via Email. Your formal Administrative Appeal for further review of your concerns should be forwarded to the address below:

Attention: Complaint Coordinator
 Athens Area Health Plan Select, Inc.
 295 West Clayton Street
 Athens, Georgia 30601

E-mail: memberservices@ahps.com

Administrative Appeals about non-medical issues, such as dissatisfaction with the health plan, Exclusions and limitations of the plan, are reviewed by a committee composed of the Director of Claims, Director of Member Services, Director of Quality and Utilization, and the Director of Network Development. Any three of these constitute a quorum. Second Level Administrative Appeals are reviewed by the Appeals Committee, which is composed of the Executive Director, Chief Operating Officer, and Chief Financial Officer, any two of which constitute a quorum.

The Appeals Coordinator will issue a written decision to you following the Appeal Committee meeting and, if applicable, to your provider, within five (5) working days. The decision will include:

- a. The names and titles of the members of the Appeal Committee.
- b. A statement of the Appeal Committee's understanding of the nature of the Administrative Appeal and all pertinent facts.

- c. The Appeal Committee's decision and the rationale behind that decision.
- d. A description of or reference to the Evidence of Coverage or Group Healthcare Contract considered by the Appeal Committee in support of its decision.
- e. A statement that the decision is HPS' final determination in the matter.
- f. A statement that the member may appeal to the Georgia Department of Insurance and/or the Georgia Department of Human Resources at the following addresses:

Office of Insurance and Safety Fire Commissioner
Consumer Services Division
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King Jr. Drive
Atlanta, Georgia 30334

Georgia Department of Human Resources
Complaint Intake Unit
2 Peachtree Street, NW
32nd Floor
Atlanta, GA 30303

If an Appeal or Complaint is made to the Georgia Department of Insurance, or the Department of Human Resources, that Department will provide a copy of the Appeal or Complaint to HPS. HPS will provide a written response within ten (10) working days to the requesting agency.

SECTION XV GENERAL PROVISIONS

A. Consent to the Release of Medical Information.

Unless state law requires a specific consent, you consent to the release of medical information to HPS by any provider, any third party administrator and any payor for yourself and enrolled Dependents, upon signing the Enrollment/Change Form. In addition, you authorize HPS to release any information regarding any claim for the delivery of medical care to any other person or organization that might be responsible for providing or paying for your medical care. HPS agrees that such information and records will be considered confidential. HPS shall have the right to submit any and all records concerning Covered Services rendered to you to appropriate medical review bodies. HPS has the right to have your Dependents sign a separate consent to release medical information to HPS.

Unless otherwise prohibited by law, you give implied consent to release medical information upon presenting Your Membership Card to any provider. HPS shall have the right to deny Covered Services or to refuse reimbursement for Covered Services to you if you refuse to consent to the release of medical information.

In the event of a question or dispute concerning the provision of Covered Services or payment of such services under the Contract, HPS may reasonably require that a Participating Physician designated by HPS examine you, at HPS's expense.

B. HIPAA Notice.

HPS complies with the Health Insurance Portability and Accountability Act (HIPAA). Member's Protected Health Information (PHI) will not be used or disclosed for any purpose other than treatment, payment of claims, and insurance operations purposes. We will not release your PHI to any party unless it is for one of these purposes or you have authorized the release or it is authorized by law.

Members are given a copy of HPS's Privacy Statement when coverage is first effective. You also may request a copy of the Privacy Statement by contacting Member Services Department at the address listed in the Complaint and Appeal Section above or by calling (706) 549-0549, extension 2301.

C. Written Notice.

All notices to the parties to the Contract shall be in writing, postage prepaid, registered or certified mail, return receipt requested, and shall be deemed given when mailed. The notices shall be mailed:

If to Policyholder: at Policyholder's most current address on file with HPS (it is Policyholders' responsibility to timely notify HPS of address changes).

If to HPS:

Athens Area Health Plan Select, Inc.
295 West Clayton Street
Athens, Georgia 30601

or to such other address or person designated by either party, in writing, during the term of the Contract.

Notice given by HPS to an authorized representative of the Policyholder shall be deemed notice to all affected Members and includes termination of the Contract or the termination of your coverage. The Policyholder agrees to provide appropriate notice to all affected Members at its own expense.

D. Waiver of Terms.

The failure of HPS to insist upon the strict performance of any term or requirement of this Evidence of Coverage shall not constitute a waiver of the future performance of such term or requirement. Any waiver of any term or requirement of this Evidence of Coverage must be in writing and signed by an authorized representative of HPS.

E. Member Rights and Responsibilities.

HPS guarantees you the right to:

1. Obtain complete current information from HPS about your coverage and benefits in language that is understandable by a layperson; and
1. Have access to HPS's Member Services staff and make inquiries for explanation of any procedures or benefits covered by HPS; and
3. Have a Membership Card clearly identifying you as a Member of HPS and the procedures for prior approval and access to Member services; and
4. Have all patient care information kept confidential by HPS, and to be treated in a dignified manner with respect for the need of privacy; and
5. Have complaints and appeals regarding services provided by HPS providers investigated and processed in accordance with the Member appeal procedure; and
6. Have an assurance that HPS will not: decline to enroll; refuse to continue to enroll; cancel the enrollment; limit the amount, extent or kinds of health care plans available; or charge an individual a different rate for the same health benefit plan on the basis of race, color, national origin, sex, age, religion, ancestry, marital status, health status or sources of payment; and
7. Be notified immediately of any material change in the operation or organization of HPS, which will affect you directly.

You have the responsibility to:

1. Follow the plans and instructions for care that you have agreed upon with your medical provider or to notify your medical provider of reasons it cannot be followed as soon as possible; and
2. Notify HPS of any loss or theft of your Membership Card; and
3. Only use your Membership Card and not allow anyone else to use your card for accessing services. If you permit someone else to use your Identification Card, or use your Identification Card after your coverage under this Plan terminates, you will be responsible for payment of any charges or expenses connected with the unauthorized use of your card; and
4. Present your Membership Card when accessing healthcare services; and
5. To the best of your capabilities; be familiar with the Plan procedures or call Member Services for clarification; and
6. Honestly provide Plan providers and HPS with accurate, complete medical information; and
7. Make every effort to fulfill any agreed upon appointments, follow-up visits, and Preventive Care plans; and
8. Treat the providers and staff with courtesy and respect.
9. Pay the required Copayments when treatment is received.
10. Treat HPS staff with courtesy and respect. Abusive or threatening language should not be used. Continued use of abusive or threatening language will be considered noncompliance with Plan rules.

F. Obligations of HPS and Participating Provider.

In accordance with the agreement between HPS and its Participating Providers, Participating Providers may not seek compensation from you for any of the Covered Services and supplies described in this Evidence of Coverage or Benefit Summary, except for approved Copayments, Deductibles, and Coinsurance.

In the event that HPS no longer provides the Covered Services described in this Evidence of Coverage, it has arranged for all Covered Services and supplies described in this Evidence of Coverage and your Benefit Summary to be provided to you until the earlier of the termination of this contract or its next annual renewal date. Such healthcare coverage may be provided through any one (1) or more of the following methods: (1) insolvency insurance; (2) provisions in Participating Provider agreements; (3) agreements with other organizations or insurers providing automatic conversion rights upon discontinuation of the plan; and/or (4) other arrangements approved by the Commissioner of Insurance.

G. Fraudulent or Unauthorized use of Identification Card.

If you use your HPS Identification Card after your coverage has terminated or if you allow someone else to use your ID card you will be held responsible for any charges or expenses that result from that use. If you allow someone else to use your ID Card your coverage under this Plan can be terminated.

H. Grace Period.

After the Effective Date of coverage the premium for coverage under this Plan is due from the Policyholder on the 1st day of each month. There is a thirty-one (31) day grace period for payment of the premium. If premium is not paid by the Policyholder prior to the end of the grace period coverage under this Plan will be terminated for non-payment of premium. During the Grace Period the coverage will remain in effect unless the Policyholder has given notice of discontinuance of the coverage at least thirty (30) days in advance of the date of discontinuance in accordance with this Evidence of Coverage and the Group Healthcare Contract. The Policyholder will be responsible for payment of pro rata premium for the time the coverage is in force during the Grace Period.

I. Plan Administrator Notice.

HPS is not the Plan Administrator under the Employee Retirement Income Security Act (ERISA). If the Policyholder does not appoint a Plan Administrator then the Policyholder is the Plan Administrator for the Policyholder's employee benefit plan. While HPS will cooperate with the Policyholder in complying with state and federal laws HPS does not assume any responsibilities of the Plan Administrator for the Policyholder's plan. The Policyholder is responsible for compliance with ERISA and all other state and federal laws which apply to the Employer.

J. Clerical Error.

If a clerical error or other mistake occurs that mistake or error will not create any right to benefits or coverage nor will it deprive you of any benefits or coverage you would otherwise be entitled to had the mistake or error not occurred. Such mistake or clerical error will not act in such a way to provide or extend coverage under this Plan if such person is not eligible for coverage, to incorrectly pay or deny a claim for medical services, or to incorrectly set premium rates for any person covered by this Plan. If a clerical error is made HPS will take appropriate steps when it is discovered to correct any error in coverage, processing of claims, or calculation of premium rates as soon as practical. HPS will not make retroactive adjustments beyond a sixty (60) day period.

K. Entire Contract: Amendments:

This Evidence of Coverage, the Benefit summary, the Group Healthcare Contract, application forms and riders, if any, constitute the entire contract of insurance. No change in this Evidence of Coverage shall be valid until approved by an executive officer of the HPS and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Evidence of Coverage or to waive any of its provisions. HPS reserves the right, in HPS's sole discretion, to modify, change, or amend this Evidence of Coverage without your approval. No change shall be effective until your date of renewal and HPS will give sixty (60) days prior notice to the Policyholder of any such modification, change, or amendment.

L. Legal Action:

No lawsuit may be filed to recover benefits under this Evidence of Coverage until sixty (60) days after the submission of a claim for such benefits has been filed. An insured under this Evidence of Coverage cannot file any legal action after three years from the date a service was received

M. Governing Law.

This Evidence of Coverage and the Contract will be governed by the laws of the State of Georgia.

N. Refunds of Overpayments:

If we pay benefits that a Member is not legally obligated to pay or we pay more than the benefits a Member is entitled to under the terms of this Evidence of Coverage, we may request a refund from the Member or from the Provider that received the overpayment. If we seek a refund from a party other than the Member, the Member must cooperate with us in pursuing the refund. If the refund is due from the Member, we may reduce the amount of future benefits paid under this Plan in an amount equal to the overpayment.

O. Time Limit on Certain Defenses:

After two years from the date of this policy and in the absence of fraud, no misstatements made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two-year

period. In order for the insurer to void the policy or to deny a claim for loss incurred or disability based upon an applicant's fraudulent misstatement in an application, a copy of such application must be furnished to the policyholder or his or her beneficiary, and such fraudulent misstatement must have been in writing, must be material to the risk assumed by the insurer, and, in the case of a claim, must also relate to the specific type of loss or disability for which the claim is made.

SECTION XVI

Certificate of Creditable Coverage

When your coverage under this Plan ends you will be provided with a Certificate of Creditable Coverage that will indicate the dates you were covered under this Plan. The Certificate of Creditable Coverage is an important document because you may be required to provide it to your new health plan. You should keep it in a safe place. You can also request a replacement Certificate of Creditable Coverage at any time up to twenty-four (24) months after your coverage under this Plan ends by contacting Member Services at the above address or telephone number. If more than two Certificates of Creditable Coverage are requested in any three month period a reasonable charge will be made for additional copies.

SECTION XVII

Your Rights Under ERISA

NOTE: Athens Area Health Plan Select, Inc. is not the Plan Administrator or the named fiduciary (as defined in ERISA) for this group healthcare plan. You should contact your Employer to determine who the Plan Administrator is for this Plan.

Receive Information About Your Plan and Benefits

As a participant in your Employer's group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
2. Obtain, upon written request to the Plan Administrator, copies of governing the operation of the plan, including the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies; and
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
4. Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

1. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

2. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from this plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension Welfare Benefits Administration, U.S.

Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You may also obtain certain publications about your right and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

APPENDIX A- BENEFITS SUMMARY (Attached)