

CELTIC INSURANCE COMPANY

Home Office: 233 South Wacker Drive, Chicago, Illinois 60606-6393

Ohio Open Enrollment Policy

Celtic Insurance Company will pay *benefits to you, the insured person*, for covered loss due to *sickness or bodily injury* as outlined in this *policy*. *Benefits* are subject to *policy* definitions, provisions, limitations and exceptions.

RENEWABILITY

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


TEN DAY RIGHT TO RETURN POLICY

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

CONSIDERATION

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

Celtic Insurance Company

A handwritten signature in black ink, appearing to read 'James P. Daly', with a large circular flourish on the left side.

James P. Daly
Chief Operating Officer and Executive Vice President

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SECTION I – DEFINITIONS

Note: Italicized words are defined in this *policy*.

Masculine pronouns used in this *policy* include the feminine.

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

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

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

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

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

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

Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

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

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

Calendar Year Deductible is the amount of *incurred eligible expenses* that must be paid by or on behalf of the *insured person* per *calendar year* before *we* pay *benefits*. The *calendar year deductible* is shown on *your* Schedule of Benefits.

Calendar Year Maximum is the total amount of *benefits* *we* will pay during a *calendar year*

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

Complication of Pregnancy is a condition that is distinct from *pregnancy* but is adversely affected by *pregnancy*. Examples of such conditions include: acute nephritis, nephrosis, cardiac decompensation, missed abortion and conditions of comparable severity. It also includes conditions such as emergency non-elective cesarean section, ectopic pregnancy, hyperemesis gravidarum and spontaneous abortion occurring when a viable birth is not possible.

It does **NOT** include: false labor, occasional spotting, *physician*-prescribed rest during *pregnancy*, morning sickness, pre-eclampsia or other conditions related to a difficult *pregnancy*.

Creditable Coverage means health insurance coverage an *insured person* had prior to the effective date of this policy. *Creditable coverage* includes:

- an employer group health plan, including COBRA or continuation coverage under a similar State provision;
- a fully-insured health plan;
- health insurance or Health Maintenance Organization coverage;
- Medicare or Medicaid;
- military health care (CHAMPUS);
- a medical care program of the Indian Health Services or of a tribal organization;
- a State health benefits risk pool;
- a health plan offered under the Federal Employee Health Benefits Program;
- a public health plan as defined under Federal regulations;
- a health benefit plan under Section 5(e) of the Peace Corps Act; or
- any other health insurance coverage permitted and defined as creditable coverage under Federal Law or regulations.

Creditable coverage does not include coverage under a non-medical dental or vision plan.

Custodial Care is treatment designed to assist an *insured person* with activities of daily living and not specifically aimed at curing or assisting in recovery from a *sickness* or *bodily injury*. *Custodial care* includes (but is not limited to) the following:

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

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

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

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

Durable Medical Equipment is equipment which:

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

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

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

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

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

Emergency Room Deductible is the amount of *incurred eligible expenses*, in addition to the *calendar year deductible* that must be paid by or on behalf of the *insured person* for emergency room charges before we pay benefits. The *emergency room deductible* is shown on the Schedule of Benefits. If an *insured person* is *hospital confined* immediately following an emergency room visit, the *emergency room deductible* will not apply. The *emergency room deductible* may not be used to satisfy the *out-of-pocket maximum*.

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

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

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

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

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

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

Federally Eligible Individual means an individual as defined in the Health Insurance Portability and Accountability Act of 1996 and later amended (HIPAA) who has 18 or more months of *creditable coverage*, as

defined in HIPAA, and who is entitled to guaranteed availability of individual health insurance coverage under HIPAA.

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

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

- Part-time or intermittent home nursing care from, or supervised by, a *nurse*;
- Part-time or intermittent home health aid services;
- Physical therapy, occupational therapy and speech therapy;
- Medical supplies, drugs and medication prescribed by a *physician*; and
- Laboratory services to the extent such charges or costs would have been covered had the *insured person* received them in a *hospital*.

Each visit by each person providing home health care services will be considered one visit. If a visit lasts for more than four consecutive hours, each four hour segment or less will be counted as one visit.

Home health care includes only treatment which is *medically necessary* and does **NOT** include *custodial care* or educational care. *Home health care* does **NOT** include treatment for alcoholism, drug or other substance abuse, neurosis, psychoneurosis, psychopathy, psychosis, or mental, nervous or emotional disease or disorder of any kind.

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

Home Health Care Agency means an agency which is

- approved as a provider of *home health care* under Medicare;
- an agency licensed or certified as a *home health care agency* in the state where it is located; or
- accredited home health care agency or as a provider of home health care by the National League of Nursing, the American Public Health Association or Joint Commission on Accreditation of Hospitals.

Hospice Services are services provided under a coordinated comprehensive program of palliative and supportive rather than curative care on a 24 hour, seven days per week basis for persons who have been diagnosed as terminally ill (people with a life expectancy of 6 months or less). Palliative care includes: pain and symptom management by a medical team; psychosocial, spiritual and practical support for the patient and family; and bereavement care.

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

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

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

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

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

Individual Out-of-Pocket Maximum is the dollar amount *you* must pay, in addition to the *calendar year deductible*, before *we* pay benefits at 100%. This amount is shown on the Schedule of Benefits.

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

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

Lifetime Maximum Benefit is the total amount of *benefits* payable during an *insured person's* lifetime.

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

Medical Emergency means an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonable expect the absence of immediate medical attention to result in any of the following:

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

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

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

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

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

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

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

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

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

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

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

Policy is the contract between Celtic and the *primary insured person*.

Pregnancy means a normal *pregnancy*, normal childbirth or elective cesarean section (refer to the *Complication of Pregnancy* definition in this section).

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

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

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

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

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

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

Rehabilitation Facility is a licensed facility other than a *hospital* that provides rehabilitation care and treatment. The facility must be under full-time supervision by at least one *physician* trained and experienced in rehabilitation or a related field, and must have 24 hour nursing service. The facility must provide:

- Social services, occupational therapy, physical therapy and speech-language pathology services;
- Specialists such as dietitians, prosthetists and orthodontists on an as-needed basis; and
- Services which are multi-disciplinary, coordinated, integrated, goal-oriented and determined based on individual periodic assessment of basic fundamental ability.

Facilities licensed as *hospitals, extended care facilities* or *skilled nursing facilities* are not included in this definition.

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

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

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

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

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

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

- Prevents a *primary insured person* from being able to do any work or employment for wages or profit; or
- Prevents a *dependent* from engaging in all normal activities of a person of like age and sex who is in good health.

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

Transplant Related Expenses are costs associated with pre-*transplant* phase testing, chemotherapy or radiation therapy when supported by *transplant* procedures, harvest and reinfusion of stem cells or bone marrow, drugs and medications (including those administered to mobilize stem cells for *transplants*), inpatient hospitalization and outpatient services.

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

SECTION II – ELIGIBILITY

You are eligible for coverage under this *policy* if:

- You meet the definition of a *Federally Eligible Individual*; or
- You are a Non-Federally Eligible Individual who meets the following conditions:
 - You are not applying for coverage as an employee of an employer;
 - You do not have any other health coverage and are not eligible to be covered under any private or public health benefit plans including the following:
 - Medicare or Medicare Supplement;
 - Medicaid;
 - Any Cobra or state continuation coverage plan;
 - Other health benefits arrangement; and
- Celtic has not met the statutory limit for Federally Eligible and Non-Federally Eligible individuals for open enrollment set by Ohio law.

To qualify as a *Federally Eligible Individual* the following criteria must be met:

- You must have an aggregate of at least 18 months *creditable coverage* and the most recent prior *creditable coverage* must have been under an employer based group health plan, governmental plan or church plan without a break in coverage greater than 63 days;
- You must not be eligible for coverage under a group health plan, Medicare or Medicaid;
- Your most recent coverage must not have terminated due to nonpayment of premium or for fraud; or
- You must have elected COBRA or a State Continuation plan, if offered,, and must have exhausted all COBRA or State continuation coverage.

Dependents

To be eligible as a *dependent* the child(ren) must meet the definition of *dependent*, be under 19 years of age and be principally dependent on the *primary insured person* for the majority of their support and maintenance.

Upon attainment of the limiting age, coverage for an unmarried *dependent* may be extended through age 27, if requested by the *primary insured person*, and all of the following are true:

- the *dependent* is the natural child, stepchild, or adopted child of the *primary insured person*;
- the *dependent* is a resident of this state or a full-time student at an accredited public or private institution of higher education;
- the *dependent* is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- the *dependent* is not eligible for coverage under the Medicaid program established under Chapter 511. of the Revised Code or the Medicare program established under Title XVIII of the “Social Security Act,” 42 U.S.C.1395.

Handicapped Child

Coverage may be continued for a *dependent* who is unable to earn his own living because of a handicapped condition and is primarily dependent on the *primary insured person* for support and maintenance. Celtic may request proof of such a handicap no earlier than two months prior to the date the *dependent* reaches the limiting age. Proof acceptable to Celtic must be furnished within 60 days.

Celtic may require satisfactory proof of the continuance of such incapacity and dependency, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

When an *insured person* is required by a court or administrative order to provide health coverage for a *dependent* child, and the *insured person* is eligible for family coverage, *we* shall do the following:

- Providing the *dependent* child is otherwise eligible for coverage, permit the *insured person* to enroll the *dependent* child under family coverage, without regard to any enrollment period restrictions;
- If the *insured person* is enrolled under the health coverage but fails to make application to obtain coverage for the *dependent* child, enroll the child under family coverage upon application of the child's other parent, or pursuant to a child support order containing provisions in compliance with sections 3119.29 to 3119.56 of the Revised Code; and
- not terminate coverage of the *dependent* child unless Celtic is provided satisfactory written evidence that:
 - the court or administrative order is no longer in effect; or
 - the *dependent* child is or will be enrolled under comparable health coverage through another insurer that will take effect not later than the effective date of the termination of the current coverage.

Any *dependent* in full-time military service is not eligible for coverage under this *policy*.

Newborn Children

Children born to an *insured person* while this *policy* is in force will be insured without evidence of insurability from the moment of birth for an initial thirty-one (31) day period. For eligibility to continue after the initial thirty-one (31) day period, children born to an *insured person* must meet the definition of *dependent*. *You* must notify *us* of the birth within thirty-one (31) days after the birth and pay any additional required premium. If *you* do not notify *us* of the birth of such children or fail to pay the additional required premium, their coverage will end thirty-one (31) days after the birth.

Adopted Children

Children adopted by a *primary insured person* while this *policy* is in force will be insured without evidence of insurability for an initial thirty-one (31) day period, from the moment of placement with the *primary insured person*. For eligibility to continue after the initial thirty-one (31) day period, children adopted by a *primary insured person* must meet the definition of *dependent*. *You* must notify *us* within thirty-one (31) days of the placement and pay any additional required premium. If *you* do not notify *us* of the placement with a *primary insured person*, or fail to pay the additional required premium, their coverage will end thirty-one (31) days after their placement with the *primary insured person*.

Effective Date

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

SECTION III – THE HEALTH CARE CERTIFICATION PROGRAM

Cost Containment Features

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

Certified Treatments

The Health Care Certification Program requires Certification for the following:

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

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

Certification

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

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

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

Non-Certification

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

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

Notification

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

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

Notification of an Elective Hospital Confinement, Psychiatric Care, Outpatient Surgery or other Treatment

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

Notification of an Emergency Hospital Confinement

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

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

- The *insured person* is unconscious, in a coma or otherwise physically unable to request that notification be made; or
- In the case of a *dependent*, if the *insured person* is not informed of the *hospital confinement* then the requirement for Notification is met provided that Notification is made as soon as reasonably possible.

Notification of Additional Days

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

Penalty

There is a penalty if treatment is not certified due to the lack of notification to the Health Care Certification Program. The penalty is a 20% reduction of *eligible expenses* for all charges related to the treatment up to a \$10,000 maximum.

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

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

Penalties cannot be applied toward the required *deductible* or *coinsurance* payment. Remaining *eligible expenses* are subject to all *policy* provisions, including the *deductible* and *coinsurance*.

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

Pregnancy

Only *complications of pregnancy* are covered under this *policy* unless Maternity and Routine Nursery Care are shown as covered on *your* Schedule of Benefits. However, even if *you* believe that the *pregnancy* will be normal and therefore not covered, Celtic strongly encourages Notification of the *pregnancy* in order to properly certify treatment if a complication arises later. Notification of all *pregnancies* is encouraged to be made prior to delivery and within 24 hours following delivery.

Second Surgical Opinion

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

Medical Case Management

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

Other Requirements

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

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

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

Appeal Process

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

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

SECTION IV – BENEFITS

Your Benefits

The following apply to all *benefits*:

- *Benefits* are only paid for *eligible expenses* that are *incurred* as a result of a *sickness, bodily injury* or normal pregnancy if Maternity and Routine Nursery Care are shown as covered on *your* Schedule of Benefits;
- *Benefits* are not paid for those expenses that are excluded from coverage (refer to Section V Exclusions and Limitations);
- *Benefits* are only paid after the *deductible* is satisfied (refer to the Schedule of Benefits);
- *Benefit* payment is subject to a 30% or 50% *coinsurance* payment (refer to the Schedule of Benefits);
- *Benefits* for *eligible expenses* are paid at 100% after the *deductible* and *individual out-of-pocket maximum* have been satisfied for each *insured person*;
- Depending on the plan chosen, *benefits* for *eligible expenses* are only paid up to the *calendar year maximum* or the *lifetime maximum benefit*, for each *insured person*, (refer to the Schedule of Benefits);
- Under the Health Care Certification Program, an *elective hospital confinement, hospital confinement* as the result of a *medical emergency, psychiatric care, outpatient surgery, major diagnostic tests, home health care, extended care facility* confinements, *hospice care, rehabilitation or skilled nursing facility* confinements and transplants must be certified, or else a penalty applies which reduces *benefit* payments in accordance with the Health Care Certification Program (refer to Section III The Health Care Certification Program).

Eligible Expenses

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

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

- **HOSPITAL CHARGES** for medical services and supplies *incurred* by an *insured person* while *hospital confined* up to the maximum of the average semi-private room and board charge in that *hospital*.
 - For *intensive care*, the maximum *eligible expense* is three (3) times the average semi-private room charge.
 - For confinement in a convalescent home, *skilled nursing or extended care facility* and charges for *home health care* or *hospice*, *eligible expenses* are limited to a *calendar year* maximum. Please refer to *your* Schedule of Benefits.
- **SURGICAL CHARGES** made by a *physician* for surgical services.
 - Assistant Surgeon - Required services of an assistant surgeon, when medically appropriate, are paid at 20% of all eligible expenses made by the surgeon performing the operation.
 - Multiple Surgeries - If two or more surgical procedures are performed in the same operative session, the maximum payment is limited to:
 - The amount payable for the procedure having the greater payment for procedures performed through the same incision;
 - The amount payable for the procedure having the greater payment plus one-half of the amount that would have otherwise been payable for the procedure having the lesser benefit when surgery is performed through separate incisions.
 - Anesthesia Charges - *Eligible expenses* are limited to the anesthesia *reasonable and customary charge* for the surgery(s) performed regardless of the number of *providers* administering the anesthesia.
- **MEDICAL SERVICE CHARGES** for the following medical services:
 - Nonsurgical professional services by a *physician* or *nurse*;
 - Radiologist or laboratory for x-ray or radiation therapy; diagnosis or treatment;
 - Charges by a *hospital* while an *insured person* is not *hospital confined*;
 - Outpatient rehabilitation therapy, up to the calendar year maximum shown on *your* Schedule of Benefits;
 - Local professional ground transportation in an ambulance to or from the nearest *hospital*;
 - Coverage for screening by low-dose mammography as follows:
 - one baseline mammogram for an *insured person* age 35 through 39;
 - one mammogram every 2 years for an *insured person* age 40 through 49 or annually if a licensed *physician* has determined an *insured person* has risk factors for breast cancer; or
 - one mammogram per *calendar year* for an *insured person* age 50 and over.The maximum payment for this benefit will not exceed one hundred thirty percent (130%) of the Medicare reimbursement rate for a screening mammography in the state of Ohio; and

- One cytological screening for the presence of cervical cancer per *calendar year*.
- **MEDICAL SUPPLY CHARGES** for the following medical supplies:
 - Outpatient *prescription drugs* up to the *calendar year* maximum shown on *your* Schedule of Benefits;
 - Blood, blood plasma, oxygen and anesthesia and their administration;
 - Initial artificial limbs or eyes needed to replace natural limbs or eyes that are lost while an *insured person's* coverage is in force;
 - Initial prosthetic devices required as a result of mastectomy performed while an *insured person's* coverage is in force;
 - Casts, splints, surgical dressings, crutches, the rental of wheel chairs, *hospital* beds, and other *durable medical equipment*. Rental fees are for no longer than six (6) months and cannot exceed the purchase price.
- **BIOLOGICALLY BASED MENTAL ILLNESS CHARGES** for diagnosis and treatment of a *biologically based mental illness* are covered the same as any other *sickness* if both of the following apply:
 - The biologically based mental illness is clinically diagnosed by a *physician* authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732 of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757 of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723 of the Revised Code whose nursing specialty is mental health.
 - The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.
- **HUMAN ORGAN AND TRANSPLANT CHARGES** for *medically necessary, non-experimental* human *organ transplants*. *Eligible expenses* for *transplants* include all *transplant-related expenses* such as initial testing and diagnosis, immunosuppressant drug therapy before and after surgery, complications resulting from surgery, organ rejection or failure, and repeat transplants of same organ. *Eligible expenses* do not include storage charges *incurred* beyond 60 days of the removal of an *organ*.

Certified non-experimental *transplant* procedures are covered up to the lifetime maximum shown on *your* Schedule of Benefits. Covered transplants include: heart, heart/lung, lung, liver, kidney, bone marrow, pancreas and cornea. No other *organ* transplants are covered.

- **CANCER CLINICAL TRIALS** eligible expenses includes routine patient care costs incurred as a result of an *insured person's* participation in any stage of an eligible cancer clinical trial provided that care would be covered if the *insured person* was not participating in a clinical trial. An eligible cancer clinical trial must meet the following criteria:
 - The purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
 - The treatment provided as part of the trial is given with the intention of improving the trial participant's outcomes;
 - The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
 - The trial does one of the following:
 - Tests how to administer a health care service, item or drug for the treatment of cancer;

- Tests responses to a health care service, item or drug for the treatment of cancer;
 - Compares the effectiveness of a health care service, item or drug for the treatment of cancer;
 - Studies new uses of a health care service, item or drug for the treatment of cancer; and
 - The trial is approved by one of the following entities:
 - The national institute of health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 - The United States Food and Drug Administration;
 - The United States Department of Defense;or
 - The United States Department of Veteran Affairs.
- **MANIPULATIVE THERAPY CHARGES** up to the calendar year maximum shown on *your* Schedule of Benefits. Manipulative therapy includes diagnosis and non-surgical treatment of structural imbalance, distortion, dislocation, misplacement or subluxation of vertebrae or the spinal column.
 - **MENTAL/NERVOUS/ALCOHOLISM AND DRUG ADDICTION CHARGES**
 - Inpatient charges include *hospital* charges, medical service charges and medical supply charges while *hospital confined*, up to the calendar year maximum shown on *your* Schedule of benefits.
 - Outpatient Services up to the calendar year maximum shown on *your* Schedule of Benefits. Services shall be legally performed by or under the clinical supervision of a physician or licensed psychologist whether performed in an office in a hospital or in a community mental health facility so long as the hospital or community mental health facility is approved by the Joint Commission on Health Care Organizations or certified by the department of mental health.
 - **CHILD HEALTH SUPERVISION SERVICES** for children from the moment of birth to age nine. Child health supervision services means periodic review of a child's physical and emotional status performed by a physician or by a health care professional under the supervision of a physician in accordance with the recommendations of the American Academy of Pediatrics. The periodic review includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests. Benefits for Child Health Supervision Services are subject to the *calendar year deductible* and *coinsurance* and a calendar year maximum. Please refer to *your* Schedule of Benefits.
 - **RECONSTRUCTIVE BREAST SURGERY** charges for reconstructive breast surgery as a result of a partial or total mastectomy. Coverage is provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed. Coverage includes prosthetic devices necessary to restore symmetry.

SECTION V – EXCLUSIONS AND LIMITATIONS

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

- Transportation, except local to or from a hospital by professional ground ambulance services;
- Normal childbirth, *pregnancy* or routine nursery care, unless Maternity and Routine Nursery care are shown as covered on *your* Schedule of Benefits, elective cesarean section or voluntarily induced abortion;
- Fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer
- Replacement of artificial limbs or artificial eyes;
- Blood or blood plasma which has been replaced;
- Donation of any body organ by an *insured person*;
- Services performed by a person who ordinarily resides in the *insured person's* home or is a close relative of the *insured person* or by the *insured person's* employer or partner;
- Any cosmetic surgery, except as stated in the *policy* or required to restore a part of the body that has been altered as a result of a *bodily injury* or *sickness*;
- *Custodial care*;
- Services or treatments not prescribed by a doctor or for services or treatments not shown as covered;
- *Sickness* or *bodily injury* that arises out of, or in the course of, employment for wages or profit;
- *Eligible expenses incurred* after insurance coverage terminates;
- Treatment, services or medication that is *experimental* or *investigational* in nature;
- Eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy; or for eye refractions, eye glasses or contact lenses including fitting and examinations;
- Treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion does not apply to a non-service connected *sickness* of a veteran of the United States armed forces who does not have a service connected *sickness*;
- Services and supplies eligible for payment by a government or charitable program, except as required by law;
- Hearing aids, including fitting and examinations;
- Non-medically necessary care or treatment of a *sickness* or *bodily injury*;
- Charges which would not be made if no insurance existed;
- Recreational or educational therapy or vocational rehabilitation;
- Speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma, except as allowed under eligible expenses;
- Any otherwise *eligible expense* for which the *insured person* is not legally obligated to pay;
- Treatment or services that are not generally accepted medical practices in the United States for a given *sickness*;
- Treatment of obesity, morbid obesity or for weight reduction purposes;
- Sickness that results from participation in any assault, unlawful act, strike, civil disorder or riot;
- Treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis;

- Routine physical examination or premarital examination except as may be covered under the child health supervision benefit. Mammograms and pap smears are covered;
- A private room in excess of the average semi-private room and board rate;
- A pre-existing condition;
- *Incurred* charges in excess of the *reasonable and customary* charges;
- Services or supplies prohibited by law;
- Sex changes;
- Sterilization and reversal of sterilization;
- Suicide or attempted suicide or intentionally self-inflicted *bodily injury* while sane or insane, unless such act is the result of an underlying medical condition;
- Examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair of injury to sound natural teeth, (including their replacement) as a result of an accidental *bodily injury*. Treatment must be given within ninety (90) days of the date of the accident;
- *Sickness or bodily injury* caused by any act of war, declared or undeclared;
- Surrogate pregnancy;
- Surgery of the jaw or for any treatment of temporomandibular joint disorder (TMJ). Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion;
- Treatment or complications arising from or connected in any way with a surgical or medical treatment or procedure that is not an *eligible expense* under the terms of the *policy*, whether or not the *insured person* was insured under the *policy* at the time the non-covered treatment or procedure was performed;
- For foot care due to:
 - treatment of weak, strained or flat feet or instability or imbalance of the foot; and
 - treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illness of similar medical seriousness;
- Contraceptives, infertility drugs or growth hormones;

Pre-existing Conditions Limitation

A *pre-existing condition* is a *sickness or bodily injury* for which an *insured person* received a diagnosis, medical advice, consultation or treatment from a *physician* during the six (6) months prior to the effective date of coverage, or which, in the opinion of a *physician*, caused symptoms during the six (6) months prior to the effective date that were obvious enough to cause an ordinarily prudent person to seek diagnosis, medical care or treatment.

Benefits are paid for an *insured person's pre-existing condition* once coverage is in force for 12 continuous months after the effective date.

Any treatment or service for an excluded *pre-existing condition*, including any *complications* or conditions resulting from treatment of a *pre-existing condition* are not *eligible expenses*.

This pre-existing conditions limitation does not apply to federally eligible individuals.

Weekend Admissions Limitations

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

SECTION VI – TERMINATION OF COVERAGE

Coverage Terminates

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

- The *insured person* gives prior written notice of termination;
- The *insured person* fails to make any required premium payments;
- All policies of the same class of this form initially delivered or issued for delivery in this state are terminated.

Continuation or Conversion of Coverage

When this coverage ends as a result of a *primary insured person's* death or dissolution of marriage or attainment of the limiting age by a *dependent, dependents*, if insured under the plan immediately prior to termination, may apply for a new *policy* issued on the same form as this *policy*, if approved in the state where they live. Proof of good health will not be required. A new *policy* will be issued subject to the following:

- The *dependent* must notify Celtic in writing within 31 days of the date of the *primary insured person's* death or entry of a judgment of divorce or attainment of the limiting age by a *dependent*. Failure to provide such notice will result in the loss of coverage;
- The first premium must be sent to *us* and received within 31 days after the *dependent* ceases to be an *insured person* or within 60 days after the entry of a judgment of divorce of the *primary insured person*, if later;
- The premium will be based on the attained age and rating class applicable to the *insured person* for the *policy*;
- The new *policy* will not provide *benefits* greater than those provided under this *policy*; and
- The effective date of the new *policy* will be the date coverage ends under this *policy*;

SECTION VII – CLAIM PAYMENT PROVISIONS

Filing a Claim

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

Proof of Loss

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

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

Payment of Claims

Benefits are paid to the applicable *insured person* or *beneficiary* upon receipt of proof of loss. An *insured person* may authorize payment of *benefits* directly to the person or *provider* upon whose charges the loss is based.

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

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

Any *benefit* payable to the deceased *insured person* will be paid to their estate. Any payment made in good faith will fully discharge *us* to the extent of the payment.

Claims shall be paid or denied within thirty days after receipt of the claim, unless Celtic determines that additional information is needed. Celtic must request that additional information be provided within thirty days after receipt of the claim. If additional information is required, *we* will have forty-five days in which to pay or deny the claim in accordance with state law.

Claims Investigation

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

An investigation may require submission of *physician* office records, pharmacist drug statements, *hospital* medical records or other relevant information. *We* can require medical examinations at *our* own expense. Where legally permitted, *we* can also require an autopsy.

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

Alternative Treatment

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

If *our physician* advisor determines that a more cost-effective treatment is appropriate, only charges for the least costly alternative treatment are considered *eligible expenses*. We will advise *you* of those charges that are considered *eligible expenses* under this provision.

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

Beneficiary

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

If more than one *beneficiary* is named but there is no indication what portion of the *benefit* each is to receive, the *benefit* is payable in equal shares to the *beneficiaries*. If a *beneficiary* dies before *you* do, the *beneficiary's* share of the *benefit* is divided among the living *beneficiaries*.

If *you* die without naming a *beneficiary*, or the sole *beneficiary* named has died before *you* do, the *benefit* is paid to the first surviving class of the following individuals in this order: spouse and child(ren), either naturally or legally adopted; parents; brother(s) and sister(s); or the executors or administrators of the estate.

In order to identify eligible *beneficiaries*, Celtic may rely solely on a sworn statement signed by a member of the first surviving class of the above classes of *beneficiaries* listing the names and addresses of the members of the class.

Claim Appeal Process

There is an appeal process to provide a review of the initial claim determination. A claimant may have additional information which could change that decision. A review will be completed by a person other than the same person who made the original determination on which the appeal is based.

All appeals must be submitted within 60 days of the date *we* send notice to *you*. Written appeals must be submitted to:

Celtic Insurance Company
ATTN: Policy and Procedures
233 S. Wacker Dr., Suite 700
Chicago IL, 60606-6393

A decision will be rendered within 60 days of receipt of request. A copy of all decisions made will be sent to the *insured* and treating provider, if applicable.

The Ohio Department of Insurance will review complaints that are for services that have been denied as not covered by the health plan. If the complaint involves an issue of medical necessity, you may have a right to an external

review as described in Section VIII. You may file a complaint with the Ohio Department of Insurance should you disagree with Celtic's final decision:

For Consumers:

Ohio Department of Insurance
Consumer Services division
2100 Stella Court
Columbus, Ohio 43215-1067
(614)-644-2673
(800)-686-1526-toll free

For Producers:

Ohio Department of Insurance
Market Regulation Division
Provider Complaint Unit
2100 Stella Court
Columbus, Ohio 43215-1067
(614)-644-6428.

Legal Action

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

SECTION VIII – EXTERNAL REVIEW PROVISION

The superintendent of insurance maintains a system for receiving and reviewing complaints received from *insured's* that have been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the *insured's* certificate.

Upon receipt of a written request from an *insured* or authorized person, the superintendent shall consider whether the health care service is a service covered under the terms of the *insured's* certificate, except that the superintendent shall not conduct a review unless the *insured* has exhausted Celtic's internal appeal review process. Celtic and the *insured* or authorized person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review.

The superintendent shall determine whether the health care service at issue is a service covered under the terms of the *insured's* certificate. The superintendent will not review if the complaint involves making a determination which requires the resolution of a medical issue. The superintendent shall notify the *insured* and Celtic of its determination or that it was not able to make a determination because the determination requires the resolution of a medical issue. Once the superintendent notifies Celtic that making a determination requires the resolution of a medical issue, Celtic shall initiate an external review.. If the superintendent notifies Celtic that the health care service is not a covered service, Celtic is not required to cover the service or afford the *insured* an external review.

An external review may be requested by the *insured*, an authorized person, the *insured's* provider or a health care facility rendering a health care service to the *insured*. The *insured* may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without the prior consent of the *insured*.

An external review must be requested in writing, except for an expedited review, and within one hundred eighty (180) days after receipt by the *insured* of notice from the superintendent of insurance that making a determination requires the resolution of a medical issue. An external review request can be submitted to:

Celtic Insurance Department
Attn: Betty Kearns
Senior Regulatory Analyst
233 S. Wacker Drive, Suite 700
Chicago, Illinois 60606-6393
(312) 332-5401 ext 8727

An external review request must meet both of the following criteria:

- Celtic has denied, reduced, or terminated coverage for what would be a covered health care service except that Celtic has determined that the health care service is not medically necessary; and
- Except in the case of expedited review, a request for an external review must be accompanied by written certification from the *insured's* provider or the health care facility rendering the health care service to the *insured* that the proposed service, plus any ancillary services and follow-up care, will cost the *insured* more than five hundred dollars if the proposed service is not covered by Celtic.

An external review will not be granted in any of the following circumstances:

- The superintendent of insurance has determined under section 3923.66 of the Revised Code that the health care service is not a service covered under the terms of the *insured's* certificate;
- The *insured* has failed to exhaust Celtic's internal appeal review process; and
- The *insured* has previously afforded an external review for the same denial of coverage, and no new clinical information has been submitted to Celtic.

An Independent Review Organization (IRO) assigned by the superintendent of insurance will conduct the review and shall issue a written decision no later than thirty days after the filing of the request for review, provided that all requested information has been received by the IRO from Celtic and the *insured*. The IRO shall send a copy of its decision to all parties involved. The cost of the review shall be borne by Celtic.

Celtic may elect to cover the health care service requested and terminate the review. Notification of such a decision by Celtic will be communicated to all parties involved by mail or with the consent of the *insured* by electronic means.

Expedited External Review

An external review meeting the criteria of an expedited review, as listed below, can be requested orally or by electronic means with written confirmation of the expedited review request submitted to Celtic no later than five days after the request is made. For an expedited review, the *insured's* provider must certify that the *insured's* condition could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of the *insured* or, with respect to a pregnant woman, the health of the *insured* or the unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

An IRO shall issue a written decision not later than seven days after the filing of the request for review.

External Review of Terminal Conditions

An external review can be requested by the *insured* or authorized person for review of denial of treatment for terminal conditions. A review will be provided for *insured*'s who meet all of the following criteria:

- The *insured* has a terminal condition that, according to the current diagnosis of the *insured's physician*, has a high probability of causing death within two years.
 - The *insured* requests a review not later than sixty days after receipt by the *insured* of notice from the superintendent of insurance that making a determination requires resolution of a medical issue.
- (1) The *insured's physician* certifies that the *insured* has a terminal condition with a high probability of death within two years and any of the following situations are applicable:
 - Standard therapies have not been effective in improving the condition of the *insured*.
 - Standard therapies are not medically appropriate for the *insured*.
 - There is no standard therapy covered by the insurer that is more beneficial than therapy described in number (4).
 - (2) The *insured's physician* has recommended a drug, device, procedure, or other therapy that the *physician* certifies, in writing, is likely to be more beneficial to the *insured*, in the *physician's* opinion, than standard therapies, or the *insured* has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
 - (3) The *insured* has been denied coverage by the insurer for a drug, device, procedure, or other therapy recommended or requested pursuant to number (4), and has exhausted the insurer's internal review process.
 - (4) The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service except for the insurer's determination that the drug, device, procedure, or other therapy is *experimental* or *investigational*.

An external review shall be requested in writing, except that if the *insured's physician* determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to Celtic not later than five days after the oral or written request is submitted.

For expedited reviews, an IRO shall issue a written decision not later than seven days after the filing of the request for review. In all other cases the IRO shall issue a written decision not later than thirty days after the filing of the request for review, provided that all requested information has been received by the IRO from Celtic and the *insured*. The IRO shall provide Celtic with the opinions of the experts. Celtic shall make the experts' opinions on which a determination was based upon available to the *insured* and the *insured's physician*, upon request.

SECTION IX– GENERAL PROVISIONS

Entire Contract and Changes

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

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

Conformity with State and Federal Law

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

Grace Period

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

Reinstatement

If any premium is not paid by the end of the grace period *your* coverage will terminate. Later acceptance of premium by *us*, within four calendar days of the end of the grace period, will reinstate *your policy* with no break in *your* coverage. We will refund any premium that we receive after this four (4) day period.

Reinstatement shall not change any provisions of the *policy*.

Premium Calculation and Adjustment

The premium for each *insured person* is determined by *us*. *We* may change premiums by giving *you* 30 days advance written notice of the change.

Premiums are payable in advance at *our* home office or at the office of *our* authorized administrator.

Right of Reimbursement

You may be paid *benefits* under the *policy* for medical treatment resulting from injuries arising from the acts or negligence of another person or organization. To the extent of such payment, *we* have a right of reimbursement and are subrogated to all *your* rights of recovery. This provision applies to recoveries from third parties or others responsible for payment due to third party liability, including but not limited to no-fault insurance, Worker's Compensation claims, uninsured and underinsured motorist coverage and medical payments of any other *policy*.

By accepting *benefits* hereunder, *you* hereby grant a lien and assign to Celtic an amount equal to the *benefits* paid against any recovery made by or on *your* behalf.

This assignment is binding on any attorney who represents *you* whether or not as *your* agent and on any insurance company or other financially responsible party against whom *you* may have a claim provided said attorney, insurance carriers or others have been notified by Celtic or its agents.

In the event Celtic is required to take legal action to enforce its rights hereunder, *you* shall be responsible for the payment of any and all costs of collection *incurred* by *us*, including, but not limited to, attorney's fees. The *insured person* must complete and return any forms or papers that the insurance company requires to secure its rights under this provision.

Misstatement of Age

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

Time Limit on Certain Defenses

We rely on *your* application issue the *policy*. No statement made by *you*, except a fraudulent misstatement or omission, shall be used to void coverage, reduce *benefits* or defend against a claim for loss *incurred* after 24 months from the effective date.

Worker's Compensation

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