

Health Net Life Insurance Company

Group Policy/Certificate

HEALTH NET LIFE INSURANCE COMPANY

GROUP POLICY NUMBER: 1440

ISSUE TO: (the "Policyholder") **COUNTY OF SAN BERNARDINO**

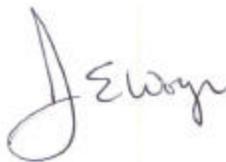
EFFECTIVE DATE: July 1, 2007

PREMIUMS DUE - on the Effective Date and on the 1st day of each month thereafter.

Health Net Life Insurance Company, (the "Company"), in consideration of the Application of the Policyholder and the payment of Premiums as due, agrees to provide the benefits according to the provisions set forth in this and the following pages with respect to Members in the eligible classes of the Policyholder.

The Policy/Certificate is delivered in California and is governed by the laws thereof.

SIGNED FOR HEALTH NET LIFE INSURANCE COMPANY
BY ITS PRESIDENT AT ITS EXECUTIVE OFFICES
IN WOODLAND HILLS, CALIFORNIA



PRESIDENT

GROUP POLICY/CERTIFICATE

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INTRODUCTION

Important Notice To California Certificateholders

In the event that the Member needs to contact someone about this insurance coverage for any reason, please contact:

**Health Net Life Insurance Company
1600 Los Gamos Drive, Suite 300
San Rafael, CA 94903
(800)-777-9276**

If the Member has been unable to resolve a problem concerning this insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, the Member may contact:

**California Department of Insurance, Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP**

MANAGED CARE FEATURES OF THIS POLICY/CERTIFICATE

This Policy/Certificate is administered in accordance with the Company's Managed Care Program. "Managed Care Program" means the monitoring of the use of these benefits by the Company to determine that the coverage available is consistent with certain standards used to determine the medical need for the benefit (sometimes called "Medical Necessity") and the appropriateness of the fees charged for the service. The availability and the level of certain Covered Services and Supplies under this Policy/Certificate depends upon the Member's compliance with the Managed Care Program described in this document.

DEFINED TERMS

NOTE: Not all defined terms herein are used in their usual meaning and some have meanings which limit their application; therefore, please refer to Definitions section for a helpful understanding of the defined terms which are capitalized within this Policy/Certificate.

SCHEDULE OF BENEFITS
Mental Health and Substance Abuse Benefits

Outpatient Mental Health Services (Exempt group employees only)

Following is the current plan's benefit schedule:

Number of Private Sessions	Amount of Co-payment	Number of Group Sessions	Amount of Co-payment
1-5	\$0.00	1-5	\$0.00
6-10	\$9.00	6-10	\$4.50
11-15	\$18.00	11-15	\$9.00
16 +	\$30.00	16 +	\$15.00

Specialized service programs for treatment of alcohol and substance abuse	50% of cost of Outpatient services up to a maximum charge of \$1,200. The maximum reimbursement is \$600 per Family Unit in any benefit year.
Non-Contracted Providers	\$25.00 per session with a yearly maximum of \$600.00 per family unit.
Lifetime Maximum:	Not applicable

DEFINITIONS

Note: All defined terms are capitalized in this Policy/Certificate.

Acute means the sudden onset or abrupt change of a mental health condition requiring prompt attention, but which is of limited duration, as determined by the Company.

Alternate Treatment means a planned, medical therapeutic program for persons with Mental Disorders. This includes diagnosis, medical care, and treatment when the patient does not require full-time, Inpatient, Acute hospitalization, but does need more intensive care than traditional Outpatient Sessions.

Appeal Process means the formal process by which the Company offers a mechanism to review a denial of Authorization.

Application means all forms required to be completed by the Policyholder.

Authorization means a decision in writing by the Medical Director or his/her designee, that benefits are payable for certain services that a Member will receive or has received under this Plan or Policy/Certificate. Requests for Authorization will be denied if not Medically Necessary, if in conflict with the Company's policies or are otherwise not covered under the Policy/Certificate or Plan.

Behavioral Healthcare Services means Chemical Dependency, Substance Abuse and/or Mental Healthcare Services which are Covered Services under this Policy/Certificate or Plan.

Calendar Year means that period of time commencing at 12:01 a.m. on January 1 and ending at 12:01 a.m. on the next January 1. Each succeeding like period will be considered a new Calendar Year.

Chemical Dependency or Substance Abuse means a psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and Medically Necessary treatment as determined by the Company. Chemical Dependency does not include addiction to or dependency on nicotine or food substances in any form.

Claims means invoices or other standard billing documents containing details of Behavioral Healthcare Services.

Company means Health Net Life Insurance Company or its Administrator, MHN Services.

Complaint means any expression of dissatisfaction from a member, whether received in writing or on the telephone.

Coordination of Benefits means allocations of responsibility to pay for health care between two or more group health insurance plans.

Copayment means the payment to be collected directly by the Practitioner from the Member for Covered Services, excluding permitted Deductibles, if any.

Covered Charges or Covered Services mean those Medically Necessary Behavioral Healthcare Services and supplies provided for in this Policy/Certificate or Plan which are eligible for reimbursement.

Member or Member means an Eligible Employee or Dependent who applies for and receives approval for coverage under the terms and conditions of the Policy/Certificate, is enrolled under this Plan and for whom all required Prepayment Fees or Premiums have been received and accepted by the Company.

Custodial Care means care rendered to a patient who meets any of the following conditions:

- ? Disabled mentally or physically and such disability is expected to continue and be prolonged.
- ? Requires a protected, monitored, or controlled environment whether in an institution or in a home.
- ? Requires assistance to support the essentials of daily living.
- ? Not under active and specific psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

A determination that Custodial Care is required is not precluded by the fact that a patient is under the care of a supervising or attending physician or other Practitioner and that services are being ordered and prescribed to support and generally maintain the patient's condition, provide for the patient's comfort, or ensure the manageability of the patient.

Deductible means that portion of the cost of Covered Services, if any, required under this Policy/Certificate or Plan to be paid by the Member prior to any liability for payment by the Company.

Dependent means a Dependent who is eligible for coverage as stated in the "Eligibility, Enrollment and Effective Date of Coverage" section of this Policy/Certificate.

Diagnostic and Statistical Manual of Mental Disorders (DSM) means a listing of diagnostic categories and criteria which provides guidelines for making diagnoses of mental and Substance Abuse disorders. The DSM is a widely accepted basis for describing the presence and type of these disorders. A DSM diagnosis of mental or Substance Abuse disorder is a minimum requirement for the demonstration of Medical Necessity. The diagnosis must be contained in the most recent edition of the DSM.

Domiciliary Care means Inpatient institutional care provided to the Member not because it is Medically Necessary, but because care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes Domiciliary Care.

Effective Date means the date stated as the Effective Date on the face of the Policy/Certificate.

Emergency or Emergency Admission or Psychiatric Emergency Medical Condition means the sudden onset of a condition manifesting itself by Acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate Behavioral Healthcare Services, could reasonably result in:

1. serious impairment to bodily functions;
2. placing the health of the Member, or others, in serious jeopardy; or
3. serious dysfunction of any bodily organ or part.

Emergency Services and Care means screening, examination and evaluation by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility.

Employee or Eligible Employee or Subscriber means the covered primary person who is an exempt employee of Employer (as defined by Employer) and who continues to satisfy the eligibility criteria established by the Policyholder and for whom a Prepayment Fee is paid to the Company by the Employer. No individual shall be eligible to participate while in active military service.

Employer or Group means an Employer, trust fund, licensed health plan or insurer, or other group or business entity that has contracted with the Company for the provision of Behavioral Healthcare Services to Members.

Experimental or Investigational means medical care that is essentially investigatory or an unproven procedure or treatment regimen that does not meet the generally accepted standards of usual professional medical or mental health practice in the general professional community, unless otherwise deemed appropriate by an Independent Medical Review organization.

Facility means a health or Residential Treatment Center which is duly licensed by the state in which it operates to provide Inpatient, residential, day treatment, Partial Hospitalization or Outpatient care for the diagnosis and/or treatment of Chemical Dependency and/or Mental Disorders.

Grace Period means a period of thirty-one (31) days beyond the date monthly Premium payments are due. The monthly Premium payment may be made to the Company without lapse of coverage during this Grace Period.

Grievance means a Complaint that is handled through the process. These Complaints do not concern denials of Authorization for clinical services.

Hospital means an Acute care Facility operated pursuant to applicable state laws which:

1. is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or by the Medicare Program; and
2. is primarily engaged in providing, for compensation from its patients, diagnostic and intervention facilities for the care and treatment of Behavioral Healthcare Services by and under the supervision of a staff of physicians; and
3. has 24-hour nursing services by Registered Nurses (RN); and
4. is not primarily a place for rest or Custodial Care, nursing home, and convalescent home or similar institutions.

Independent Medical Review (“IMR”) means an appeal required by certain states, including California, providing for Independent Medical Review of denial decisions by health care service plans on the basis that the services are not Medically Necessary or are Experimental or Investigational.

Inpatient means a Member who has been admitted to a Hospital or other authorized institution for bed occupancy for purposes of receiving Medically Necessary Behavioral Healthcare Services, with the reasonable expectation that the Member will remain in the institution at least twenty-four (24) hours.

Medical Director means a physician licensed to practice medicine in the state of California and employed by MHN to coordinate and monitor the quality management, utilization management, and Provider services for the Company.

Medically Necessary or Medical Necessity means a healthcare service, treatment or supply which meets all of the following conditions as determined by the Company:

- The requested services provide for the diagnosis and/or active treatment of a covered current DSM–IV Axis I Mental Disorder or substance-related disorder.
- The proposed treatment plan represents an active, necessary and appropriate intervention for the timely resolution of the patient’s symptoms and the restoration to baseline level of functioning. The proposed services are not primarily Custodial in nature.
- The type, level and length of the proposed services and setting are consistent with the Company’s level of care criteria and guidelines and are rendered in the least restrictive level of care in which the patient can be safely and effectively treated.
- The proposed treatment is not Experimental or Investigational in nature.

- The proposed treatment plan has been demonstrated in peer reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to possible alternative treatment interventions.
- The proposed treatment plan utilizes clinical services in an efficient manner when compared to alternative treatment interventions and contributes to effective management of the patient's benefit.
- Treatment is provided by a mental health professional licensed to practice independently who meets the Company's credentialing standards.

Mental Disorder: A Mental Disorder is a nervous or mental condition that meets all of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern.
- It is associated with a painful symptom, such as distress.
- It impairs a patient's ability to function in one or more major life activities.
- It is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

Mental Retardation means subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both.

Non-Participating Provider means the Practitioner, Hospital or Facility is not participating in MHN's network of Participating Providers.

Other Plan or Plan means any of the following Plans which provide full or partial benefits for Behavioral Healthcare Services:

- ? Group, blanket or franchise insurance coverage.
- ? Group or Hospital services plan contract, group practice, individual practice and other prepayment coverages.
- ? Any coverage under labor-management trustee plans, union welfare plans, Employer or group organization plans, employee benefit organization plans or self-insured employee benefit plans.
- ? Any coverage under governmental programs, and any coverage required or provided by any statute.

The term Other Plan refers separately to each policy, contract or other arrangement for services and benefits, and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the services and benefits of Other Plans into consideration in determining its benefits and that portion which does not.

Outpatient means an ambulatory Member receiving Covered Services who has not been admitted to a Hospital or Facility.

Partial Hospitalization or Day Treatment Center means it is designed to meet the needs of those individuals who no longer need the structure provided by hospitalization. The Day Treatment Center also meets the needs of those persons who do not require the intensity of an Inpatient program and 24-hour supervision but require a structured program of therapeutic intervention.

Participating Provider means the Practitioner, Hospital or Facility is participating in MHN's network, meets the Company's credentialing standards and has agreed, by signing a Participating Provider agreement with the Company, to accept the provisions of the applicable agreement, including the contractually agreed upon compensation, as the total charge, whether paid fully by the Company or requiring cost sharing by the Member.

Peer Reviewer means a mental health professional licensed to practice medicine in the state in which he or she practices and who provides ongoing services involving peer review, utilization review and Claims payment review.

Policyholder means the Employer to whom this Policy/Certificate has been issued.

Practitioner means a psychiatrist, licensed psychologist, licensed clinical social worker or a marriage family therapist who is duly licensed or certified under the laws of the State where treatment is delivered.

Premium or Prepayment Fee means a sum of monies paid monthly to the Company by the Policyholder in order for the Eligible Employees and their covered Dependents to receive benefits and services covered by this Policy/Certificate.

Preauthorization means approval for coverage from the Company prior to the Member obtaining Covered Services. Requests for Preauthorization will be denied if not Medically Necessary, if in conflict with the Company's medical policies, or otherwise not covered under this Plan or Policy/Certificate.

Provider means a Participating Provider or a Non-Participating Provider, as the case may be.

Prudent Layperson means a person who is without clinical training and who draws upon their practical experience when making a decision regarding whether emergency treatment is needed. They are considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observing the clinical symptoms at hand, that emergency treatment was necessary.

Residential Treatment Center means a supervised line-in treatment program for those individuals who require 24-hour supervision in a non-medical setting.

Session means any in-person or telephone consultation with a Practitioner for Covered Services under this Plan or Policy/Certificate.

Total Disability or Totally Disabled means, for an Employee, a Chemical Dependency or Mental Disorder that prevents the Employee from performing the material and substantial duties of any occupation for which he or she is qualified by education, training or experience. For a Dependent, a Chemical Dependency or Mental Disorder that prevents the Dependent from performing the activities and duties of an individual of like age and sex.

Usual, Customary and Reasonable (UCR) means the usual charge made for the necessary services and supplies generally furnished for cases of comparable severity and nature in the geographical area in which the services or supplies are furnished.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

1. **EMPLOYEE** – An individual who is an “Exempt Employee” (as defined by Client) and their eligible dependents are eligible for outpatient mental health services and for whom a fee is paid by Client to MHN. Eligibility begins on the first of the month following employee’s date of hire with Client. The County uses this term “Exempt Employees” to mean all officials, employees and their eligible dependents who are provided County Exempt Group Benefits. They include elected County officials and their staff, County Administrative Officer and staff, County Counsel and staff, department heads and their secretaries, departmental division chiefs, Human Resources officers/analysts and division secretaries for the Department of Human Resources, and Court Exempt and Court Non-Represented employees.” Coverage for eligible Employees begins on the first day of active work with the Policyholder.

2. **DEPENDENT** - A Dependent is eligible to apply for coverage if his/her relationship to the Employee is one of the following: any person who is the Subscriber's lawful spouse or unmarried dependent child up to age nineteen (19) or up to age twenty-three (23) if a full-time student, or of any age and incapable of self-sustaining employment due to a mental or physical handicap.

Eligibility Requirements for an Employer and its Employees

Employer will not become a Policyholder until approved by the Company or its authorized representative.

No person may be covered hereunder as a Dependent and an Employee at the same time.

EFFECTIVE DATES

1. Subject to the payment of Premium by the Policyholder for the individual, coverage under this Policy/Certificate shall become effective on the later of:
 - a. the date this Policy/Certificate takes effect; or
 - b. on the first day of the month following the first day of employment with the Policyholder.

NOTIFICATION OF ELIGIBILITY CHANGE

The Policyholder and/or the Member must notify the Company within thirty-one (31) days of any change in status that affects a change in eligibility. This includes notification of a Dependent's ability to meet eligibility criteria.

TERMINATION OF INSURANCE - EMPLOYEES AND DEPENDENTS

EMPLOYEE: Except as provided in any Extension of Benefits provision, an Employee's insurance will end on the earliest of:

1. the date he or she ceases active employment, unless the Employee is on leave of absence, temporary layoff or Total Disability. In that case, the Policyholder may continue the coverage by paying the appropriate Premium, but not beyond the following time limits:
 - a. leave of absence, in accordance with the Policyholder's policy on leaves of absence. If the Policyholder is subject to the requirements of The Family and Medical Leave Act of 1993 (FMLA), an Employee may be eligible to continue coverage during a family leave. Consult the Policyholder for details.
 - b. temporary layoff, the last day of the month following the month the Employee's layoff began; or
 - c. Total Disability, 12 months.
2. the date he or she ceases to be in a class of Eligible Employees;
3. the date he or she retires;
4. the date the Employee or Policyholder fails to make a Premium payment;
5. the date of entry into the armed forces of any country;
6. the date the Policy/Certificate ends.

DEPENDENT: Except as provided by the Extension of Benefits provision, a Dependent's insurance will end on the earliest of:

1. the date the Employee's insurance ends;
1. the date the Employee or Policyholder fails to make a payment for Dependent insurance;
2. the date the Employee ceases to be in a class of eligible Employees for Dependent coverage;
3. the date a Dependent ceases to meet the definition of "Dependent," as set forth in this Policy/Certificate.

A Dependent child, upon reaching the termination age, may not be able to sustain employment because of Mental Retardation or physical handicap. If the Employee notifies the Company in writing within thirty-one (31) days after such age, the Company will continue coverage as long as the Employee's coverage continues and the child continues to be handicapped and dependent upon the Employee for support, and as long as the Premium for coverage for such child is paid before the end of the Grace Period. The Company may require that proof of such incapacity and dependency be furnished to the Company but not more frequently than annually after the two year period after the Dependent child reaches the limiting age set forth in the "Eligibility and Effective Date of Coverage" section of this Policy/Certificate.

EXTENSION OF BENEFITS

If a Member is Totally Disabled due to a Chemical Dependency or Mental Disorder at the time the Policy/Certificate terminates, coverage for such Total Disability will be extended for that Total Disability. This extension will end on the earliest of these dates:

- 1) the date such person is no longer Totally Disabled;
- 2) 12 months from the date the insurance coverage terminates;
- 3) the date such person acquires coverage under a replacement plan which provides similar benefits, but only if the plan covers the condition causing the Total Disability without limitation due to the condition having begun prior to the effective date of the replacement coverage.

TERMINATION OF POLICY/CERTIFICATE

If the Policy/Certificate ends, the Policyholder will be liable for all unpaid Premiums for the period the Policy/Certificate was in force.

TERMINATION FOR NON-PAYMENT OF PREMIUM: If any Premium is not paid before the end of the Grace Period, the Policy/Certificate will terminate on the last day of the month in which Premiums were paid.

TERMINATION BY THE POLICYHOLDER: The Policyholder may end the Policy/Certificate by giving written notice to the Company at least thirty-one (31) days in advance. However, such termination will become effective during any period for which a Premium has been paid. The Company is under no obligation to make refunds of Premiums previously paid. Coverage will continue during the period for which Premiums have been paid.

TERMINATION BY THE COMPANY: The Company reserves the right to terminate the Policy/Certificate if:

1. less than 100% of the Eligible Employees for any non-contributory insurance are insured;
2. the Policyholder fails to promptly furnish any information which the Company may reasonably require or fails to perform its duties pertaining to the Policy/Certificate in good faith; or
3. any other reason, provided that the Company gives the Policyholder thirty-one (31) days advance written notice.

COVERED SERVICES AND SUPPLIES FOR CHEMICAL DEPENDENCY AND MENTAL HEALTH BENEFITS

If a Member incurs Covered Charges for Chemical Dependency or Mental Disorders, the Company will pay a benefit as determined below.

INSURED PERCENTAGE: The Company will pay benefits at the insured percentage shown in the Schedule of Benefits.

COVERED CHARGES: The Company will pay for the following Covered Services and Supplies furnished in connection with the treatment of Chemical Dependency or Mental Disorders. Services must be Medically Necessary and incurred while insurance is in force. Payments are subject to the applicable insured percentage Copayments shown in the Schedule of Benefits and all other provisions of this Policy/Certificate.

- 1) Individualized evaluation of needs, referral into treatment and monitoring by the Company.
- 2) Medically Necessary Inpatient treatment and Residential Treatment Center room and board.
- 3) Other Chemical Dependency or Mental Disorder services and supplies Medically Necessary for the treatment of the Member, subject to Authorization by the Company.
- 4) Medically Necessary Practitioner services received at Hospitals and Facilities.
- 5) Medically Necessary Practitioner services for individual, group and family therapy or counseling.

UTILIZATION REVIEW/CARE MANAGEMENT

PREAUTHORIZATION: In order to obtain maximum benefits available under this Policy/Certificate, the Member must obtain Preauthorization prior to the commencement of any Medically Necessary services. As used herein, "Preauthorization" means that the Member must:

- 1) call the Company at the toll-free number provided in the Policy/Certificate and/or health insurance identification card prior to obtaining services; and
- 2) provide the Company with any requested information.

If the Chemical Dependency or Mental Disorder services are Medically Necessary, the Company will refer the Member to an appropriate Provider for the Member's condition. The Company will contact the Provider regarding the initial authorized Covered Services. The Provider may be issued an Authorization letter describing the authorized treatment.

Concurrent reviews typically occur on a regular basis throughout the Member's treatment. During such reviews, the Company monitors the Member's course of treatment to determine the necessity of continuous stay or Sessions and appropriateness of the level of care. For maximum reimbursement, the Company must authorize all extended lengths of stay and transfers to different levels of care as well as any ancillary services.

Preauthorization is not required (though advisable) for an Emergency Admission; however, the Company must be contacted by the Member, his or her Practitioner, the Hospital or one of the Member's family members within 24 hours of admission.

Care Management Reduction

Refer to The Schedule of Benefits for any penalties or reductions in payments resulting from Policy/Certificate non-compliance.

Use of Participating Provider

This Policy/Certificate will pay a greater percentage of the Member's Medically Necessary expenses when utilizing a Participating Provider. Please contact Managed Health Network at 800-777-9276 to obtain a referral to a Participating Provider.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be made by the Company for any of the following care, services or supplies:

1. Treatment of detoxification in newborns.
2. Treatment of congenital and/or organic disorders. This includes, without limitation, Alzheimer's Disease, Mental Retardation (other than the initial diagnosis), Organic Brain Disease, Delirium, Dementia, Amnesic Disorders and Other Cognitive Disorders as defined in the DSM.
3. Treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal and nicotine-related disorders.
4. Treatment of obesity and eating disorders unless otherwise required by law. This does not include the diagnosis of anorexia and bulimia nervosa as defined in DSM.
5. Court-ordered testing and treatment.
6. Private Hospital rooms and/or private duty nursing, unless determined to be Medically Necessary and Authorization by the Medical Director or his designee is obtained.
7. Ancillary services such as:
 - a. Vocational rehabilitation.
 - b. Behavioral training.
 - c. Speech or occupational therapy.
 - d. Sleep therapy and employment counseling.
 - e. Training or educational therapy for reading or learning disabilities.
 - f. Other education services.
8. Testing, screening or treatment for:
 - a. Learning Disorders, Expressive Language Disorders, Mathematics Disorder, Phonological Disorder and Communication Disorder NOS.
 - b. Motor Skills Disorders and Developmental Coordination Disorder.
 - c. All Disorders of Infancy and Early Childhood and Developmental Disorders including, but not limited to, Communication Disorders, Pervasive Developmental Disorders, Autistic Disorder, Rett's Disorder, Asperger's Disorder (except as otherwise required by law).
 - d. Disorders resulting from general medical conditions, including but not limited to, Catatonic Disorder Due to General Medical Condition, Personality Change Due to General Medical Disorder, Narcolepsy, Stuttering, Stereotypic Movement Disorders, Sleep Disorders, TIC Disorders, Elimination Disorders, Sexual Dysfunctions, Primary Insomnia.
 - e. Personality Disorders.
 - f. Pedophilia.
 - g. Primary Sleep Disorders, Primary Hypersomnia, and Dyssomnia NOS.
 - h. Age-Related Cognitive Decline.

9. Treatment of conditions which are medical in nature, even when such conditions may have been caused by a Mental Disorder, Chemical Dependency or Substance Abuse.
10. Treatment by Practitioners other than those within licensing categories then recognized by the Administrator as providing Covered Services in accordance with applicable medical community standards.
11. Treatment rendered for conditions not listed as an Axis I disorder (V Code diagnoses listed as an Axis I disorder are also excluded unless otherwise specified in the Policy/Certificate).
12. Services in excess of those with respect to which Authorization by the Medical Director or his designee is obtained.
13. Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports.
14. Missed appointments. The Administrator will consider one of the Member's counseling Sessions used if the Member fails to cancel with the Practitioner at least 24 hours in advance, unless the appointment is missed because of an Emergency or circumstances beyond the Member's control.
15. All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a Practitioner in connection with the Member's treatment as an Inpatient at a Hospital or as a patient at a Facility providing Alternate Treatment.
16. Inpatient services, treatment, or supplies rendered without Authorization, if required, except in the event of an Emergency.
17. Healthcare services, treatment, or supplies rendered in a non-Emergency by a Non-Participating Provider, unless Member has received Authorization by the Medical Director or his designee or otherwise provided by the Policy.
18. Damage to a Hospital or Facility caused by the Member.
19. Healthcare services, treatment or supplies determined to be Experimental by the Medical Director or his or her designee in accordance with accepted mental health standards, except as otherwise required by law.
20. Healthcare services, treatment or supplies:
 - a. Provided as a result of any Workers' Compensation law or similar legislation.
 - b. Obtained through, or required by, any governmental agency or program.
 - c. Caused by the conduct or omission of a third party for which the Member has a claim for damages or relief.
21. Healthcare services, treatment, or supplies for military service disabilities for which treatment is reasonably available under governmental healthcare programs.
22. Treatment for biofeedback, acupuncture or hypnotherapy.

23. Healthcare services, treatment, or supplies rendered to the Member which are not Medically Necessary. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or Domiciliary Care as determined by the Administrator.
24. Services received before the Member's effective date, during an Inpatient stay that began before the Member's effective date or services received after the Member's coverage ended, except as specifically stated herein.
25. Services for which:
 - a. The person is not legally obligated to pay.
 - b. No charge is made to the person.
 - c. No charge is made to the person in the absence of insurance coverage.
 - d. It is provided without cost to the person by a local, state or federal government agency.
26. Services in connection with conditions caused by an act of war.
27. Conditions caused by release of nuclear energy, whether or not the result of war.
28. Emergency room services not provided by a psychiatrist directly related to the treatment of a Mental Disorder, Chemical Dependency or Substance Abuse problem in accordance with the limitations listed above.
29. Professional services received from a person who lives in Member's home or who is related to Member by blood or marriage.
30. Any services or supplies to the extent they are covered under Parts A or B of Medicare if either:
 - (A) The Member is enrolled in Part A of Medicare, whether or not the Member is enrolled in Part B of Medicare, or
 - (B) The Member is entitled to enroll in Medicare and has made the required number of quarterly contributions to the Social Security System, whether or not the Member has actually enrolled in Medicare or claimed Medicare benefits.
31. Services performed in any emergency room which are not directly related to the treatment of a Mental Disorder or Chemical Dependency problem.
32. Services received out of the Member's primary state of residence except in the event of an Emergency and as otherwise authorized by the Administrator.
33. All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits outlined in the Schedule of Benefits and/or specifically included as Covered Services elsewhere in this Policy/Certificate.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) means that benefits are paid so that no more than 100% of Usual, Customary, and Reasonable (UCR) expenses will be covered under the combined benefits of all plans.

The Company will coordinate UCR benefits with benefits payable under Other Plans. The Other Plans are those that provide services in connection with medical or dental care or treatment through:

1. group, blanket or franchise insurance (other than school accident policies);
2. group Hospital or medical service organizations, group practice, or other prepayment coverage on a group basis;
3. a labor management trustee plan, union welfare plan, Employer or Employee benefit plan, or any other arrangement of benefits for individuals or a group;
4. Medicare (Parts A and B) when a Member is eligible for Medicare coverage. For purposes of determining Medicare benefits, a Member will be deemed to have enrolled for all coverage for which the Member is eligible under Medicare (Parts A and B), whether or not he or she actually enroll;
5. any coverage under government programs or coverage required or provided by law, but not Medicaid.

How Coordination Works

One of the plans involved will pay the benefits first. That plan is "Primary". The Other Plans will pay benefits next. Those plans are "Secondary".

If this plan is Primary, it will pay its benefits first. Benefits under this plan will not be reduced due to benefits payable under Other Plans.

If this plan is Secondary, benefits under this plan may be reduced due to benefits payable under Other Plans Primary to this plan.

The amount of UCR expenses will be determined first. Then the amount of benefits paid by plans Primary to this plan will be subtracted from this amount. This plan will pay the difference but no more than the amount it would have paid without this provision.

Which Plan is Primary

In order to pay Claims, the Company must find out which plan is Primary and which plan is Secondary.

There are rules to find out which plan is Primary and which plans are Secondary. The rules are used until one is found that applies to the situation. They are always used in the following order:

1. A plan that has no Coordination of Benefits provision will be Primary to a plan that does have a Coordination of Benefits provision.
2. A plan that covers the person as an Employee will be Primary to the plan that covers the same person as a Dependent.
3. The plan that covers the person as a Dependent of the person whose birthday is earlier in the Calendar Year will be Primary to a plan which covers that person as a Dependent of a person whose birthday is later in the Calendar Year.

If both parents have the same birthday, the plan which has covered the parent longer will be Primary to the plan that has covered the other parent for the shorter period of time.

The Other Plan may not have a rule based on birthdays similar to this rule. If the Other Plan has a rule based on the gender of the parent, the rule of the Other Plan will determine which plan is Primary.

However, the person may be covered as a Dependent under two or more plans of divorced or separated parents. In that case, the plan of the parent with custody will be Primary to the plan of the parent without custody.

Further, the parent with custody may have remarried. In that case, the order of payment will be as follows:

1. The plan of the parent with custody will pay benefits first.
2. The plan of the spouse of the parent with custody will pay benefits next.
3. The plan of the parent without custody will pay benefits next.

There may be a court decree which has specific terms giving one person financial responsibility for the medical, dental or other health expenses of the Dependent child. If the Company has been provided with notice of those terms, the benefits of that plan will be determined first.

A plan may cover a person as an Employee who is not laid off or retired, or as a Dependent of that Employee. This plan will be Primary to any plan that covers the person as a laid-off or retired Employee, or as a Dependent of that Employee. The Other Plan may not have a rule for laid-off or retired Employees similar to this rule. In this case, this rule will not apply.

If none of the above rules apply, the plan that covered the person for the longest time will be Primary to all Other Plans.

The Company may obtain or release any information needed to carry out the intent of the Coordination of Benefits provision. The Member must inform the Company of coverage under Other Plans when making a claim. The Company has the right to recover from the Member, or any other organization or person, any amounts that are overpaid.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purposes of determining the applicability and implementing the terms of this provision of this Policy/Certificate or any provision of similar purpose of any Other Plan, the Company may, without the consent of or notice to any other person, release to or obtain from any other insurance company or other organization or person any information if permitted by law, with respect to any person, which the Company deems to be necessary for such purposes. Any person claiming benefits under this Policy/Certificate shall furnish the Company such information as may be necessary to determine the benefits payable or coverage to be provided under this Policy/Certificate.

GOVERNMENT PROGRAMS

The benefits under this Policy/Certificate are not designed to duplicate any benefits to which Members are, or would be, entitled under government programs for which they are eligible, including Medicare. All sums payable under such programs for services provided pursuant to this Policy/Certificate shall be payable to, and retained by, the Company. Each Member shall submit to the Company such consents, releases, assignments, and other documents as may be required by the Company in order to obtain or assure reimbursement under government programs for which Members are eligible.

ACTS OF THIRD PARTIES

If a Member is injured through the wrongful act, negligence or omission of another person, the Company shall provide the Member with Covered Services and Supplies. However, the Company shall have the right to recover the value of the Covered Services and Supplies that the Member collects from the liable third party, and the Member shall agree to the following as a condition of coverage:

1. To reimburse the Company to the extent of Covered Services and Supplies received, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise; and
2. To cooperate fully with the Company by furnishing information, forms, assignments or liens which will enable the Company to recover the value of the Covered Services and Supplies that the Member collects from the liable third party.

CONTINUATION OF GROUP COVERAGE (COBRA and Cal-COBRA)

If coverage through this Policy/Certificate ends, the terminated Member may be eligible for additional periods of coverage under this plan through the Company.

- **COBRA Continuation Coverage:** Many Employers are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside California. Members whose coverage is terminated may check with their Employer to determine if they are eligible for COBRA continuation.
- **Cal-COBRA Continuation Coverage:** If the Member began receiving federal COBRA coverage on or after January 1, 2003, has exhausted federal COBRA coverage and has had less than 36 months of COBRA coverage, he or she has the opportunity to continue group coverage under this Policy/Certificate through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

The Company will Offer Cal-COBRA to Members: The Company will send Members whose federal COBRA coverage is ending by U.S. mail information on Cal-COBRA rights and obligations along with the necessary Premium information, enrollment forms, and instructions to formally choose Cal-COBRA Continuation Coverage. This information will be sent with the notice of pending termination of federal COBRA.

Choosing Cal-COBRA: If a Member wishes to choose Cal-COBRA Continuation Coverage, he or she must deliver the completed enrollment form (described immediately above) to the Company by first class mail, personal delivery, express mail, or private courier company. The address appears on the ID card.

The Member must deliver the enrollment form to the Company within 60 days of the later of (1) the Member's termination date for COBRA coverage or (2) the date he or she received a notice from the Company that he or she has the right to Cal-COBRA Continuation.

Payment for Cal-COBRA: The Member must pay the Company 110% of the applicable group rate charged for employees and their dependents.

The Member must submit the first payment within 45 days of delivering the completed enrollment form to the Company in accordance with the terms and conditions of the health plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA Continuation Coverage. The Member's first payment must be delivered to the Company by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to the Company, the Member's Cal-COBRA election is not effective and no coverage is provided.

All subsequent payments must be made on the first day of each month. If the payment is late, the Member will be allowed a grace period of 30 days. Fifteen days from the due date (the first of the month), the Company will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Member fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by the Company. If the Member makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Member by the Company within 20 business days.

Employer Replaces Previous Plan: There are two ways the Member may be eligible for Cal-COBRA Continuation Coverage if the Employer replaces the previous plan:

1. If the Member had chosen Cal-COBRA Continuation Coverage through a previous plan provided by his or her current Employer and replaced by this plan because the previous policy was terminated, or
2. If the Member selects this plan at the time of the Employer's open enrollment.

The Member may choose to continue to be covered by this plan for the balance of the period that he or she could have continued to be covered by the prior group plan. In order to continue Cal-COBRA coverage under the new plan, the Member must request enrollment and pay the required Premium within 30 days of receiving notice of the termination of the prior plan. If the Member fails to request enrollment and pay the Premium within the 30-day period, Cal-COBRA Continuation Coverage will terminate.

Employer Replaces this Plan: If the Policy between the Company and the Employer terminates, coverage with the Company will end. However, if the Employer obtains coverage from another insurer or HMO, the Member may choose to continue to be covered by that new plan for the balance of the period that he or she could have continued to be covered by the Company plan.

When Does Cal-COBRA Continuation Coverage End? When a Qualified Beneficiary has chosen Cal-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

1. 36 months from the Member's original COBRA effective date (under this or any Other Plan)*.
2. The Member becomes entitled to Medicare; that is, enrolls in the Medicare program.
3. The Member fails to pay the correct Premium amount on the first day of each month as described above under "Payment for Cal-COBRA."
4. The date the Employer's coverage with the Company terminates. (See "Employer Replaces this Plan.")
5. The Member becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

If the Member becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this plan will continue. Coordination of Benefits will apply, and Cal-COBRA plan will be the primary plan.

* The COBRA effective date is the date the Member first became covered under COBRA continuation coverage.

- **Additional COBRA-like Coverage (Senior-COBRA):** California law provides that an employee and his or her spouse who elected COBRA coverage following termination of employment may be entitled to additional COBRA-like coverage.

If the principal Member was 60 years of age or older on the date of his or her termination of employment and had worked for the Employer for the previous five years, the principal Member and his or her spouse may be eligible for additional coverage when the federal COBRA coverage expires. Additionally, a former spouse of an employee or former employee whose coverage under COBRA or Cal-COBRA expires may be entitled to additional COBRA-like coverage.

The principal Member may request additional information from the Company. If the principal Member wishes to purchase this additional COBRA-like coverage, he or she must notify the Company in writing of his or her wish to do so within 30 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end.

PREMIUM CALCULATIONS

The initial and subsequent Premiums will be paid to the Company by the Policyholder on or before the date specified on the Policy/Certificate face page. The Company has the right to change the initial Premium to reflect the actual number, ages or classes of Members on the Effective Date of the Policy/Certificate and from time to time, as long as the Policy/Certificate remains in effect. Premium is payable to the Company's home office, or to an authorized representative of the Company.

The payment of any Premium will not keep the Policy/Certificate in force beyond the due date of the next Premium except as provided in the Grace Period. If any Premium is not paid before the end of the Grace Period, the Policy/Certificate will automatically end at the end of the period for which the last Premium payment has been paid.

PREMIUM CHANGES

The Company reserves the right to change Premiums under the Policy/Certificate on any Policy anniversary giving the Policyholder at least 60 days prior written notice. However, Premiums may be changed at any time due to the following:

1. if the provisions of the Policy/Certificate are changed as to benefits or as to classes of Employees; or
2. following any state or federal legislation or regulations or other governmental regulations affecting the Company's liability under the Policy/Certificate.

WAIVER OF RIGHTS

If the Company fails to enforce any provision of the Policy/Certificate, such failure will not affect its right to do so at a later date, nor will it affect its right to enforce any other provision of the Policy/Certificate.

REINSTATEMENT

An Employee will be eligible to have his or her insurance reinstated on the first day of the month which follows the resumption of his or her employment if his or her insurance was ended because of termination of employment and if such resumption is within six (6) consecutive months following his or her termination.

REQUIRED INFORMATION

The Policyholder will furnish the Company with all information necessary for the calculation of Premium and all other information that may be reasonably required by the Company. The Company has the right to examine at any reasonable time any records of the Policyholder, any person, company, or organization hired to assist in the administration of the Policy/Certificate which have a bearing on the Premiums and benefits.

This right will exist:

- 1) during the continuance of the Policy/Certificate; and
- 2) until final determination of all rights and obligations under the Policy/Certificate.

CLAIMS

CLAIMS PROCEDURE: The procedure outlined below must be followed by Members to obtain payment of benefits under this Policy/Certificate.

NOTICE OF CLAIM: A written notice of a Claim must be furnished to the Company within twenty (20) days after the occurrence or commencement of any loss covered by this Policy/Certificate, or as soon thereafter as is reasonably possible.

A Member must give the Company written notice within 20 days after the occurrence or commencement of any loss covered by this Policy/Certificate. The notice should be sent to the Company at 1600 Los Gamos Drive, Suite 300, San Rafael, California 94903 with information sufficient to identify the Member. The Company shall consider this as the required notice.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office in case of Claim for loss for which this Policy/Certificate provided any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of Claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof of loss within the time required shall not invalidate nor reduce any Claim if proof is provided as soon as reasonably possible. Except in the absence of legal capacity, the Company is not required to accept proof later than one year from the time proof of loss is otherwise required.

LIMITATION OF LIABILITY: The Company shall not be obligated to pay any benefits under the Policy/Certificate for any Claims if the proof of loss for such Claim was not submitted within the period provided, unless it is shown that (1) it was not reasonably possible to have submitted the proof of loss within such period and (2) the proof of loss was submitted as soon as it was reasonably possible.

In no event will the Company be obligated to pay benefits for any Claim if the proof of loss for such Claim is not submitted to the Company within one year after the date of loss, except in the case of legal incapacity of the Member.

PAYMENT OF OTHER CLAIMS:

TIME OF PAYMENT

MEDICAL EXPENSE REIMBURSEMENT - Benefits for incurred medical expenses which are covered under this Policy/Certificate will be paid immediately upon receipt of proper proof of loss by the Company and the applicable time period thereafter.

PERIODIC PAYMENTS - Payment of accrued periodic payments for continuing losses which are covered under this Policy/Certificate will be made immediately upon receipt of proper written proof of loss by the Company.

PAYMENT OF BENEFITS:

TO MEMBER - All benefits, unless assigned, under this Policy/Certificate are payable to the Employee whose sickness or injury, or whose covered Dependent's sickness or injury, is the basis of a Claim.

DEATH OR INCAPACITY OF MEMBER - In the event of the death or incapacity of Member and in the absence of written evidence to the Company of the qualification of a guardian for his or her estate, the Company may, in its sole discretion make any and all such payments to the individual or institution which, in the opinion of the Company, is or was providing the care and support of such Member.

ASSIGNMENTS: Benefits for medical expenses covered under this Policy/Certificate may be assigned by a Member to the person or institution rendering the services for which the expenses were incurred. No such assignment will bind the Company prior to the payment of the benefits assigned. The Company will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Member and the assignee, has been received before the proof of loss is submitted.

APPEAL OF CLAIM DENIAL:

In the event a Claim is denied, the Member will be provided with written notice of the specific reason or reasons for the denial, and an explanation of the Claim review procedure for the Policy/Certificate. A claimant, within 180 days after receipt of notification of the denial of a Claim, may request in writing that the denial be reviewed by the Company.

If the Member is still in treatment, the Member can initiate a request for an appeal of a denial of Authorization of care by calling the service team at 800-777-9276. The Company care manager assigned to the case shall arrange for a telephonic appeal with a Peer Reviewer within one (1) business day. The appeal is conducted by a Peer Reviewer different from the one who issued the initial denial of Authorization. Additional information may be transmitted to the Peer Reviewer by facsimile, but the sender must inform the patient that the misdialing by the transmitter may result in confidential information being received by an entity other than the Company.

If the Member has completed treatment, only written appeals shall be accepted. The written appeal request should be accompanied by a complete copy of the relevant Hospital or other clinical records and sent to: Appeals Unit, 503 Canal Boulevard, Pt. Richmond, CA 94804. A Peer Reviewer, different from the one who made the initial denial decision, shall review the request and written notification shall be sent to the Member and Provider within thirty (30) days of the written appeal request. In the event the denial is upheld, Independent Medical Review will be offered according to applicable state law.

ARBITRATION

Sometimes disputes or disagreements may arise between the Employer or Members (including Dependents enrolled under the Policy, or their heirs or personal representatives) and the Company regarding the construction, interpretation, performance or breach of this Policy/Certificate, or regarding other matters relating to or arising out of the Member's enrollment under the Policy/Certificate. Typically such disputes are handled and resolved through the Company's Appeal Process described above. However, in the event that a dispute is not resolved in that process, the Company uses binding arbitration as the final method for resolving all such disputes, which arise out of or relate to coverage under the Policy/Certificate, whether stated in tort, contract or otherwise.

All disputes the Employer or a Member has with the Company, except those described below, also must be submitted to final and binding arbitration. Likewise, the Company agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that the Employer, Members, and the Company are bound to use binding arbitration as the final means of resolving disputes that may arise between the Employer, Members, and the Company, and thereby both parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by the Company's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

The Company's binding arbitration process is administered by the American Arbitration Association (AAA), in accordance with the Commercial Arbitration Rules of AAA. Any disputes with the Company arising under the Policy/Certificate must be submitted to AAA for handling. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. Arbitration can be initiated by obtaining a Demand for Arbitration Form from the AAA and filing it with the nearest AAA office. If an AAA office cannot be located nearby, the demand should be filed with the Los Angeles office at the following address:

American Arbitration Association
3055 Wilshire Boulevard, 7th Floor
Los Angeles, California 90010-1108

AAA will arrange the arbitration at a time and location that is mutually agreed to by both parties.

The arbitrator is required to follow applicable state or federal law. The arbitrator will not have the authority to make any award not available under state or federal law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be binding on all parties.

The parties will share equally the AAA administrative fees and any arbitrator's fee involved in the arbitration except that, upon a Member's request, the AAA may allocate all of the Member's share of the AAA and arbitrator's fees to the Company. Each party will be responsible for their own attorneys' fees.

Effective July 1, 2002, Members who are enrolled in an Employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by the Company to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by the Company to deny, reduce, terminate or not pay for all or a part of a benefit. However, Members and the Company may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

GENERAL PROVISIONS

ENTIRE CONTRACT - The Policy/Certificate (with the Employer Applications) make up the entire contract. In the absence of fraud, all statements made by the Policyholder or by any Member shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid insurance or reduce benefits unless contained in a written instrument signed by the Policyholder or Member and a copy of the document has been furnished to the Company and/or the Subscriber.

No agent nor other individual, except the Chief Financial Officer, President or Secretary of the Company, can approve a change to the Policy/Certificate or extend the time for payment of any Premium. No change will be valid unless it is made by an endorsement to the Policy/Certificate, or by an amendment signed by the Policyholder and the President or Secretary of the Company. Any change made will be binding on each Member and on any other individual(s) referred to in the Policy/Certificate.

PHYSICAL EXAMINATIONS - The Company reserves the right to have a Practitioner of its own choosing examine any Member whose condition, sickness, or injury is the basis of a Claim. All such examinations shall be at the expense of the Company. This right may be exercised when and as often as the Company may reasonably require during the pendency of a Claim. The opportunity to exercise this right shall be a condition precedent to obtaining payment of benefits for the Claim.

AUTOPSY - The Company reserves the right to have an autopsy performed upon any deceased Member whose condition, sickness, or injury is the basis of a Claim. This right may be exercised only where not prohibited by law.

GRACE PERIOD - After payment of the first Premium, the Company will allow the Policyholder a Grace Period of thirty-one (31) days, following a Premium due date, to pay subsequent Premiums. During this Grace Period, the Policy/Certificate will remain in force. The Policyholder will be liable for payment of Premium for the period the Policy/Certificate continues in force.

CONFORMITY WITH STATE STATUTE - Any provision of the Policy/Certificate which, on its Effective Date, is in conflict with the state laws in which the Policy/Certificate was issued or delivered, is hereby amended to meet the minimum requirements of the law.

WORKERS' COMPENSATION - The Policy/Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

AGE - When a Member's age has been misstated, a Premium adjustment may be made so that the Company will receive the correct Premium for the true age.

NEW ENTRANTS - The Policyholder may add from time to time, new Eligible Employees and Dependents as the case may be, in accordance with the Eligibility section of this Policy/Certificate.

TIME LIMIT ON CERTAIN DEFENSES - A claim shall not be denied nor shall the validity of insurance be contested because of any statement with respect to insurability made by the Insured Person while eligible for coverage under the Policy/Certificate, if:

1. the insurance has been in force for at least three (3) years before any such contest; and
2. the person with respect to whom any such statement was made is alive during such three (3) years.

RECOVERY OF PAYMENTS - The Company reserves the right to deduct from any benefits properly payable under this Policy/Certificate the amount of any payment which has been made:

1. in error;
2. pursuant to a misstatement contained in a proof of loss;
3. pursuant to a misstatement made to obtain coverage under this Policy/Certificate within two (2) years after the date such coverage commences;
4. with respect to an ineligible person;
5. pursuant to a Claim for which benefits are recoverable under any Policy/Certificate or act of law provided for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Company to pay benefits under this Policy/Certificate in any such instance.

Such deduction may be made against any Claim for benefits under this Policy/Certificate by an Employee or by any of his or her covered Dependents if such payment is made with respect to such Employee or any person covered or asserting coverage as a Dependent of such Employee.

LEGAL ACTION - No legal action will be brought to recover benefits under the Policy/Certificate prior to the expiration of sixty (60) days after written proof of loss has been furnished. No such action will be brought after the expiration of three (3) years following the time written proof of loss is required to be furnished.

END OF POLICY/CERTIFICATE