GoodHealth
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GHDP Summary

Features/Benefits	GHW	GH1	GH2	GH3	GH4	GH5
Telemedicine	✓	✓	✓	✓	✓	✓
BestChoiceRX Group Discount Program	✓	✓				
BestChoiceRX (Accute & Wellness $0 Co-pay Maintenance Generic $5 Co-Pay)			✓			
BestChoiceRX Plus - Includes non-preferred Generic & Brand with a co-pay up to a maximum of $150/mo				✓	✓	✓
Preventative Care[2]	✓	✓	✓	✓	✓	✓
Annual Wellness Exam	✓				✓	✓
Specialty Drugs - Prescription Assistance Program	✓	✓	✓	✓	✓	✓
Healthcare Ninja		✓	✓	✓	✓	✓
Primary Care Physician Visits[1,2]		3	4	4	4	5
Specialist / UC Visit[1,2]		1	2	4	4	5
Hospital Indemnity Benefit[3]		✓	✓	✓	✓	✓
Emergency Room Services[3]					✓	✓
Ambulance Services[3]					✓	✓
In-Out patient surgery[3]					✓	✓
Dental	**1500 Plan**		**3000 Plan**		**5000 Plan**	
Individual & Family Dental Plans	$1,500 annual max per person		$3,000 annual max per person		$5,000 annual max per person	
Dental/Vision Bundle	**Dental + Our Vision is different. Our digital-1st platform easily replaces traditional vision insurance, while keeping costs low and satisfaction high.**					

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(2) Outpatient physician services and wellness benefits are subject to in-network providers only. Inpatient Hospital indemnity benefits are not.
(3) Hospitalization benefits are not payable for a Pre-Existing Condition as defined in Section 2.56 Definitions for the first Twelve [12] Months of coverage

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Colorectal Cancer Screening benefit subject to at home test kit for initial screening before benefits are payable for a colonoscopy procedure. If the initial screening test is positive, the plan will provide benefits for a colonoscopy.

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GHDP-W

Physician Services[1] (Utilizes the First Health Network)[2]	Details		
Wellness Exam	1 Visit / yr	Co-pay	Maximum/ Visit
		$25	$150

Telemedicine	Details	
RECURO HEALTH	$0 Consult Fee	No Maximum

BestChoiceRX Participating Pharacies only	Discount Prescriptions Only

Some people need care. Everyone can use support.	Details
Kindly Human™	Hearing from and connecting with someone who can relate to what we're facing is a fundamental human need. When we know we're not alone in what we're facing, everyone feels better. Kindly Human is designed to provide easy access to support 24/7 for everyday challenges that we all face.

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GHDP-1

Physician Services[1] (Utilizes the First Health Network)[2]	Details			
Primary Care Office Visit	3 visits / yr	Co-pay	Maximum / Visit	
		$25	$150	
Specialist or Urgent Care Office Visit	1 visits / yr	Co-pay	Maximum / Visit	
		$50	$300	
In-Patient Hospitalization Benefit	$1,000 / Day	$5,000 / Year Maximum		12/12 mo Pre-Ex[3]
Telemedicine	**Details**			
RECURO HEALTH	$0 Consult Fee		No Maximum	
BestChoiceRX Participating Pharmacies only	**Discount Prescriptions Only**			
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Advocacy	**Details**			
MyHealthcare NINJA	Hospital Bill Reducer			

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GHDP-2

Physician Services[1] (Utilizes the First Health Network)[2]	Details		
Primary Care Office Visit	4 visits / yr	Co-pay	Maximum/ Visit
		$25	$150
Specialist or Urgent Care Office Visit	2 visits / yr	Co-pay	Maximum / Visit
		$50	$300
In-Patient Hospitalization Benefit	$1,000 / Day	$10,000 / Year Maximum	12/12 mo Pre-Ex[3]

Telemedicine	Details	
RECURO HEALTH	$0 Consult Fee	No Maximum

BestChoiceRX Participating Pharmacies only	Details	
Preventive & Acute Prescriptions - (Subject to Formulary - Not subject to a monthly maximum)		
Pharmacy Retail – up to a 30 day supply (Acute & Preventive Generic)	Member Pays	Generic - $0 Copay
Pharmacy Retail up to a 30-day supply or Mailorder up to a 90-day supply. (200 Generic Maintenance Drugs)	Member Pays	Preferred Generic - $5 Copay

Prescription Terms & Conditions

RX Plan includes discounts when the prescription is off of the formulary. Specialty drugs are not covered but the RX provider offers a Prescription Assistance Program - Member must qualify for PAP according to income guidelines. Mail order is optional for generic and brand drugs.

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Advocacy	Details
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GHDP-3

Physician Services[1] (Utilizes the First Health Network)[2]	Details		
Primary Care Office Visit	4 visits / yr	Co-pay	Maximum/ Visit
		$25	$150
Specialist or Urgent Care Office Visit	4 visits / yr	Co-pay	Maximum / Visit
		$50	$300
In-Patient Hospitalization Benefit	$1,000 / Day	$15,000 / Year Maximum	12/12 mo Pre-Ex[3]

Telemedicine	Details	
RECURO HEALTH	$0 Consult Fee	No Maximum

BestChoiceRX Participating Pharmacies only	Details	
Preventive & Acute Prescriptions - (Subject to Formulary - Not subject to the monthly maximum)		
Pharmacy Retail – up to a 30 day supply (Acute & Preventive Generic)	Member Pays	Generic - $0 Copay
Pharmacy Retail up to a 30 day supply or Mailorder up to a 90-day supply. (200 Generic Maintenance Drugs)	Member Pays	Preferred Generic - $5 Copay
Non-Prefered Generic	Member Pays	Retail 30-day $5 & $10 Copay Mail Order 90-day $5 & $20 Copay
Brand (Prior Authorization Required)	Member Pays	Retail 30-day $40, Mail Order 90-day $80

Prescription Terms & Conditions

Non-Preventive Maintenance Prescriptions - (All available generic and brand drugs. Specialty drugs are not covered). For all non-preventive generic & brand name drugs there is $150 benefit limit per person per month. RX Plan includes discounts when the monthly benefit limit of $150 per person is exceded. Specialty drugs are not covered but the RX provider offers a Prescription Assistance Program - Member must qualify for PAP according to income guidelines. Mail order is optional for generic and brand drugs.

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Advocacy	Details
MyHealthcare NINJA	Hospital Bill Reducer

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GHDP-4

Physician Services[1] (Utilizes the First Health Network)[2]	Details		
Wellness Exam	1 Visit / yr	Co-pay: $25	Maximum/ Visit: $150
Primary Care Office Visit	4 visits / yr	Co-pay: $50	Maximum/ Visit: $150
Specialist or Urgent Care Office Visit	4 visits / yr	Co-pay: $75	Maximum / Visit: $300
In-Patient Hospitalization Benefit	$1,000 / Day	$10,000 / Year Maximum	12/12 mo Pre-Ex[3]
In/Outpatient Surgery	$1,000 / Year	$2,000 / Year Maximum	12/12 mo Pre-Ex[3]
Emergency Room (if admitted)	$1,000/Per Incident		12/12 mo Pre-Ex[3]
Ambulance Benefit (if admitted)	$500/Per Incident		12/12 mo Pre-Ex[3]

Telemedicine	Details	
RECURO HEALTH	$0 Consult Fee	No Maximum

BestChoiceRX Participating Pharmacies only	Details	
Preventive & Acute Prescriptions - (Subject to Formulary - Not subject to the monthly maximum)		
Pharmacy Retail – up to a 30 day supply (Acute & Preventive Generic)	Member Pays	Generic - $0 Copay
Pharmacy Retail up to a 30 day supply or Mailorder up to a 90-day supply. (200 Generic Maintenance Drugs)	Member Pays	Preferred Generic - $5 Copay
Non-Prefered Generic	Member Pays	Retail 30-day $5 & $10 Copay Mail Order 90-day $5 & $20 Copay
Brand (Prior Authorization Required)	Member Pays	Retail 30-day $40, Mail Order 90-day $80

Prescription Terms & Conditions

Non-Preventive Maintenance Prescriptions - (All available generic and brand drugs. Specialty drugs are not covered). For all non-preventive generic & brand name drugs there is $150 benefit limit per person per month. RX Plan includes discounts when the monthly benefit limit of $150 per person is exceded. Specialty drugs are not covered but the RX provider offers a Prescription Assistance Program - Member must qualify for PAP according to income guidelines. Mail order is optional for generic and brand drugs.

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Advocacy	Details
MyHealthcare NINJA	Hospital Bill Reducer

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GHDP-5

Physician Services[1] (Utilizes the First Health Network)[2]	Details			
Wellness Exam	1 Visit / yr	Co-pay	Maximum/ Visit	
		$25	$150	
Primary Care Office Visit	5 visits / yr	Co-pay	Maximum/ Visit	
		$50	$150	
Specialist or Urgent Care Office Visit	5 visits / yr	Co-pay	Maximum / Visit	
		$75	$300	
In-Patient Hospitalization Benefit	$1,500 / Day	$15,000 / Year Maximum		12/12 mo Pre-Ex[3]
In/Outpatient Surgery	$1,500 / Day	$4,500 / Year Maximum		12/12 mo Pre-Ex[3]
Emergency Room (if admitted)	$1,000/Per Incident			12/12 mo Pre-Ex[3]
Ambulance Benefit (if admitted)	$500/Per Incident			12/12 mo Pre-Ex[3]

Telemedicine	Details	
RECURO HEALTH	$0 Consult Fee	No Maximum

BestChoiceRX Participating Pharmacies only	Details	
Preventive & Acute Prescriptions - (Subject to Formulary - Not subject to the monthly maximum)		
Pharmacy Retail – up to a 30 day supply (Acute & Preventive Generic)	Member Pays	Generic - $0 Copay
Pharmacy Retail up to a 30 day supply or Mailorder up to a 90-day supply. (200 Generic Maintenance Drugs)	Member Pays	Preferred Generic - $5 Copay
Non-Prefered Generic	Member Pays	Retail 30-day $5 & $10 Copay Mail Order 90-day $5 & $20 Copay
Brand (Prior Authorization Required)	Member Pays	Retail 30-day $40, Mail Order 90-day $80

Prescription Terms & Conditions

Non-Preventive Maintenance Prescriptions - (All available generic and brand drugs. Specialty drugs are not covered). For all non-preventive generic & brand name drugs there is $150 benefit limit per person per month. RX Plan includes discounts when the monthly benefit limit of $150 per person is exceded. Specialty drugs are not covered but the RX provider offers a Prescription Assistance Program - Member must qualify for PAP according to income guidelines. Mail order is optional for generic and brand drugs.

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MEC/Preventive Health Services Summary of Benefits

Preventive Health Services - Covered Benefits[1]

Benefits are automatically subject to 29 CFR § 2590.715 -2713(a). Amendments to this section through legislative act or regulation are automatically incorporated into this document by reference. Preventive Services covered in this section are explained in more detail through the following official resources:

• Medical services with a rating of "A" or "B" from the current recommendations of the United States Preventive Services Task Force. See https://www.uspreventiveservicestaskforce.org

• Preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Guidelines can be found in https://www.hrsa.gov

• Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for certain individuals only. See https://www.cdc.gov/vaccines/acip

Benefit	Interval	Requirements
Abdominal Aortic Aneurysm Screening	1 per lifetime	By ultrasonography in men ages 65-75 years who have ever smoked.
Adult Annual Standard Physical	1 per plan year	**Adults**, one (1) physical preventive exam per plan year.
Alcohol Misuse: Unhealthy Alcohol Use Screening and Counseling	1 per plan year	Screenings for unhealthy alcohol use in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
Aspirin: Preventive Medication	As prescribed	**Adults** ages 50 to 59 with high risk of cardiovascular diseases and for the primary prevention of cardiovascular disease and colorectal cancer. Low-dose aspirin (81 mg/d) as preventive medication for **women** after 12 weeks of gestation who are at high risk for preeclampsia.
Bacteriuria Screening	1 per plan year	Screening for asymptomatic bacteriuria with urine culture in **pregnant women** at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
BRCA Risk Assessment and Genetic Counseling/Testing	1 per plan year	Screening to **women** who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast Cancer Preventive Medications	As prescribed	Risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
Breast Cancer Screening	1 time every 2 plan years	Screening mammography for **women** age 50 years and older. Coverage limited to 2D mammograms only.

[1]None of the Preventive Health Services are covered if they are provided at a hospital.

GoodHealth Distribution Partners

MEC/Preventive Health Services Summary of Benefits

Preventive Health Services		
Benefit	**Interval**	**Requirements**
Breastfeeding Support, Supplies and Counseling	In Conjunction with each birth	Interventions during **pregnancy** and **after birth** to support breastfeeding. Costs for renting breastfeeding equipment will be covered in conjunction with each birth.
Cervical Cancer Screening: with Cytology (Pap Smear)	1 time every 3 plan years	**Women** age 21 to 65 years with cervical cytology alone.
Cervical Cancer Screening: with Combination of Cytology and Human Papilloma Virus (HPV) testing	1 time every 5 plan years	**Women** age 30 to 65 years with high-risk papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology.
Chlamydia Screening	1 per plan year	Sexually active **women** age 24 and younger and in older women who are at increased risk infection.
Colorectal Cancer Screening benefit subject to at home test kit for initial screening. If positive, the plan will provide benefits for a colonoscapy.	1 time every 5 plan years	Starting in **adults** at age 50 years and continuing until age 75 years.
Contraceptive Methods and Counseling	As prescribed	Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, not including abortifacient drugs.
Dental Caries Prevention: Infants and Children Up to Age 5	1 per plan year	Application of fluoride varnish to the primary teeth of all **infants and children** starting at the age of primary tooth eruption and prescription of oral fluoride supplementation starting at age **6 months for children** whose water supply is fluoride deficient.
Depression Screening	1 per plan year	Screening for major depressive disorder (MDD) in **adolescents** aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up
		Screening for depression in the general **adult** population, including **pregnant and postpartum women**. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Pregnant and postpartum persons at increased risk of perinatal depression should be refer to counseling interventions.
Diabetes Screening	1 per plan year	Screening for abnormal blood glucose as part of cardiovascular risk assessment in **adults** aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Fall Prevention: Older Adults	1 per plan year	Exercise interventions for community-dwelling adults age 65 years and older who are at increased risk for falls.
Folic Acid Supplementation	As prescribed	Daily supplement containing 0.4 to 0.8 mg (400 to 800µg) of folic acid for all **women** planning or capable of pregnancy.
Gestational Diabetes Mellitus Screening	1 per plan year	Asymptomatic **pregnant women** after 24 weeks of gestation.

GoodHealth Distribution Partners

MEC/Preventive Health Services Summary of Benefits

Preventive Health Services		
Benefit	**Interval**	**Requirements**
Gonorrhea Prophylactic Medication	As prescribed	Prophylactic ocular topical medication for all **newborns** for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea Screening	1 per plan year	Sexually active **women** age 24 years or younger and in older women who are at increased risk for infection.
Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease	1 per plan year	**Adults** who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hemoglobinopathies Screening	1 per plan year	Screening for sickle cell disease in **newborns.**
Hepatitis B Screening	1 per plan year	**Non-pregnant** adolescents and adults at high risk for infection.
		Pregnant women at their first prenatal visit.
Hepatitis C Virus (HCV) Infection Screening	1 per plan year	**Persons** at high risk for infection and **Adults born between 1945 and 1965**.
High Blood Pressure Screening	1 per plan year	Screening for high blood pressure in **adults** aged 18 or older.
HIV Preexposure Prophylaxis for the Prevention of HIV Infection	As prescribed	**Persons** who are at high risk of HIV acquisition.
HIV Screening	1 per plan year	**Adolescents and adults** aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
		Pregnant women including those who present in labor, who are untested and whose HIV status is unknown.
Hypothyroidism Screening	1 per plan year	Screening for congenital hypothyroidism in **newborns.**
Intimate Partner Violence Screening	1 per plan year	Screening for intimate partner violence, in **women** of reproductive age and provide or refer women who screen positive to ongoing supporting services.
Lung Cancer Screening	1 per plan year	With low-dose computed tomography in **adults** aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and Counseling	1 per plan year	To **children and adolescents** 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
		Screening all **adults**. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
Osteoporosis Screening	1 per plan year	In **women** aged 65 and older and in younger postmenopausal **women** at increased risk of osteoporosis.
Phenylketonuria Screening	1 per plan year	Screening for phenylketonuria in **newborns.**

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MEC/Preventive Health Services Summary of Benefits

Preventive Health Services		
Benefit	**Interval**	**Requirements**
Preeclampsia Screening	1 per plan year	**Pregnant women** with blood pressure measurements throughout pregnancy.
Rh Incompatibility Screening: First Pregnancy Visit	1 per plan year	Rh (D) blood typing and antibody testing for all **pregnant women** during their first visit for pregnancy - related care.
RH Incompatibility Screening: 24–28 Weeks' Gestation	1 per plan year	Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative **women** at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D) - negative.
Sexually Transmitted Infections Counseling	1 per plan year	Intensive behavioral counseling for all sexually active **adolescents and for adults** who are at increased risk for sexually transmitted infections.
Skin Cancer Behavioral Counseling	1 per plan year	Counseling young **adults, adolescents, children, and parents of young children** about minimizing their exposure to ultraviolet radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk for skin cancer.
Statin Preventive Medication	As prescribed	**Adults** without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
Syphilis Screening	1 per plan year	**Non-pregnant persons** who are at increased risk for infection.
		All **pregnant women.**
Tobacco Use Counseling and Interventions	2 per plan year	Provide behavioral interventions for cessation to **all adults** who use tobacco, advise them to stop using tobacco, and provide behavioral interventions, U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco is covered.
		Provide behavioral interventions for cessation to **pregnant women** who use tobacco.
		Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged **children and adolescents.**
Tuberculosis Screening	1 per plan year	Screening for latent tuberculosis infection in **populations** at risk.
Vision Screening	1 time every 2 plan years	**All children** aged 3 to 5 years to detect amblyopia or its risk factors.
Well-Woman Visits	1 per plan year	**Women** under 65 to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care.
Well-Child Visits	1 per plan year	**Children** to obtain the recommended preventive services that are age and developmentally appropriate. (Covers 1 visit except as more frequently recommended for children under the age of 3 years.)

Immunizations

IMMUNIZATIONS - recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in children, adolescents, or adults*

Birth Through Six Years Old

Abbreviations	Vaccines	Age Requirements and Limitations
HepB	Hepatitis B	Ages 4 weeks- 2 months
		Ages 6 months- 18 months
DTaP	Diphtheria, tetanus, and acellular pertussis	Ages 15 months- 18 months
Hib	Haemophilus influenzae type b	Ages 12 months- 15 months
PCV13	Pneumococcal 13-valent conjugate	Ages 12 months- 15 months
IPV	Inactivated poliovirus	Ages 6 months-18 months
Flu	Influenza (yearly)	Ages 6 months- 6 years
MMR	Measles, mumps, and rubella	Ages 12 months- 15 months
VAR	Varicella	Ages 12 months- 15 months
HepA	Hepatitis A	Ages 12 months-23 months (1st dose)
		Six months after the last dose (2nd dose)
RV	Rotavirus	Ages 2 months- 6 months (if recommended)

Children From Seven Through Eighteen Years Old

Abbreviations	Vaccines	Age Requirements and Limitations
Flu	Influenza (yearly)	Ages 7 - 18 years
Tdap	Tetanus, diphtheria, and acellular pertussis	Ages 11- 12 years
HPV	Human papillomavirus	Ages 11- 12 years (2 shots series) Note: A 3-shot series of HPV vaccine is needed for those with weakened immune systems and those who start the series at 15 years or older
MenACWY	Meningococcal serogroups A,C,W,Y	Ages 11- 12 years
MenACWY	Meningococcal A,C,W,Y Booster	Age 16 (recommended)

Immunizations

Adults Nineteen Years or Older

Abbreviations	Vaccines	Age Requirements and Limitations
IIV	Influenza inactivated	Ages 19 ≥ 65 years (1 dose annually)
RIV	Influenza recombinant	
LAIV	Influenza live attenuated	Ages 19 - 49 years (1 dose annually)
Tdap	Tetanus, diphtheria, and acellular pertussis	Ages 19 ≥ 65 years (1 dose Tdap, then TD booster every 10 years)
MMR	Measles, mumps, and rubella	Ages 19 - 60 years - 1 or 2 doses depending on indication (if born in 1957 or later)
VAR	Varicella	Ages 19 -37 years - 2 doses (if born in 1980 or later)
RZV	Zoster recombinant	Ages 50 ≥ 65 years - 2 doses
ZVL	Zoster live	Ages 60 ≥ 65 years - 1 dose
HPV - Female	Human papillomavirus	Ages 19 - 26 years - 2 or 3 doses depending on age at initial vaccination
HPV- Male	Human papillomavirus	Ages 19 - 21 years - 2 or 3 doses depending on age at initial vaccination
PCV13	Pneumococcal 13-valent conjugate	Ages ≥ 65 years
PPSV23	Pneumococcal 23-valent polysaccharide	Ages ≥ 65 years

* Immunization illustrations listed herein are based upon CDC recommendations contained in the following schedules: (i) Recommended Child and Adolescent Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html), and (ii) Recommended Adult Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html). Additional immunization scenarios not included in the aforementioned illustrations (such as catch-up immunization recommendations, immunization recommendations for certain high-risk groups, and immunization recommendations subject to individual clinical decision-making) may also be covered under this Plan pursuant to CDC recommendation. Information concerning these additional covered immunization scenarios (including vaccine type, age requirements, and frequency) is available online under the CDC schedule links listed above. Paper copies of these CDC schedules can also be obtained free of charge by written request to the Plan Administrator.

Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
   a. Sports,
   b. Camp,
   c. Employment,
   d. Travel,
   e. Insurance,
   f. Marriage,
   g. Legal proceedings
2. Routine foot care for treatment of the following:
   a. Flat feet,
   b. Corns,
   c. Bunions,
   d. Calluses,
   e. Toenails,
   f. Fallen arches,
   g. Weak feet,
   h. Chronic foot strain
3. Dental procedures
4. Any other medical service, treatment, or procedure not covered under this Plan
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by this Appendix A or otherwise explicitly provided in this Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of or in the course of any employment for wage or profit
10. Claims which would otherwise be covered by a Worker's Compensation policy for which a participant is entitled to benefit

11. Any claim arising from service received outside of the United States, except for the reasonable cost of claims billed by the Veterans Administration or Department of Defense for benefits covered under this Plan and not incurred during or from service in the Armed Forces of the United States
12. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
13. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
14. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
15. Claims due to an act of war, declared or undeclared, not including acts of terrorism
16. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
17. Abortion Services
18. Travel, unless specifically provided in the schedule of benefits
19. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
20. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
21. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
22. Services or supplies which are primarily educational
23. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
24. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
25. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
26. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
27. Any claims for fertility or infertility treatment
28. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
29. Claims for disability resulting from reversal of sterilization
30. Claims for the completion of forms, or failure to keep scheduled appointments
31. Recreational or diversional therapy
32. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
33. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
34. Claims that arise primarily due to medical tourism
35. Supportive devices of the foot
36. Treatments for sexual dysfunction
37. Aquatic or massage therapy
38. Biofeedback training
39. Skilled nursing facilities
40. Durable medical equipment and prosthetics
41. Hospice care, private duty nursing, or long-term care
42. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
43. Claims for temporomandibular joint syndrome
44. Claims for biotech or specialty prescriptions
45. Any claim which is not explicitly covered in the schedule of benefits
46. Genetic testing unless explicitly covered in the schedule of benefits
47. Organ transplants
48. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures.
49. Chiropractic care
50. Radiation and chemotherapy
51. Dialysis
52. Acupuncture
53. Alternative medicine/homeopathy
54. Children dental and vision
55. Neonatal intensive care (NICU)
56. Rehabilitative therapies
57. PCP surgery
58. Routine eye care (Adult)
59. Non-emergency care when traveling outside the U.S.
60. Pregnancy Benefits, including office visits and childbirth/delivery professional and facility services.
61. Routine well-baby care of newborn infant while inpatient.

"The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan."

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Individual & Family Plans

GHD,LP Dental is a self-funded PPO plan that utilizes the MaximumCare PPO networks including Careington, Connection Dental, and Dentemax. To locate a provider, Click Here.

Dental 1500	Dental 3000	Dental 5000
▶ $1,500 annual max per person	▶ $3,000 annual max per person	▶ $5,000 annual max per person

- $50 annual deductible for basic and major services (per person)
- $150 max (per family)
- No deductible for preventative services.

PREVENTIVE CARE (100% Coverage*) No Waiting Period

- Routine Exam (2 per 12 months)
- Bitewing X-rays (1 per 12 months)
- Cleaning (2 per 12 months)
- Fluoride for children under age 16 (1 per 12 months)

BASIC CARE (80% Coverage*) No Waiting Period

- Full Mouth/Panoramic X-rays (1 per 3 years)
- Sealants (ages 6 through 16)
- Space Maintainers (child under 16)
- Restorative Amalgams (fillings)
- Simple Extractions

MAJOR CARE (50% Coverage*) 12 Month Waiting Period

- Onlays
- Oral Surgery
- Crowns (1 per tooth, per 7 years)
- Crown Repair
- Endodontics (nonsurgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Denture Repair
- Dentures (1 appliance per 5 years)
- Bridge (1 per 7 years)
- Complex Extractions
- Anesthesia

Products are not available in all states, including: MA, MD, ME, NH, OR, VT, WA.

This plan follows the "Carve Out" Coordination of Benefits method. This means that it first calculates the normal plan benefits that would be paid, then reduces this amount by the amount paid by the primary plan.

*Limitations & Exclusions

1. No Benefits are payable under the Policy for the Services listed below. In addition, the Services listed below will not be recognized toward the satisfaction of any Deductible:

2. Any Services which are not included in the Schedule of Covered Procedures;

3. Any Service started or appliance installed before the Effective Date or after the Termination Date, except in those instances noted in this Certificate;

4. Any Service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least 5 years, as determined by Us;

5. Any procedure We determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is experimental in nature;

6. Any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations unless such procedure is listed in the Schedule of Covered Procedures;

7. Appliances, Services or procedures relating to:
- *a. the change or maintenance of vertical dimension;*
- *b. splinting;*
- *c. correction of attrition, abrasion, erosion, or abfraction;*
- *d. bite registration; or*
- *e. bite analysis;*

8. Replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;

9. Replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;

10. Replacement of crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;

11. For Orthodontia Services;

12. Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain unless such procedure is listed as a Covered Procedure in the Schedule of Covered Procedures;

13. Charges for precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments;

14. Athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointment; charges for completion of Claim forms, infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than Us, personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances; augmentation and socket preservation, tissue and bone grafting, implant connecting bars and supporting structures.

15. Prescription drugs, premedication, pharmaceuticals, or analgesia;

*Limitations & Exclusions

16. Dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism or taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;

17. Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;

18. Any charge for a Service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if You did not purchase the coverage that is available to You;
20. Any charge for a Service performed outside of the United States other than for Emergency Treatment. Benefits for Emergency Treatment performed outside of the United States are limited to a maximum of $100 per Plan Year.

19. The initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a Natural Tooth extracted while the Person is insured under the Policy;

20. The initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Natural Tooth extracted while the Person is insured under the Policy, provided that tooth was not an abutment to an existing partial denture. Frequency Limitations for replacement of Dentures and bridges are stated in the Schedule of Covered Procedures. Benefits are payable only for the replacement of those teeth which were extracted while the Person was insured under the Policy;

21. The replacement of teeth beyond the normal complement of 32;

22. The replacement of an existing removable partial denture with a fixed partial denture unless upgrading to a fixed partial denture is essential to the correction of the Covered Person's dental condition;

23. Local, including light anesthetic, as a separate fee;

24. Any Treatment Plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these Services;

25. Services with respect to congenital (hereditary) or developmental (before birth) malformations, except during the 31 day period immediately following the birth of Your Child, including but not limited to; cleft palate, maxillary and mandibular (upper and lower) malformations, enamel hypoplasia (lack of development), fluorosis, and anodontia;

26. Dental care paid for, required, or provided by or under the laws of a national, state, local or provincial government, or treatment furnished within a hospital or other facility owned or operated by a national or state government unless the Insured Person has a legal obligation to pay;

27. Dental services performed in a hospital and related hospital fees;

28. Services covered under an existing medical plan;

29. The portion of an expense which is in excess of the reasonable charge;

30. Fees associated with a cancelled or missed appointment;

31. Nitrous Sedation

*Limitations & Exclusions

Alternate Benefits: *There is often more than one Service that can be used to treat a dental problem or disease. In determining the Benefits payable on a Claim, different materials and methods of treatment will be considered. The amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by us. The Covered Person and his or her Provider may decide on a more costly procedure or material than We have determined to be satisfactory for the treatment of the condition. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits Payable for Covered Expenses for the least costly Service. We will not pay the excess amount.*

Resin fillings on posterior teeth (molars and bicuspid/premolar) will be paid at the rate for amalgam fillings. Resin fillings on anterior teeth will be paid at the rate for amalgam fillings when lingual (indicated as surface code "L") as an access surface for restoration placement is inclusive in the restoration. Porcelain crown/bridge units on posterior teeth will be paid at the rate of the full cast crowns/bridge units.

Missing Tooth Clause Limitation: We will not pay benefits for replacement of teeth missing on a Covered Person's Effective Date of insurance for the purpose of the initial placement of a full denture, partial denture, or fixed bridge. In addition, such replacement will not be recognized toward the satisfaction of any Deductible. However, expenses for the replacement of teeth missing on the Effective Date will be considered for payment as follows:

1. The initial placement of full or partial dentures will be considered a Covered Procedure if the placement includes the initial replacement of a Natural Tooth extracted while the Covered Person is covered under the **Group Policy.**

2. The initial placement of a fixed bridge will be considered a Covered Procedure if the placement includes the initial replacement of a Natural Tooth extracted while a Covered Person is covered under the policy. However, the following restrictions will apply:

a. Benefits will only be paid for the replacement of the teeth extracted while a Covered Person is covered under the Group Policy

b. Benefits will not be paid for the replacement of other teeth which were missing on the Covered Person's Effective Date.

c. Missing teeth limitation will be waived after a Covered Person has been covered under the plan for 5 continuous years unless it is a replacement of an existing unserviceable prosthesis.

Timely filing limit: A clean claim (meaning no missing or incorrect numbers or information) must be submitted to us within 12 months, or one calendar year, from the date of service. Claims will be denied if they arrive after the deadline date.

Coordination of Benefits (COB)
When a Covered Person has dental coverage under more than one Plan, as defined below, the benefits payable between the Plans will be coordinated.

Benefit Coordination: This policy follows the "Carve Out" Coordination of Benefits method. This means that it first calculates the normal plan benefits that would be paid, then reduces this amount by the amount paid by the primary plan.

Order of Benefit Determination:
1. When this is the Primary Plan, we will pay Benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

*Limitations & Exclusions

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

a. Non-Dependent/Dependent. A Plan that covers a person other than as a Dependent will pay before a Plan that covers that person as a Dependent.

b. Dependent Child/Parents Not Separated or Divorced. For a Dependent Child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Dependent Child for the longer period will pay first.

c. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the Child are determined in the following order:

i. The Plan of the parent who has responsibility for providing insurance as determined by a court order.
ii. The Plan of the parent with custody of the Child.
iii. The Plan of the Spouse of the parent with custody; and
iv. The Plan of the parent without custody of the Child.

d. Dependent Child/Joint Custody: If the joint custody court decree does not specifically state which parent is responsible for the Child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

e. Longer/Shorter Length of Coverage. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

Right to Receive and Release Needed Information: We may release to, or obtain from, any other insurance company, organization, or person information necessary for COB. This will not require the consent of, or notice of, you or any claimant. You are required to give us information necessary for determining COB.

Right to Make Payments To Another Plan: COB may result in payments made by another Plan that should have been made by us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

Right to Recovery: COB may result in overpayments by us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

Appeal Process: If We send you a Written statement denying your claim in whole or in part, you may submit a written appeal to us that outlines your concerns and your efforts to resolve the matter including the date(s) of service and claim number(s). The appeal must be filed within 60 days of the receipt of denial. A Written decision with respect to the appeal shall be sent to you within 15 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to you as soon as possible.

Please send to:
Merchants Benefit Administration
Attn: Appeals Department,
18700 N Hayden Rd, Ste 390
Scottsdale, AZ 85255

If You are not satisfied by the appeal response or for any reason, please refer to the plan document.

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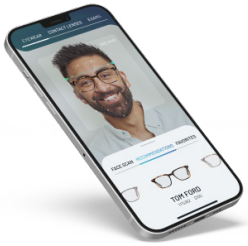

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