Sarah M Riazati
2161 Peachtree Rd NE
Apt 205
Atlanta GA 30309

Welcome to the Assurant Health family!

Thanks for choosing our family to help take care of you and yours. We'll be there each step of the way to make sure your plan works for you, on your terms. Be assured that your plan meets the requirements of health care law and provides the major medical benefits and strong financial protection you need.

Begin using your plan

You can start using your plan on March 01, 2015, the day your coverage begins. You'll find full details of your policy in your insurance contract, enclosed in this package.

Your medical insurance cards, which include information about your network, will arrive separately. Please keep them in your wallet and present them whenever you go to the doctor, hospital or pharmacy.

Get to know your plan's features and benefits

Enclosed, you'll find information that explains your plan's helpful features and benefits.

- Find network doctors and hospitals offering discounts on medical care
- Save on prescriptions, lab work and more

We want you to feel that this plan meets your health care needs. Please review the information in this package and contact us with any questions or concerns.

Welcome again to our family, and thank you for choosing Assurant Health to be a part of yours.

WHAT TO DO

- Learn about your plan and benefits in the enclosed information
- Review your policy and store it in a safe place
- Register to view your plan and claims online at members.assurant.com

QUESTIONS? CONTACT US

Call 800.553.7654
Monday-Friday,
7 a.m. to 6 p.m. Central time

IMPORTANT: These are your insurance ID Cards

ASSURANT Health

Dear Sarah M Riazati:

Thank you for choosing an Assurant Health insurance plan. Here are your new insurance identification cards. Remove them, fold them at the center and carry them with you. Please replace old cards with these. To ensure proper claims handling, please show your card to your providers.

Thank you for your business. If you have questions about your new cards, please call Customer Service at the number on the back panel.

Sarah M Riazati
2161 Peachtree Rd NE
Apt 205
Atlanta GA 30309

Effective: March 01, 2015

If you are viewing this information online, you'll receive your permanent insurance identification cards in the mail shortly.

Use this side for Medical Benefits

ASSURANT Health

Sarah M Riazati
POLICY: 0062481938
PPO HOSPITAL / MD PLAN
ER Access Fee $100
Office Copay: PCP $30 SPEC $30 (10 Visit limit then Ded/Coins)
Ind. OOP Max $1,500
For network provider information visit
www.assuranthealth.com/networksavings1.
Original Effective Date: 03/01/2015
Aetna Signature Administrators® PPO
By aetna®

This card does not guarantee coverage or benefits. To receive maximum medical benefits, authorization is required. Failure to call may result in reduced benefits. For authorization, call 800-454-5105. For verification of patient coverage, call Customer Service at 1-800-553-7654.
Providers: Send your electronic claims to Assurant Health/ASA via the, payor #58730, or mail a standard form to Assurant Health/ASA, P.O. Box 91604, Lubbock, TX, 79490-0000.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

Visit us at www.assuranthealth.com.

Aetna Participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna or Assurant Health.

Quest Diagnostics LabCard Select
www.LabCardSelect.com
1.800.750.1253

First Health National

Use this side for Prescription Drug Benefits

RXBIN: 004336 RXPCN: ADV RXGRP: RX4217
ID #: Z00624819380001

DEP ID# DED$

Riazati
Sarah M 001 0

To maximize your retail prescription drug benefit, present this card and your prescription(s) to a participating pharmacy. To locate a participating pharmacy, please visit our web site at caremark.com or call 800-551-5681. At the time of service you must pay the pharmacy any copayment and/or other charges required by your plan. Only eligible person(s) named on this card may obtain covered prescription drug benefits. Pharmacy: Please obtain positive identification of the person presenting this card.

THIS CARD DOES NOT GUARANTEE COVERAGE OR BENEFITS

For Assistance: Pharmacists can call 800-364-6331. Insureds can call 1-800-553-7654.

CVS CAREMARK

CVS Caremark Claims Department
P.O. Box 52136
Phoenix, AZ 85072-2136

COPAY G $15, PB $35, NPB $60

Use this side for Prescription Drug Benefits

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ASSURANT Health

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For network provider information visit
www.assuranthealth.com/networksavings1.
Original Effective Date: 03/01/2015

Aetna Signature Administrators® PPO
By aetna®

This card does not guarantee coverage or benefits. To receive maximum medical benefits, authorization is required. Failure to call may result in reduced benefits. For authorization, call 800-454-5105. For verification of patient coverage, call Customer Service at 1-800-553-7654.
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Visit us at www.assuranthealth.com.

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Quest Diagnostics LabCard Select
www.LabCardSelect.com
1.800.750.1253

First Health National

Assurant Health
501 W. Michigan Street
P.O. Box 624
Milwaukee, WI 53201-0624
800-800-1212

February 12, 2015

This is not a bill

Agency Number: 000336AN0AP001
* * AGENT DATA * *
ASSURANT HEALTH DIRECT SALES
000336AN0AP001

ACCOUNT STATEMENT
as of 02/12/2015

This Account Statement has been prepared to inform you and your agent of the status of the initial payment, in connection with your new policy. Any difference between the amount submitted with your application/enrollment form and the initial payment is shown in detail below. If you receive a bill please pay in response to it and not this statement. After the initial full amount due by you has been paid, billing will occur as requested on your application/enrollment form.

Full payment must be received by Time Insurance Company before claims can be considered for payment.

POLICYHOLDER INFORMATION

Name/Address	Birth Date	Sex		
Sarah M Riazati	1988-11-20	F	Policy Number:	0062481938
2161 Peachtree Rd NE			Effective Date:	March 1, 2015
Apt 205			Form Number:	1400-GA
Atlanta GA 30309			Bill Type:	Credit Card
			Account No:	0002800228
			Policy Status:	IN FORCE

ACCOUNT INFORMATION

Insured Responsibility	$157.89
Amount Paid	$0.00
Your Balance Due	$157.89
Account Status	The balance due will be collected based on bill type selected.

If you have any questions please contact the number listed on the back of your identification card or your agent.

IMPORTANT NOTICES - MEDICAL

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state insurance program.

New 10/2014

Assurant Health
501 W. Michigan Street
P.O. Box 624
Milwaukee, WI 53201-0624
800-800-1212

HOW YOUR PRESCRIPTION DRUG CARD PROGRAM WORKS

Your coverage for outpatient drugs is provided through Assurant Health's prescription drug card program, administered through CVS Caremark. The drug card is easy to use and may offer you savings each time you fill a covered prescription at a retail pharmacy!

IMPORTANT FEATURES

- To receive maximum benefits, a prescription must be 1) prescribed by a licensed physician, 2) dispensed by a participating pharmacy, **and** 3) processed on the drug card.
- You must present your card at your participating retail pharmacy each time a prescription is filled.
- Some medications may have quantity limits, or may require pre-authorization before they qualify for coverage. If the pharmacy informs you pre-authorization is required please call the phone number located on the back of your insurance ID card or send an email to ahpharmacyservices@assurant.com. If sending an email please include the word "Confidential" in the subject line.
- No claim forms are needed when you use your prescription drug card.
- Register on CVS Caremark's website at **caremark.com**, to locate a participating pharmacy nearest you, access benefit information and health and wellness information. When utilizing the website you will need your member ID number to complete the one-time registration process. If you do not have internet access or need assistance locating a participating pharmacy, call 800-551-5681.
- Some plans may offer selected maintenance medications through mail order. If you have questions about the mail order service, and/or need to request a mail order form, please call 1-800-553-7654. You can also print mail-order forms at caremark.com.
- If your plan has Mail Order benefits you may be able to receive the same benefit at a retail pharmacy if required by applicable state law. Please contact Customer Service at the number located on your ID card.
- The amount paid by us for the prescription drug may not reflect the ultimate cost of the prescription drug to us. Any amounts that the covered person is responsible for paying are paid on a per prescription or refill basis and will not be adjusted if we receive any retrospective volume drug discounts or prescription drug rebates. Manufacturer product discounts, also known as rebates, may be sent back to us and may be related to certain drug purchases. These amounts will be retained by us.

HOW TO USE THE DRUG CARD

- You must present your card at your participating retail pharmacy each time a prescription is filled. Within seconds, the pharmacy transmits the prescription information to CVS Caremark. Any available prescription benefits are analyzed and a response is sent back to your pharmacist.
- If you do not use the drug card or if you use a non-participating pharmacy, a record of your expenses will not automatically be maintained by CVS Caremark. You must then submit a

pharmacy prescription receipt and a prescription drug claim form to CVS Caremark. This form may be obtained by calling Assurant Health's Customer Service at 1-800-553-7654, or by visiting caremark.com. **Prescription claims that are mailed to CVS Caremark for processing are subject to the contracted rate and you may have usual and customary reductions in your benefits.**

SERVICES NOT COVERED

- Medications not covered under your Prescription Drug Card Program are listed in your insurance contract.

FOR MORE INFORMATION, CONTACT:

Assurant Health
CUSTOMER SERVICE
1-800-553-7654
1-414-271-3011 (Milwaukee)

- If any information on your card is incorrect.
- If you need a prescription drug claim form.
- To obtain a mail order form.
- To obtain a copy of the Drug Formulary List.
- If you are told prior-authorization is required.
- If you have further questions.

CVS Caremark
800-364-6331
Have your pharmacist call:

- If your pharmacy would like to participate in the CVS Caremark network.
- If your pharmacy will not accept your card.

DRUG FORMULARY PROGRAM

Assurant Health is committed to helping its members reduce their prescription drug costs and has contracted with CVS Caremark to lead that effort. An important component of Assurant Health's prescription drug benefit is the CVS Caremark Drug Formulary Program, also known as a "Rx Preferred Drug Guide." The purpose of the Drug Formulary is to promote the use of cost-effective prescription medications when medically appropriate for Assurant Health members, and to help reduce your prescription drug costs.

Assurant Health is proud to be working with CVS Caremark to manage your prescription drug benefit program. Please contact Assurant Health's Customer Service at 1-800-553-7654 with any questions you may have regarding the Prescription Drug Card Program. You may also visit our website at www.assuranthealth.com under Current Customers for more information regarding the drug card program.

ASSURANT Health®

Three-Tier Drug Coverage
Frequently Asked Questions
IM

What is a generic drug?

A generic drug is an FDA-approved therapeutic equivalent of a brand name drug and is listed as a generic drug in Time Insurance Company national drug database. A generic drug has the same active ingredient(s) as the brand name drug but does not carry a drug manufacturer's brand name on the label. Generic drugs have the lowest copay.

What is a preferred brand drug?

A preferred brand drug is a brand name prescription drug within a drug category that is determined to be the most cost effective when a generic drug is not available. The lower brand copay or applicable coinsurance applies to the preferred brand drug.

What is a non-preferred brand drug?

A non-preferred brand drug is a brand name prescription drug that is less cost effective than a preferred brand drug or a generic drug within a drug category. The highest brand copay or applicable coinsurance applies to the non-preferred brand drug.

What is an ancillary charge?

An ancillary charge is the difference in cost between a brand name drug and the cost we cover for a generic drug. An ancillary charge applies when a generic drug substitute exists but the brand name drug is dispensed.

How are drug benefits paid?

Once a covered person's drug deductible is satisfied (if applicable), he or she is responsible for a copay or coinsurance (plus ancillary charges, if applicable) for each covered generic or brand prescription filled at a participating pharmacy. After that, the plan pays the remainder of the covered prescription charge.

What if a brand drug is purchased when a generic is available?

If a covered person receives a brand name drug when a generic is available and any applicable drug deductible has already been satisfied, he or she must pay the non-preferred brand copay or coinsurance plus the difference in the cost between the brand and generic drugs (ancillary charge).

EXAMPLE – Cost if brand drug is selected when generic equivalent is available.

Copay Structure:	$15 / $50 / $75
Non-Preferred Brand Drug Cost:	$150
Generic Drug Cost:	$90
Ancillary Charge:	$60 ($150-$90)

	$60	(ancillary charge)
+	$75	(non-preferred brand copay)
	$135	**- total cost paid by the covered person**

Time Insurance Company
501 W. Michigan Street
Milwaukee, WI 53201

PREFERRED PROVIDER ORGANIZATION INDIVIDUAL MAJOR MEDICAL COVERAGE
With Child Dental and Vision Benefits
OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

MAJOR MEDICAL EXPENSE COVERAGE: The Policy is designed to provide coverage for major hospital, medical, and surgical expenses Incurred as a result of a covered Sickness or Injury. Benefits are subject to any applicable Emergency Room Access Fee, Coinsurance, Copayment, Deductible or other fees shown in the Coverage Information section below and on the Benefit Summary and all the terms, limits and conditions in the Policy.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

AUTHORIZATION REQUIREMENT: To be eligible to receive the maximum benefits available, read the Utilization Review Provisions section in the Policy carefully. Failure to follow the Utilization Review Provisions section could result in no payment or a reduction in benefits.

PAYMENT OF BENEFITS: After the Covered Person has paid any Emergency Room Access Fee, Copayment, Deductible, Coinsurance and any other applicable fees, We will pay benefits for Covered Charges. Benefits are subject to any Maximum Benefit provided under the plan.

COVERAGE INFORMATION		
Check for either: Single Plan _X_ or Family Plan ___		
Medical Benefit Coverage:		
If plan has an Integrated Deductible check here: __ (Covered Charges Incurred by all Covered Persons count toward satisfying this Deductible.)		
	Participating Provider	Non-Participating Provider
Plan Deductible	$1,500	$6,000
Plan Coinsurance (Percentage of Covered Charges You pay)	0%	40%
Out-of-Pocket Limit	$1,500	$19,050
(The Out-of-Pocket Limit includes the Deductible listed above.)		

Office Visit Copayment plan: yes __X __ no __ __ Check if Office Visit Copayment is limited to Primary Care Practitioner Office Visits only: __ __	$30 Limited to 10 visits per Calendar Year per Covered Person.	Subject to Plan Deductible and Coinsurance
Emergency Room Access Fee:	$100 Waived if the Covered Person is subsequently admitted to the hospital for an Inpatient Stay.	
Outpatient Prescription Drug Benefit Coverage:		
Check here if subject to Plan Deductible and Plan Coinsurance: _		
Check if Outpatient Prescription Drug Deductible ___		

subject to: Outpatient Prescription Drug Copayment __X__		
	Participating Pharmacy	Non-Participating Pharmacy
Generic Drug Copayment	$15	$15
Preferred Brand Name Drug Copayment	$35	$35
Non-Preferred Brand Name Drug Copayment	$60	$60
PREMIUM INFORMATION		
Premium Payment Mode	monthly	
Total Modal Premium Amount	$298.89	

COVERED CHARGE: An expense that We determine meets all of the following requirements:

- It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.
- It is Incurred by a Covered Person while coverage is in force under the plan as the result of a Sickness or an Injury or for preventive medicine services or family planning services as outlined in the Medical Benefits section of the Policy.
- It is Incurred for services or supplies listed in the Medical Benefits section or Outpatient Prescription Drug Benefits section of the Policy.
- It is Incurred for treatment, services or supplies which are Medically Necessary.
- It is not in excess of the Maximum Allowable Amount.

Charges from the Covered Person's Non-Participating Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by Us.

MAXIMUM ALLOWABLE AMOUNT: The maximum amount of a billed charge We will consider when determining Covered Charges, as determined by Us. Benefit payments of Covered Charges are not based on the amount billed but, rather, they are based on what We determine to be the Maximum Allowable Amount. Amounts billed in excess of the Maximum Allowable Amount by or on behalf of a Health Care Practitioner, facility or supplier are not payable by Us under the plan.

PROVIDER CHARGES: You and Your Covered Dependents are free to use any provider You choose. It is the Covered Person's responsibility to determine if a provider is a Participating Provider or a Non-Participating Provider before any services are rendered. Please see the Benefit Summary for specific benefit levels that apply to each type of provider.

Non-Participating Providers may bill more than We determine to be a Maximum Allowable Amount and the Covered Person is responsible for payment of any amount billed above the Maximum Allowable Amount. The Covered Person is not responsible for payment of amounts billed by a Participating Provider in excess of the Maximum Allowable Amount for Covered Charges received within the Covered Person's network.

OTHER INSURANCE: If there is other insurance which provides coverage for medical expenses, benefits under the Policy may be reduced.

BENEFITS PROVIDED BY THE POLICY: Only the services and supplies listed in the Policy will be considered Covered Charges. How Covered Charges are paid and the maximum benefit for the covered services and supplies are shown in the Benefit Summary. The plan considers

benefits for Behavioral Health and Substance Abuse disorders on the same basis as Sickness. The Policy provides benefits for the following Covered Charges:

Inpatient Hospitalization Services

- Daily room and board.
- Routine nursing services.
- Other Medically Necessary services received in an Acute Medical Facility.
- Transplants including, but not limited to, kidney, cornea, skin, lung(s), heart, simultaneous heart/lung, liver, simultaneous kidney/pancreas and allogeneic and autologous bone marrow transplant/stem cell rescue when a transplant is authorized in advance by Us prior to transplant evaluation, testing, preparative treatment or donor search. Transplant donor expenses are subject to a $10,000 Maximum Benefit per transplant. Transplant travel expenses are subject to Our guidelines and are subject to a $10,000 Maximum Benefit per transplant when a Designated Transplant Provider or Participating Provider is used. Transplant services received from a Non-Participating Provider are subject to a Maximum Benefit of $100,000 per transplant.
- Inpatient services for treatment of Behavioral Health and Substance Abuse disorders when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

Emergency and Ambulance Services

- Emergency Treatment for Sickness or Injury.
- Professional ground or air transportation in an ambulance to the nearest Acute Medical Facility that can treat the Sickness or Injury.

Outpatient Medical Services

- Office Visits including evaluation and management services as defined in the most recent edition of Current Procedural Terminology and preventive medicine services, including, but not limited, to contraception management, patient education, and counseling.
- Services performed in an Acute Medical Facility's Outpatient department, a Free-Standing Facility or an Urgent Care Facility, including Outpatient surgery for a Medical Emergency.
- Health Care Practitioner Services including, but not limited to, services of a primary surgeon, an Assistant Surgeon or a Surgical Assistant. Covered Charges for services rendered by an Assistant Surgeon who is a Non-Participating Provider are limited to 20% of the Covered Charges allowed for the surgeon performing the surgical procedure. Covered Charges for services rendered by a Surgical Assistant who is a Non-Participating Provider are limited to 10 of the Covered Charges allowed for the surgeon performing the surgical procedure.
- Dental services related to the dental extraction of teeth as a prerequisite of scheduled radiation therapy or covered surgery.
- Treatment of a Dental Injury from an Accidental blow to the face causing trauma to teeth, the gums or supporting structures of the teeth.
- Coverage for the administration of general anesthesia and services in an Acute Medical Facility or Free-Standing Facility when dental treatment is provided to a Covered Person who is a child age 13 or younger or is developmentally disabled; a person who has a medical condition for which a successful result cannot be expected for treatment under local anesthesia in the dental office; or has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.
- Services for removal of tonsils and adenoids.
- Services for permanent sterilization.

- Routine Patient Costs Incurred by a Clinical Trial Qualified Individual while participating in an Approved Clinical Trial, including an Approved Clinical Trial for treatment of children's cancer.
- Surgical treatment of Temporomandibular Joint or Craniomandibular Joint Dysfunction.
- Non-surgical treatment of Temporomandibular Joint or Craniomandibular Joint Dysfunction, limited to a medical history, diagnostic examinations, injection of muscle relaxants, therapeutic drug injections, diathermy therapy, ultrasound therapy and splint therapy with necessary adjustments, except for removable appliances designed for orthodontic purposes.
- Services for surgical treatment of bunions, hemorrhoids and varicose and spider veins.
- Services for surgical treatment of inguinal hernia.
- The following services are for a Covered Person with diabetes: one routine eye examination per Calendar Year, nutritional counseling when first diagnosed and when changes in condition occur, diabetic self-management training and education programs, two routine foot exams per Calendar Year, home glucose monitoring and diabetic supplies.
- Growth hormone therapy treatment, diagnosis or supplies when such treatment is clinically proven to be effective for growth hormone deficiency, growth retardation secondary to chronic renal failure before or during dialysis, or AIDS wasting syndrome.
- Telemedicine and Telehealth Services.
- Reconstructive surgery to restore function after an Injury; that is incidental to or follows a covered surgery resulting from a Sickness or an Injury of the involved part; that follows a Medically Necessary mastectomy; or because of congenital Sickness or anomaly of a Covered Dependent child that resulted in a functional defect.
- Intravenous injectable parenteral drug therapy for total parenteral nutrition and other fluids, blood and blood products, and medications that would be administered intravenously.
- Non-Intravenous injectable parenteral drug therapy for Prescription Drugs that can be administered by means of intramuscular or subcutaneous injection.
- Specialty Pharmaceuticals obtained from a Designated Pharmacy Provider and identified on Our Drug List including, but not limited to, intravenous and non-intravenous injectable parenteral drugs. Charges for Specialty Pharmaceuticals obtained from a provider other than a Designated Pharmacy Provider will not accrue to any Out-of-Pocket Limit.

- Chronic disease management.
- Outpatient services for Behavioral Health and Substance Abuse disorders when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Behavioral Health or Substance Abuse in an office setting, including treatment of Autism.

<u>Preventive Medicine and Wellness Services</u>

- Preventive medicine services for well child care, adult care, including immunizations as evidence-based items or services that have, in effect, a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention or the American Academy of Pediatric Committee statements for children in effect for at least one year prior to the Effective Date of this plan.
- Cervical cancer screening (with HPV screening) for women with cytology (Pap smear) when performed upon the order of a Health Care Practitioner.

- Colorectal cancer screening, examinations and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, for the ages, family histories, and frequencies referenced in such guidelines and recommendations and deemed appropriate by the attending Health Care Practitioner after conferring with the Covered Person.
- Osteoporosis screening using scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") with respect to infants, children, and adolescents, in effect for at least one year prior to the Effective Date of this plan.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA in effect for at least one year prior to the Effective Date of this plan.
- Mammography screening consisting of one baseline mammogram for women 35 through 39 years of age, a mammogram every 1 to 2 years for women 40 through 49 years of age, an annual mammogram for women 50 years of age or older and when ordered by a Health Care Practitioner for a Female At Risk.
- Injectable contraceptives, contraceptive implants, and services ordered by a Health Care Practitioner in relation to administration and dispensing of FDA-approved contraceptive Prescription Drugs or injections or the fitting or dispensing of an IUD or diaphragm and the insertion or removal of Norplant or other similar device by a Health Care Practitioner.
- Prostate specific antigen screening.
- Complete blood count (or component parts) testing.
- Urinalysis testing.
- An annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examinations for covered females age 35 and older at risk for ovarian cancer. At risk means a person who has a family history of relatives with ovarian cancer, breast cancer or nonpolyposis colorectal cancer or who tests positive for BRCA1 or BRCA2 mutations.
- An annual chlamydia screening test for a woman who is 29 years of age or younger.

<u>Diagnostic Imaging Services and Laboratory Services</u>
- Diagnostic Imaging services and laboratory services.
- Interpretation of Diagnostic Imaging services and laboratory services.

<u>Habilitative Services and Rehabilitative Services</u>
- Services provided on an Outpatient basis that include, but are not limited to, Physical Therapy, Occupational Therapy, Speech Therapy, pulmonary rehabilitation programs, adjustments, manipulations, Cardiac Rehabilitation Programs, services for treatment of Developmental Delay, and applied behavior analysis therapy for treatment of Autism spectrum disorders.
- Home Health Care services including visits by a licensed nurse, respiratory therapy, intravenous injectable parenteral drug therapy, non-intravenous injectable drug therapy and postsurgical follow-up visits conducted at home following a mastectomy or lymph node dissection, as determined to be appropriate by the attending physician in consultation with the patient, received in the home and provided by a Home Health Care Agency.

- Inpatient Rehabilitative Services including, but not limited to, Rehabilitative Services provided for the same or a related Sickness or Injury that required an Inpatient Acute Medical Facility stay; treatment of complications of the condition that required an Inpatient Acute Medical Facility stay; Physical Therapy, Occupational Therapy and Speech Therapy; pulmonary rehabilitation programs; and the evaluation of the need for such services.
- Subacute Rehabilitation Facility and Nursing Facility Care including services in a Subacute Rehabilitation Facility or Nursing Facility when the confinement is in lieu of acute hospitalization or when admitted within 14 days after discharge from an Acute Medical Facility after a confinement of at least 3 days.

Hospice Services

- Inpatient services when confined in a Hospice facility and home care services when care is provided by a licensed Hospice; and bereavement counseling for each Immediate Family Member who is a Covered Person after another Covered Person's death.

Durable Medical Equipment and Personal Medical Equipment

- Rental or purchase of a wheelchair, basic hospital bed, and basic crutches.
- Casts, splints, trusses and orthopedic braces, excluding foot orthotics.
- The temporary interim and an initial permanent basic artificial limb or eye.
- External breast prostheses needed because of surgical removal of all or part of the breast.
- Oxygen and the equipment needed for the administration of oxygen.
- Cochlear implant.
- The following equipment used in connection with diabetes treatment: therapeutic shoes, custom fitted inserts and related orthopedic footwear associated with the prevention and treatment of diabetes and diabetes related conditions; injection aids, including those adaptable to meet the needs of the legally blind; insulin pumps and insulin pump supplies; pen-like insulin injection devices designed for multiple use; other medical equipment that is consistent with the current standards of care established by the American Diabetes Association.
- Other Durable Medical Equipment and supplies that are approved in advance by Us.

Maternity and Newborn Care Services

- Prenatal care.
- Delivery for a minimum of 48 hours of Inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of Inpatient care following an uncomplicated caesarean section delivery.
- Postpartum care, including two home visits per delivery.
- Routine well newborn care, including nursery charges, from the moment of birth until the mother is discharged.
- Circumcision for newborn males.
- Complications of pregnancy.

Child Vision Services

This provision provides benefits only for Covered Persons under 19 years of age.

- One routine eye exam per Calendar Year.
- Eyewear, limited to the choice, per Calendar Year, of either one pair of glasses or an annual supply of contact lenses. To be considered Participating Provider benefits, eyewear must be purchased from Designated Eyewear Providers and eyewear must be part of the Pediatric Eyewear Collection.

- Low vision optical devices including low vision services.
- One comprehensive low vision evaluation every five (5) years.
- High power spectacles, magnifiers and telescopes if Medically Necessary.
- Follow up care for low vision services, limited to 4 visits in any 5 year period.

World Wide Coverage
- Treatment received outside of the United States if such treatment would be covered when received in the United States.

Alternate Medical Care Plan
- A special arrangement that is made with You, a Health Care Practitioner and Us to provide services to the Covered Person which may exceed a maximum limit for a specific benefit in exchange for the exhaustion of a specified amount of another benefit that is covered under the plan. To be considered for alternate medical care, the Covered Person must be participating in case management services provided by Us or Our designee. Alternate medical care must be approved in writing by You and the Covered Person's Health Care Practitioner and must also be approved in writing by Us.

Specialized Medical Care Plan
- Specialized care approved in advance by Us under Our Specialized Medical Care Program. Benefits under a Specialized Medical Care Plan may be offered on a one-time basis or for a designated period of time. A Specialized Medical Care Plan may provide services or supplies that: 1) coordinate with a Covered Person's Medically Necessary treatment, and/or 2) facilitate or assist in the support of such treatment. Such benefits may be provided to the Covered Person or the Covered Person's family members or caregivers as outlined in the Specialized Medical Care Plan. A Specialized Medical Care Plan may also include waiver of all or a portion of the Covered Person's cost sharing obligations for such Covered Charges or provide increased benefits.

Child Dental Services
This provision provides benefits only for Covered Persons under 19 years of age.
- Preventive dental services.
- Basic dental services.
- Major dental services.
- Orthodontic dental services.

Services received from a Non-Participating Provider are subject to a Maximum Benefit of $3,000 per Calendar Year.

Outpatient Prescription Drug Benefits
- Outpatient Prescription Drug Benefits: Benefits are payable for up to a 30 consecutive day supply for each Prescription Order or up to a 90 consecutive day supply for Prescription Maintenance Drugs that can be obtained from a 90-Day Prescription Drug Provider. This includes insulin or insulin derivatives when obtained by prescription, disposable insulin syringes and needles and disposable blood/urine/glucose/acetone testing agents or lancets. We will not limit coverage for Prescription Drug inhalants for a Covered Person with asthma or other life-threatening bronchial ailments when the Prescription Drug inhalants are ordered or prescribed by the treating Health Care Practitioner. Prescription Drugs that are payable under the Outpatient Prescription Drug Benefits section of the plan are not also payable under any other section of the plan.

EXCLUSIONS: We will not pay benefits for any of the following:

- Charges that are not specifically listed as a Covered Charge in the Medical Benefits section or Outpatient Prescription Drug Benefits section.
- Charges caused by or contributed to by war or any act of war, or participation in or commission of a felony.
- Charges for treatment that is payable or reimbursable by Medicare; treatment reimbursable under workers' compensation.
- Charges for diagnosis and treatment of infertility, sex transformation, surrogate pregnancy, sterilization reversal.
- Charges for umbilical cord storage; genetic testing or counseling, except for BRCA genetic testing, and services; prophylactic treatment, services or surgery, except for prophylactic mastectomy/hysterectomy (oophorectomy) if the Covered Person has tested positive for BRCA gene and the Covered Person meets Our medical policies for prophylactic treatment.
- Charges for treatment of lifestyle concerns including, but not limited to, hair loss, restoration or promotion of sexual function, and cognitive enhancement.
- Charges for over-the-counter drugs, drugs obtained from sources outside the United States, the difference in cost between a generic and brand name drug when the generic is available.
- Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is an Immediate Family Member, or a person who ordinarily resides with a Covered Person.

Please see the Policy for a complete listing of benefits, limitations, exclusions and terms of coverage.

RENEWABILITY PROVISION: The Policy is guaranteed renewable except for stated reasons. The Policy will terminate on the earliest of the following dates:

- The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
- The date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
- The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
- The date there is fraud or intentional misrepresentation of material fact made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.
- The date all plans the same as this one are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.
- The date We terminate or nonrenew health insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.
- The date the Policyholder moves to a state where We do not provide individual medical insurance coverage.

PREMIUM: The first page shows the total premium for the coverage that was selected. We may adjust the premium amount upon any annual renewal date. Your premium may be adjusted from time to time, or on any premium due date, based on changes to Your geographic area, or Your addition or removal of Dependents.

Licensed Agent's Signature

Date

BENEFIT SUMMARY

	POLICYHOLDER INFORMATION	EFFECTIVE DATE of COVERAGE
POLICYHOLDER	Sarah M Riazati	03/01/2015

POLICY NUMBER 0062481938

DATE OF THIS BENEFIT SUMMARY 03/01/2015

PLAN TYPE Assurant Health Silver Plan 002

This Benefit Summary contains limited information about Your plan. PLEASE READ YOUR POLICY CAREFULLY TO UNDERSTAND YOUR COVERAGE.

The Utilization Review Provisions and Participating Provider Network must be utilized to be eligible to receive the maximum benefits available under this plan. Refer to the Utilization Review Provisions for the medical benefits that must be reviewed.

Major Medical Benefits for Single Plan.

Participating Provider Network: Aetna Signature Administrators PPO.
The providers listed in the Participating Provider Network directory on the Date of This Benefit Summary were Participating Providers as of that date. However, providers move in and out of the network from time to time. In addition, a hospital or clinic may have some doctors who are not participating in the network. Before you make an appointment to see a provider, check to make certain the provider is a Participating Provider, even if he or she is in the same clinic as Your regular provider. To verify that a provider is currently in-network, call the network or visit their website. The network phone number and web site address are on your ID card.

Benefits will be paid for Covered Charges Incurred while coverage is in force. Payment of benefits will be subject to all benefit provisions and other conditions of the plan. The benefits listed in this schedule are for each Covered Person unless otherwise indicated.

This plan considers Behavioral Health and Substance Abuse disorders on the same basis as Sickness.

PLAN DEDUCTIBLES:		
	Participating Provider Benefits	**Non-Participating Provider Benefits**
Individual Deductible each Calendar Year	$1,500	$6,000
Non-Participating Provider Deductibles are distinct from Participating Provider Deductibles. Charges that accrue to one Deductible do not accrue to another, except when indicated below.		

Plan Coinsurance and Out-of-Pocket Limits:
The Coinsurance is listed below unless specified elsewhere in the Benefit Summary.
Once the Out-of-Pocket Limit is met the plan pays at 100% of Covered Charges unless otherwise specified.
Coinsurance and Out-of-Pocket Limits may apply to specific types of services. Please review the Benefit Summary for additional Coinsurance and Out-of-Pocket Limits information.
Charges for Specialty Pharmaceuticals obtained from a provider other than a Designated Pharmacy Provider will not count toward any Out-of-Pocket Limit.

	Participating Provider Benefits	Non-Participating Provider Benefits
Plan Coinsurance: Percentage of Covered Charges You pay	0% until the Out-of-Pocket Limits are satisfied	40% until the Out-of-Pocket Limits are satisfied
Individual Out-of-Pocket Limit each Calendar Year (includes deductible)	$1,500	$19,050

Inpatient Hospitalization Services:		
Subject to Plan Deductible and Plan Coinsurance		
Transplant Donor Expenses will be covered up to a $10,000 Maximum Benefit per transplant		
Transplant travel expenses will be covered up to a $10,000 Maximum Benefit per transplant when a Designated Transplant Provider or Participating Provider is used as described in the Covered Medical Benefits section		
Transplant Benefits	**Designated Transplant Provider and Participating Provider Benefits**	**Non-Participating Provider Benefits**
Transplant Services:	Subject to Plan Deductible and Plan Coinsurance No Maximum Benefit Limitation	Subject to Plan Deductible and Plan Coinsurance Benefits are limited to a Maximum Benefit of $100,000 per transplant.

Emergency and Ambulance Services:	
Subject to Plan Deductible and Plan Coinsurance	
Emergency Treatment will be considered at the Participating Provider Benefit level regardless of provider network status until the condition has Stabilized.	
Emergency Room Access Fee:	Covered Person pays $100 per Emergency Room visit, waived if the Covered Person is subsequently admitted to the hospital for an Inpatient Stay; Plan Deductible and Plan Coinsurance applies to remaining Covered Charges.

Outpatient Medical Services:		
Subject to Plan Deductible and Plan Coinsurance		
Diabetic services Covered Charges include: • Eye Examinations: Limited to one (1) examination on both eyes per Calendar Year per Covered Person. • Foot Examination: Limited to two (2) examinations on both feet per Calendar Year per Covered Person. • Nutritional Counseling: When first diagnosed and when changes in condition occur.		
	Participating Provider Benefits	**Non-Participating Provider Benefits**

Health Care Practitioner Office Visits:	$30 Copayment per Office Visit for up to 10 visits per Calendar Year per Covered Person. Additional Office Visits are subject to Plan Deductible and Plan Coinsurance	Subject to Plan Deductible and Plan Coinsurance

Preventive Medicine and Wellness Services:		
Subject to Plan Deductible and Plan Coinsurance, except as indicated below.		
	Participating Provider Benefits	**Non-Participating Provider Benefits**
Preventive Medicine and Wellness Services listed in the A and B recommendations of the USPSTF and HRSA Women's Preventive Services and mammography screening required by the ACA:	Plan pays 100%; Plan Deductible and Plan Coinsurance waived.	Subject to Plan Deductible and Plan Coinsurance

Diagnostic Imaging Services and Laboratory Services:
Subject to Plan Deductible and Plan Coinsurance

Habilitative Services and Rehabilitative Services:		
Subject to Plan Deductible and Plan Coinsurance		
	Habilitative Services Benefits	**Rehabilitative Services Benefits**
Physical Therapy and Occupational Therapy	Subject to Maximum Benefit per Calendar Year of 30 visits per Covered Person	Subject to Maximum Benefit per Calendar Year of 30 visits per Covered Person
Speech Therapy	Subject to Maximum Benefit per Calendar Year of 20 visits per Covered Person	Subject to Maximum Benefit per Calendar Year of 20 visits per Covered Person
Adjustments and manipulations	Subject to Maximum Benefit per Calendar Year of 20 visits per Covered Person	Subject to Maximum Benefit per Calendar Year of 20 visits per Covered Person
Subacute Rehabilitation Facility and/or Nursing Facility care:	Subject to Maximum Benefit per Calendar Year of 30 days per Covered Person.	Subject to Maximum Benefit per Calendar Year of 30 days per Covered Person.
Home Health Care Services	Subject to Maximum Benefit per Calendar Year of 130 visits per Covered Person	Subject to Maximum Benefit per Calendar Year of 130 visits per Covered

		Person
Applied behavior analysis therapy for treatment of Autism spectrum disorders:	Subject to Maximum Benefit per Calendar Year of 10 visits per Covered Person No limit	Not applicable.

Hospice Care Services:
Subject to Plan Deductible and Plan Coinsurance

Durable Medical Equipment and Personal Medical Equipment:
Subject to Plan Deductible and Plan Coinsurance

Maternity and Newborn Care Services:
Subject to Plan Deductible and Plan Coinsurance
Post-partum home visit benefits are limited to 2 visits per delivery.

Specialty Pharmaceutical Drugs:		
Subject to Plan Deductible and Plan Coinsurance. Charges for Specialty Pharmaceuticals obtained from a provider other than a Designated Pharmacy Provider will not count toward satisfying any Out-of-Pocket Limit. After satisfaction of any Out-of-Pocket Limit for other Covered Charges, Plan Coinsurance will still apply to all charges for Specialty Pharmaceutical Drugs obtained from a provider that is not a Designated Pharmacy Provider.		
Specialty Pharmaceuticals will not be covered unless they have been authorized by Us in accordance with the Utilization Review Provisions and Our Specialty Pharmacy Program.		
Specialty Pharmaceuticals must be obtained from a Designated Pharmacy Provider to be considered at the Participating Provider benefit level.		
	Designated Pharmacy Provider Benefits	**Non-Designated Pharmacy Provider Benefits**
Specialty Pharmaceutical Drugs Benefits	• Subject to Plan Deductible and Plan Coinsurance. • The Maximum Allowable Amount is determined in accordance with Our lowest Contracted Rate with the Designated Pharmacy Provider.	• Paid the same as Designated Pharmacy Provider Benefits. You will have to pay any difference between the billed charges and the Contracted Rate in addition to any Plan Deductible and Plan Coinsurance. • Charges for Specialty Pharmaceuticals will not count toward satisfying any Out-of-Pocket Limit.

Child Vision Services:		
Child Vision Services benefits are available only to Covered Persons under 19 years of age.		
Subject to Plan Deductible and Plan Coinsurance.		
Exam benefits are limited to a Maximum Benefit of 1 screening eye exam, per Covered Person, per Calendar Year.		
	Designated Eyewear Provider	**Non-Participating Provider Benefits**

	Benefits	
Eyewear Benefits:	Choice of: one (1) pair of glasses or an annual supply of contact lenses for eyewear in the Pediatric Eyewear Collection, per Calendar Year.	Choice of: one (1) pair of glasses or an annual supply of contact lensesper Calendar Year.
Charges for eyewear purchased from a Designated Eyewear Provider that is not part of the Pediatric Eyewear Collection are considered as Non-Participating Provider benefits.		

Child Dental Services:		
Child Dental Services benefits are available only to Covered Persons under 19 years of age.		
Not subject to Plan Deductible.		
	Participating Provider Benefits	**Non-Participating Provider Benefits**
Class I: Preventive Dental Services Coinsurance	0%	0%
Class II: Basic Dental Services Coinsurance	20%	20%
Class III: Major Dental Services Coinsurance	40%	40%
Class IV: Orthodontic Dental Services Coinsurance	40%	40%

Outpatient Prescription Drug Benefits:
Copayment: **Participating Pharmacy** Generic Drug: $15 Preferred Brand Name Drug: $35 Non-Preferred Brand Name Drug: $60
Non-Participating Pharmacy Generic Drug: $15 Preferred Brand Name Drug: $35 Non-Preferred Brand Name Drug: $60
90-Day Prescription Drug Provider: Generic Drug: $45 Preferred Brand Name Drug: $105 Non-Preferred Brand Name Drug: $180

Time Insurance Company
501 W. Michigan Street
P.O. Box 624
Milwaukee, WI 53201

PREFERRED PROVIDER ORGANIZATION MAJOR MEDICAL INSURANCE POLICY
With Child Dental and Child Vision Benefits

PLEASE READ THIS POLICY CAREFULLY. This is a preferred provider organization plan. To receive the maximum benefits available, You must receive treatment from a Participating Provider. However, if You receive Emergency Treatment from a Non-Participating Provider when You cannot reasonably reach a Participating Provider, benefits will be paid as if received from a Participating Provider.

The insurance described in this Policy is effective on the date shown in the Benefit Summary only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This Policy describes the benefits and major provisions that affect Covered Persons. The Policy is issued in the State of Georgia and is governed by applicable laws of that State and federal laws.

This Policy is issued based on the statements and agreements in the enrollment form, any other amendments or supplements, and the payment of the required premium. This Policy may be changed. If that happens, You will be notified of any such changes.

Please read Your Policy carefully and become familiar with its terms, limits and conditions.

RIGHT TO EXAMINE POLICY FOR 10 DAYS

If You are not satisfied, return the Policy to Us or Our agent within 10 days after You have received it. All premiums will be refunded and Your coverage will be void.

IMPORTANT NOTICE CONCERNING STATEMENTS
IN YOUR ENROLLMENT FORM FOR INSURANCE

Please read the copy of the enrollment form included with this Policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the enrollment form. If a material omission or misstatement is made in the enrollment form, We have the right to deny any claim and/or modify the terms of the coverage or the premium amount. We may rescind this Policy in cases involving fraud or intentional misstatements of material fact. Carefully check the enrollment form and, if any information shown in the enrollment form is not correct and complete, write to Us at the address above, within 10 days.

Secretary

President

NOTICE

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

THIS POLICY CONTAINS A UTILIZATION REVIEW PROVISIONS SECTION. Benefits may be reduced or excluded if You fail to pre-authorize certain treatments. Read the Utilization Review Provisions section carefully.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

II. GUIDE TO YOUR POLICY

The sections of the Policy appear in the following order:

I. Signature Page

II. Guide To Your Policy

III. Effective Date and Termination Date

IV. Utilization Review Provisions

V. Provider Charges and Maximum Allowable Amount Provisions

VI. Medical Benefits

VII. Outpatient Prescription Drug Benefits

VIII. Exclusions

IX. Claim Provisions

X. Premium Provisions

XI. Recovery Provisions

XII. Conversion

XIII. Other Provisions

XIV. Definitions Glossary

III. EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Policyholder
A person who is eligible may elect to be covered under this plan by completing and signing an enrollment form and submitting any required premium. You must be a resident of the state where this plan is issued. Evidence of eligibility must also be provided. Your coverage will take effect at 12:01 a.m. local time at the Policyholder's state of residence on the date We approve coverage under Our coverage criteria.

If the Policyholder moves out of the state where this plan is issued, We will replace this Policy with another Policy that is issued in the Policyholder's new state of residence. Coverage under the new Policy will be effective on the date the Policyholder becomes a resident of the new state. If the Policyholder moves to a state where We do not provide insurance coverage, We will terminate the Policy.

The rates may change if the Policyholder moves to another zip code, there is a change in benefits or Dependents are added or deleted.

Eligibility and Effective Date of Dependents
To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:

1. **Adding a Newborn Child:** You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 60 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is born. If this is a Single Plan and these requirements are not met, the child will not be covered from birth. However, if this is a Family Plan and if these requirements are not met, Your newborn child will be covered only for the first 31 days from birth.

2. **Adding an Adopted Child:** A newly adopted child can be added on the date the child is placed with the Policyholder in anticipation of legal adoption and the Policyholder assumes a legal obligation for support of the child. You must call Our office or send Us written notice of the placement for adoption of the child and We must receive any required additional premium within 60 days of the placement for adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is placed for adoption. If this is a Single Plan and these requirements are not met, the child will not be covered from date of placement. However, if this is a Family Plan and if these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 31 days from placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.

3. **Adding Any Other Dependent:** To add any other Dependent, an enrollment form must be completed and sent to Us along with any required premium. Evidence of eligibility must also be provided. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date We approve coverage under Our coverage criteria.

Termination Date of Coverage
The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid in accordance with the laws in the Policyholder's state of residence minus any claims that were Incurred after the termination date and paid by Us.

This Policy will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.

2. The date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.

3. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.

4. The date there is fraud or intentional misrepresentation of material fact made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.

5. The date all plans the same as this one are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.

6. The date We terminate or nonrenew health insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.

7. The date the Policyholder moves to a state where We do not provide individual medical insurance coverage.

Coverage for a Covered Dependent will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the date the Covered Dependent no longer meets the Dependent definition in this plan.

IV. UTILIZATION REVIEW PROVISIONS

Utilization Review Process
The Covered Person must call the toll free number given on the Identification (ID) Card to obtain Our authorization for the services listed under the When To Call provision in this section. Benefits will be reduced or excluded as described in the Reduction of Payment provision in this section, if a Covered Person does not comply with this Utilization Review Process and does not obtain authorization.

A review by the Medical Review Manager does not guarantee that benefits will be paid. Payment of benefits will be subject to all the terms, limits and conditions of this plan.

The review process must be repeated if treatment is received more than 30 days after review by Our Medical Review Manager or if the type of treatment, admitting Health Care Practitioner or facility differs from what the Medical Review Manager authorized.

A determination by the Medical Review Manager does not alter, limit or restrict in any manner the attending Health Care Practitioner's ultimate patient care responsibility.

Utilization Review Procedures
To obtain authorization, the Covered Person must contact Our Medical Review Manager by calling the toll free number on the ID card. Please have all of the following information on hand before calling:

1. The Policy number for this plan.
2. The Health Care Practitioner's name and telephone number.
3. The service, procedure and diagnosis.
4. The proposed date of admission or date the service or procedure will be performed.
5. The facility's name and phone number.

The Medical Review Manager may review a proposed service or procedure to determine: Medical Necessity; whether it is a Cosmetic Service or an Experimental or Investigational Service; location of the treatment; and length of stay for an Inpatient confinement. As part of the review process, the Medical Review Manager may require, at Our expense, a second opinion from a Health Care Practitioner recommended by the Medical Review Manager.

When to Call
Contact the Medical Review Manager for authorization of the following services.

1. **Inpatient Confinements:** Call Us to obtain authorization for an admission to, or transfer between, an Acute Behavioral Health Inpatient Facility, an Acute Medical Facility, an Acute Medical Rehabilitation Facility, a Behavioral Health Rehabilitation and Residential Facility, a Subacute Rehabilitation Facility, a Hospice facility, a Nursing Facility or any other Inpatient confinement that will exceed 24 hours as follows:

    a. Non-Emergency Confinements: Call at least 7 business days prior to an Inpatient admission for a non-emergency confinement that will exceed 24 hours in length.
    b. Emergency Confinements: Call within 24 hours, or as soon as reasonably possible, after admission for an Emergency Confinement that will exceed 24 hours in length. The Covered Person must provide or make available to the Medical Review Manager the full details of the Emergency Confinement. Covered Emergency Treatment will be provided without the requirement for prior authorization, regardless of whether the provider is a Participating Provider or not.

c. Maternity Confinements: If the Inpatient confinement exceeds 48 hours following a normal, vaginal delivery or 96 hours following a caesarean section delivery, the Covered Person must call prior to the end of the confinement, or as soon as reasonably possible. Any other Inpatient confinements that occur during a pregnancy must be authorized in accordance with the Non-Emergency Confinements and Emergency Confinements provisions above.

2. **Outpatient Procedures:** Call Us to obtain authorization for the following procedures that are performed as an Outpatient in an Acute Medical Facility, an Acute Medical Rehabilitation Facility, a Free-Standing Facility, a Subacute Rehabilitation Facility, an Urgent Care Facility or in a Health Care Practitioner's office. Call at least 7 business days prior to receiving any non-emergency Outpatient services that are listed below. Call within 24 hours, or as soon as reasonably possible, after receiving the following Outpatient services for Emergency Treatment:

   a. Any surgical procedures.
   b. Invasive cardiology services for diagnostic or therapeutic cardiac procedures, except cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).
   c. Invasive radiology services for diagnostic or interventional purposes.
   d. Dialysis.
   e. Radiation therapy.

   Authorization is not required for laboratory services, endoscopies and non-invasive Diagnostic Imaging services, such as x-rays, magnetic resonance imaging (MRI), computerized axial tomography (CT scan), ultrasound or nuclear medicine scans.

3. **Outpatient Behavioral Health or Substance Abuse Disorder Services:** Call at least 7 business days prior to receiving Outpatient services for Behavioral Health or Substance Abuse in an Intensive Outpatient Behavioral Health Program or a Partial Hospital and Day Treatment Behavioral Health Facility or Program.

4. **Transplants:** Call at least 7 business days prior to any transplant evaluation, testing, preparative treatment or donor search.

5. **Pharmaceuticals:** Call at least 7 business days prior to obtaining any Specialty Pharmaceutical drug, or beginning a course of non-intravenous injectable drug therapy, or intravenous injectable parenteral drug therapy including, but not limited to, chemotherapy. Authorization is not required for insulin injections.

6. **Habilitative Services and Rehabilitative Services, including Physical Medicine, Adjustments and Manipulations:** Call at least 7 business days prior to beginning a course of treatment if the anticipated course of treatment will exceed 12 visits or will last longer than 30 days.

7. **Durable Medical Equipment and Personal Medical Equipment:** Call at least 7 business days prior to the purchase or rental of Durable Medical Equipment and Personal Medical Equipment with a purchase price in excess of $500.

8. **Home Health Care and Hospice Care:** Call at least 7 business days prior to beginning Home Health Care or Hospice Care.

9. **Child Vision Services:** Call at least 7 business days prior to obtaining pediatric glasses or contact lenses from a provider other than the Designated Eyewear Provider.

Continued Stay Review
We may request additional clinical information during an Inpatient confinement. Failure of the Health Care Practitioner or facility to provide the requested information will result in non-authorization of continued Inpatient confinement. No benefits will be considered until the additional information is received by Us.

No benefits will be paid for the days of Inpatient confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Medical Review Manager based on review of the additional information provided.

Reduction of Payment
The effect of noncompliance with the utilization review process is:

1. No benefits will be paid under this plan for any transplant services that are not authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment or donor search.

2. Benefits will not be paid for any Specialty Pharmaceuticals that are not authorized by the Medical Review Manager.

3. If authorization is not obtained for the Covered Person's course of treatment for the other services listed in the When to Call provision above, benefits will be reduced for otherwise Covered Charges by 25% but by no more than $1000 per course of treatment, if any of the following occur:

    a. The Covered Person does not contact the Medical Review Manager within the required time frame.
    b. The type of treatment, admitting Health Care Practitioner or facility differs from what was authorized by the Medical Review Manager.
    c. The treatment is Incurred more than 30 days after review by the Medical Review Manager.

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Emergency Room Access Fee, Coinsurance, Copayment, Deductible or Out-of-Pocket Limit.

V. PROVIDER CHARGES AND MAXIMUM ALLOWABLE AMOUNT PROVISIONS

You and Your Covered Dependents are free to use any provider You choose. It is the Covered Person's responsibility to determine if a provider is a Participating Provider or a Non-Participating Provider before any services are rendered. Please see the Benefit Summary for specific benefit levels that apply to each type of provider.

Non-Participating Providers and Non-Designated Pharmacy Providers may bill more than We determine to be a Maximum Allowable Amount and the Covered Person is responsible for payment of any amount billed above the Maximum Allowable Amount. The Covered Person is not responsible for payment of amounts billed by a Participating Provider in excess of the Maximum Allowable Amount for Covered Charges received within the Covered Person's network.

Payment of Participating Provider Benefits
A Covered Person may receive a higher benefit level for Covered Charges received from a Participating Provider. The Participating Provider benefit levels are shown in the Benefit Summary. Network services and supplies for which We have a Contracted Rate are not subject to Maximum Allowable Amount reductions. The Covered Person's cost sharing under this plan is based on the Contracted Rate for the covered goods or services provided.

Using a Participating Provider is not a guarantee of coverage. All other requirements of this plan must be met for Covered Charges to be considered for payment. Deductibles may vary based on whether the provider is a Participating Provider or not. See the Benefit Summary for applicable Plan Deductibles.

It is the Covered Person's responsibility to verify a provider's status within the Participating Provider Network at the time of service to ensure the Participating Provider benefit is received. Information on Participating Providers will be made available to You. If You or Your Covered Dependents are having trouble locating a Participating Provider, please call the network's phone number on the directory website or on Your identification (ID) card for assistance.

The Covered Person's benefits may also be affected based on the following factors:

1. Providers and/or networks may join or leave the Participating Provider Network from time to time. The Covered Person is responsible for verifying the participation status of a provider at the time of service. Prior to treatment, the Covered Person should call the Network Manager to verify whether a provider's participation in the network has terminated.

2. If the Covered Person Incurs Covered Charges after a Participating Provider's participation in the Participating Provider Network has terminated, Covered Charges will be processed at the Non-Participating Provider benefit level.

3. We will pay Covered Charges at the Participating Provider benefit level under certain circumstances, such as if the Covered Person begins treatment with the Participating Provider prior to the provider's date of termination as a Participating Provider.

4. If the Covered Person Incurs Covered Charges after a Provider's status within the Participating Provider Network has changed, Covered Charges will be processed according to the participation level of the Provider as of the date the service or supply is received.

Maximum Allowable Amounts for Participating Providers
For goods and services provided by a Participating Provider, facility or supplier, the Maximum Allowable Amount is the lesser of billed charges or the Contracted Rate. A Covered Person is not responsible for

payment of amounts billed by a Participating Provider in excess of the Maximum Allowable Amount for Covered Charges received within the Covered Person's network.

Payment of Non-Participating Provider Benefits
Covered Charges for treatment, services and supplies received from Non-Participating Providers are generally paid at a lower level than Participating Provider benefits and are subject to satisfaction of the Non-Participating Provider Deductible as well as any Maximum Allowable Amount reductions.

Maximum Allowable Amounts for Non-Participating Providers
Providers who have not established a Contracted Rate or Negotiated Rate with Us or Our Network Manager, or in the case of Specialty Pharmaceuticals, providers who are Non-Designated Pharmacy Providers, may charge more than We determine to be a Maximum Allowable Amount for covered services and supplies. If You or Your Covered Dependents choose to obtain covered services or supplies from such a provider, Covered Charges will be limited to what We determine to be the Maximum Allowable Amount. A Covered Person may be billed by the Non-Participating Provider or Non-Designated Pharmacy Provider or other provider for the portion of the bill We do not cover, in addition to any other applicable fees including, but not limited to, any Coinsurance, Copayment and Deductible.

For goods and services, other than Specialty Pharmaceuticals, provided by a Non-Participating Provider, facility or supplier including, but not limited to, professional, Inpatient and Outpatient claims, the Maximum Allowable Amount is the lesser of:

1. Billed charges; or
2. The Negotiated Rate; or
3. If a Negotiated Rate is not available, in accordance with one or more of the following methodologies:

    a. The amount a Health Care Practitioner, facility or supplier of a similar type and/or in the same geographic area bills for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted charge data and relative values.
    b. The amount derived by applying comparable markups from facilities of a similar type and/or in the same geographic area, to the estimated costs of the facility providing the goods and services reported on the claim, established utilizing the facility's most recently available cost reports submitted to The Centers for Medicare and Medicaid Services (CMS).
    c. The expected or estimated charges of facilities of a similar type and/or in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes, Current Dental Terminology (CDT) codes, or grouping of services as determined through standard DRG, refined DRG, APC or other standard industry methodologies, depending upon the services and setting reported on the claim.
    d. 300% of the amount, as would be allowed to the Health Care Practitioner, facility, or supplier by Medicare, for the goods and services reported on the claim, established utilizing the most currently available Medicare reimbursement schedules and methodologies.
    e. 300% of the amount, as would be allowed to the provider of a similar type and/or in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes by Medicare.
    f. The expected or estimated charges of facilities of a similar type and/or in the same geographic area, for the goods and services reported on the claim, using the facility's overall charge structures as a benchmark, determined by utilizing overall charges per discharge or encounter, adjusted by a valid, facility-specific, case or service mix index available.

g. For injectable therapy and services, the amount most commonly paid to a contracted provider or to a nationally contracted Designated Pharmacy Provider, not to exceed the Contracted Rate discounts off of Average Wholesale Price (AWP), or Average Sales Price (ASP), other nationally recognized drug cost basis used by nationally contracted vendors, or any other methodology described under this plan.
h. For Durable Medical Equipment and Personal Medical Equipment, the amount as would be allowed by Medicare for the goods and services (including rental) reported on the claim, established utilizing the most currently available Medicare, reimbursement schedules and methodologies.
i. For Child Vision Services, the amount shown in the 2012 Federal Employee Program Blue Vision Insurance Plan, High Option, as the maximum allowable fee for out of network services, equipment, and supplies. The Maximum Allowable Amount for glasses is $150; for contact lenses the Maximum Allowable Amount is $150 for regular contact lenses and $600 for Medically Necessary contact lenses.

For Specialty Pharmaceuticals that are not obtained through or supplied by a Designated Pharmacy Provider, the Maximum Allowable Amount is determined in accordance with Our lowest Contracted Rate with a Designated Pharmacy Provider.

Methodology Is Subject to Change
The Maximum Allowable Amount methodologies listed above may be amended or replaced from time to time at Our discretion, without notice. Our current methodologies can be obtained by calling Our Home Office.

Using the Participating Provider Network
To receive payment at the desired benefit level, You and Your Covered Dependents must meet the requirements for using Participating Providers and must comply with all other plan requirements. IT IS YOUR RESPONSIBILITY to verify that a provider is participating in the Participating Provider Network at the time of service.

Using Network Facilities
Even when the Covered Person receives treatment, services or supplies from a network facility, the care may be administered by Non-Participating Providers. IT IS YOUR RESPONSIBILITY to verify that a provider is a Participating Provider at the time of service.

Receiving Care for Emergency Conditions
Covered Charges for Non-Participating Provider Emergency Treatment and Emergency Confinement will be paid at the Participating Provider benefit level until the Covered Person's condition has Stabilized. After the condition has Stabilized, benefits will be paid at the Non-Participating Provider benefit level. We will, if possible, assist in the Covered Person's transfer to a Participating Provider if requested by the Covered Person. Covered Charges for Non-Participating Provider Emergency Treatment and Emergency Confinement may be subject to Maximum Allowable Amount reductions. We will limit the Maximum Allowable Amount reduction for such Emergency Treatment to no more than $1000.

Receiving Ancillary Services
Please note that certain ancillary services, such as lab tests or services performed by anesthesiologists, radiologists, pathologists or Emergency Room physicians, that are ordered by a Participating Provider are sometimes out-sourced to a Non-Participating Provider. Covered Charges for such services rendered by a Non-Participating Provider, even when provided in association with direct treatment from a Participating Provider, will be considered at the Participating Provider benefit level. However, charges are subject to the Maximum Allowable Amounts for Non-Participating Providers provision. To obtain Participating Provider benefits, it is important that such services be referred to another Participating Provider when possible. You may ask Your primary caregiver to refer such ancillary services to a Participating Provider.

VI. MEDICAL BENEFITS

We will pay Covered Charges only for the services and supplies listed as Medical Benefits in this section of the Policy. How Covered Charges are paid and the maximum benefit for the covered services and supplies listed in this section are shown in the Benefit Summary.

Refer to the Exclusions section of this Policy for services and supplies that are not covered under this plan.

The Covered Person must follow the Utilization Review Provisions section and the Provider Charges and Maximum Allowable Amount Provisions section to receive the maximum benefits available under this plan.

After the Covered Person has paid any Emergency Room Access Fee, Coinsurance, Copayment, Deductible or any other applicable fees, benefits will be paid by Us for Covered Charges for medical benefits listed in this section of the Policy for each Covered Person. Any applicable Emergency Room Access Fee, Coinsurance, Copayment, Deductible or other fees and the Covered Charges to which they apply are shown in the Benefit Summary. Benefits are subject to all the terms, limits and conditions in this plan.

This plan considers benefits for Behavioral Health and Substance Abuse disorders on the same basis as Sickness.

Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section unless they are specifically listed as Covered Charges in the Medical Benefits section.

We will consider benefits only for the following Covered Charges:

Inpatient Hospitalization Services
Covered Charges Incurred for:

1. The following services that are provided in an Acute Medical Facility:
   a. Daily room and board in the most appropriate setting in the Acute Medical Facility.
   b. Daily room and board in an intensive care setting, such as an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and a step-down unit.
   c. Routine nursing services.
   d. Other Medically Necessary services.

   Coverage is provided for care in an Acute Medical Facility following a mastectomy or lymph node dissection for an appropriate period as determined by the attending physician in consultation with the patient. It is not necessary to contact Us for authorization of an Inpatient confinement for mastectomy or lymph node dissection as required by the Utilization Review Provisions section. For benefits for postsurgical follow-up visits conducted at home or at the office, as determined to be appropriate by the attending physician in consultation with the patient, see the Outpatient Medical Services and Habilitative Services and Rehabilitative Services provisions in this section.

   Routine well newborn care at birth in an Acute Medical Facility is covered as described in the Maternity and Newborn Care Services provision in this section, and the newborn is a Covered Dependent.

   For Rehabilitative Services benefits, see the Habilitative Services and Rehabilitative Services provision even when these services are received in an Acute Medical Facility. For interpretation of Diagnostic Imaging and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section. For benefits for all other professional services, see the Emergency and Ambulance Services and Outpatient Medical Services provisions in this section.

2. Benefits for the following transplants:
   a. Kidney.
   b. Cornea.
   c. Skin.
   d. Lung(s).
   e. Heart.
   f. Simultaneous heart/lung.
   g. Liver.
   h. Simultaneous kidney/pancreas.
   i. Allogeneic and autologous bone marrow transplant/stem cell rescue including, but not limited to, the harvest and the reinfusion of the marrow or blood precursor cells.
   j. Any other transplants that are authorized by Us.

   All transplants must be authorized in advance by Us.

   Transplants with Designated Transplant Provider and Participating Providers: We have contracted with Designated Transplant Providers to provide transplantation services for specified types of transplants to Covered Persons at a Negotiated Rate. When a Designated Transplant Provider or Participating Provider is used, travel expenses for the Covered Person and one travel companion are paid, subject to Our guidelines. If the Covered Person later decides to use a Non-Participating Provider for transplant related services instead of a Designated Transplant Provider or Participating Provider, benefits will be paid as outlined below.

   A Non-Participating Provider Maximum Benefit limitation applies when the Covered Person does not use a Designated Transplant Provider or Participating Provider at the time the first service is Incurred for transplant evaluation, testing, preparative treatment and/or donor search. The Maximum Benefit will not be increased for any reason even if the Covered Person chooses to use a Designated Transplant Provider or Participating Provider at a later date unless approved by Us. The Maximum Benefit for transplant that is available when a Covered Person does not use a Designated Transplant Provider or Participating Provider applies to all transplant related services that are provided by a Non-Participating Provider. The Maximum Benefit limitation for Non-Participating Providers applies to all Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ. All Covered Charges associated with transplants are applied toward the transplant Maximum Benefit limitation.

   Covered Charges also include expenses Incurred for organ search and donor expenses. Organ search means administrative costs for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation. Benefits for donor expenses are available only when the expenses are related to a donation made to a Covered Person.

   Covered Charges for transplants authorized by Us include all related medical services Incurred 14 days before the transplant surgery until 365 days after the transplant surgery, or a lesser period not to exceed the termination date of this plan.

3. Inpatient services for treatment of Behavioral Health and Substance Abuse disorders when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

Emergency and Ambulance Services
Covered Charges Incurred for:

1. Emergency Treatment for Sickness or Injury. We will pay benefits for Covered Charges Incurred for Emergency Treatment at a Non-Participating Provider at the benefit level of a Participating Provider.

However, services received by a Non-Participating Provider may be subject to Maximum Allowable Amount reductions. Follow-up visits after the condition has Stabilized will be subject to all the terms, limits and conditions in this plan including, but not limited to, the Non-Participating Provider Deductible, Coinsurance and other Non-Participating Provider Out-of-Pocket Limits and may be subject to Maximum Allowable Amount reductions when services are received from a Non-Participating Provider. Covered Charges for services received in an Emergency Room that are not for Emergency Treatment will be paid subject to all the terms, limits and conditions in this plan as if the same services had been received in the least intensive setting.

2. Professional ground or air transportation in an ambulance for a Covered Person who needs Emergency Treatment for a Sickness or an Injury to the nearest Acute Medical Facility that can treat the Sickness or Injury. The ambulance service must meet all applicable state licensing requirements.

Outpatient Medical Services
Covered Charges Incurred for:

1. Office Visit charges Incurred during an Office Visit for a Covered Person are payable as shown in the Benefit Summary. For the purpose of this provision, Office Visits include evaluation and management services as defined in the most recent edition of Current Procedural Terminology and preventive medicine services, including, but not limited, to contraception management, patient education, and counseling. An Office Visit will also include allergy shots and immunotherapy injections of inhaled allergens. Covered Charges will not include laboratory and radiology services magnetic resonance imaging (MRI), computerized axial tomography (CT scan), surgical procedures, chemotherapy, allergy testing, or any other service not specifically listed as a Covered Charge in the Benefit Summary for an Office Visit.

2. Services performed in an Acute Medical Facility's Outpatient department, a Free-Standing Facility or an Urgent Care Facility, including Outpatient surgery for a Medical Emergency. However, Physical Medicine is covered under the Habilitative Services and Rehabilitative Services provision in this section.

3. Health Care Practitioner services including but not limited to services of a primary surgeon, an Assistant Surgeon or a Surgical Assistant during the surgery. Covered Charges for services rendered by an Assistant Surgeon who is a Non-Participating Provider are limited to 20% of the Covered Charges allowed for the surgeon performing the surgical procedure. Covered Charges for services rendered by a Surgical Assistant who is a Non-Participating Provider are limited to 10% of the Covered Charges allowed for the surgeon performing the surgical procedure. For interpretation of Diagnostic Imaging and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.

4. Dental services related to the dental extraction of teeth as a prerequisite of scheduled radiation therapy or covered surgery in accordance with a dental treatment plan approved by Us.

5. Treatment of Dental Injury from an Accidental blow to the face causing trauma to teeth, the gums or supporting structures of the teeth. Treatment of Dental Injury must begin within 90 days and be completed within 365 days of the Dental Injury. The Covered Person may submit a Dental Treatment Plan to Us before treatment starts for an estimate of any benefits that would be payable. We reserve the right to limit benefits to the least expensive procedure that will produce a professionally adequate result.

6. Coverage for the administration of general anesthesia and related medical expenses in an Acute Medical Facility or Free-Standing Facility when dental treatment is provided to a Covered Person who:

a. Is a child 13 years of age or younger or is developmentally disabled; or
b. Has a neurological or other medically compromising condition for which a successful result cannot be expected for treatment under local anesthesia in the dental office; or
c. Has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

The dental services are not covered, except as otherwise provided in the Child Dental Services provision in this section. Prior authorization for the dental care is required under either the Inpatient Confinements or Outpatient Procedures provision in the Utilization Review Provisions section. The Covered Person may submit a Dental Treatment Plan to Us before treatment starts for an estimate of any benefits that would be payable.

7. Services for removal of tonsils and adenoids.

8. Services for permanent sterilization for each Covered Person.

9. Routine Patient Costs Incurred by a Clinical Trial Qualified Individual while participating in an Approved Clinical Trial, including an Approved Clinical Trial for treatment of children's cancer.

10. Surgical treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction are only those services that are included in a treatment plan authorized by Us prior to the surgery, and the following services for non-surgical treatment of TMJ and CMJ:

    a. Medical history.
    b. Diagnostic examination.
    c. Injection of muscle relaxants.
    d. Therapeutic drug injections.
    e. Diathermy therapy.
    f. Ultrasound therapy.
    g. Splint therapy with necessary adjustments, except for removable appliances designed for orthodontic purposes.

    For Physical Therapy benefits, see the Habilitative Services and Rehabilitative Services provision in this section. For Diagnostic Imaging services, including radiographs, see the Diagnostic Imaging Services and Laboratory Services provision in this section. General dental care and cosmetic or elective orthodontic or periodontic care are not covered under this provision.

11. Services for surgical treatment of bunions, hemorrhoids and varicose and spider veins.

12. Services for surgical treatment of an inguinal hernia.

13. The following services for a Covered Person with diabetes:

    a. Routine eye exams.
    b. Nutritional counseling.
    c. Diabetic self-management training and education programs.
    d. Routine foot care.
    e. Home glucose monitoring and diabetic supplies.

    For insulin, syringes, needles, lancets and testing agents benefits, see the Outpatient Prescription Drug Benefits section. For other diabetic equipment and supplies benefits, see the Durable Medical Equipment and Personal Medical Equipment provision in this section.

14. Growth hormone therapy treatment, diagnosis or supplies, including drugs and hormones, only when such treatment is clinically proven to be effective for any of the following conditions:

    a. Growth hormone deficiency as confirmed by documented laboratory evidence.
    b. Growth retardation secondary to chronic renal failure before or during dialysis.
    c. AIDS wasting syndrome.

    Growth hormone treatment must be likely to result in a significant improvement in the Covered Person's condition.

15. Telemedicine Services and Telehealth Services that may include the use of:

    a. Telephone.
    b. Facsimile.
    c. E-mail.
    d. Internet.
    e. Compressed digital interactive video, audio or data transmission.
    f. Clinical data transmission using computer imaging by way of still-image capture and store forward.
    g. Other technology that facilitates access to the Health Care Practitioner.

16. Reconstructive surgery:

    a. To restore function for conditions resulting from an Injury.
    b. That is incidental to or follows a covered surgery resulting from a Sickness or an Injury of the involved part.
    c. Following a Medically Necessary mastectomy. Reconstructive surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and physical complications in all stages of mastectomy, including lymphedemas.
    d. Because of a congenital Sickness or anomaly of a covered child that resulted in a functional defect.

    Cosmetic Services and services for complications from Cosmetic Services are not covered regardless of whether the initial surgery occurred while the Covered Person was covered under this plan or under any previous coverage.

17. Intravenous injectable parenteral drug therapy services for total parenteral nutrition and other fluids, blood and blood products, and medications requiring a written prescription that would be administered intravenously.

18. Non-Intravenous injectable parenteral drug therapy services for Prescription Drugs that can be administered by means of intramuscular or subcutaneous injection. If the injectable drug is covered under the Medical Benefits section, any administration fees are covered under the Outpatient Medical Services provision in this section when the injectable drug is received on an Outpatient basis through a method other than self-administration. For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.

19. Specialty Pharmaceuticals obtained from a Designated Pharmacy Provider and identified on Our Drug List including, but not limited to intravenous and non-intravenous injectable parenteral drugs. For insulin injection benefits, see the Outpatient Prescription Drug Benefits section. Charges for Specialty Pharmaceuticals obtained from a provider that is not a Designated Pharmacy Provider will not accrue to

any Out-of-Pocket Limit. To be covered under this plan, Specialty Pharmaceuticals must be authorized by Us in accordance with the Utilization Review Provisions and Our Specialty Pharmacy Program.

20. Chronic disease management.

21. Outpatient services for Behavioral Health and Substance Abuse disorders when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Behavioral Health or Substance Abuse in an office setting, including treatment of Autism. Office Visit benefits will be considered in accordance with the Office Visit benefit on the Benefit Summary. For benefits for drugs prescribed for the treatment of Behavioral Health and Substance Abuse, see the Outpatient Prescription Drug Benefits section.

Preventive Medicine and Wellness Services
Covered Charges Incurred for:

1. Preventive medicine services for:

    a. Well child care and adult care, including immunizations, as evidence-based items or services that have, in effect, a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention or the American Academy of Pediatric Committee statements for children in effect for at least one year prior to the Effective Date of this plan. Such services include, but are not limited to, the recommendations for:
        i. Cervical cancer screening (with HPV screening) for women with cytology (Pap smear) when performed upon the order of a Health Care Practitioner;
        ii. Cholesterol abnormalities screening;
        iii. Colorectal cancer screening, examinations and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, for the ages, family histories, and frequencies referenced in such guidelines and recommendations and deemed appropriate by the attending Health Care Practitioner after conferring with the Covered Person;
        iv. Diabetes screening for type 2 diabetes in asymptomatic adults;
        v. Healthy diet counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease;
        vi. Osteoporosis screening using scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis;
    b. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") with respect to infants, children, and adolescents, in effect for at least one year prior to the Effective Date of this plan. Services include: a medical history: complete physical examination; measurement of height, weight and head circumference; testing of blood pressure; sensory screening including vision and hearing; hereditary and metabolic screening in accordance with Georgia law; developmental and behavioral assessment; tuberculin test; hematocrit or hemoglobin; urinalysis; anticipatory guidance for the parent or parents; and laboratory testing including screening for lead exposure as well as blood levels. Child wellness services do not include periodic dental examinations or other dental services;

c. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA in effect for at least one year prior to the Effective Date of this plan; and
d. Mammography screening. Mammography screening means one baseline mammogram for women 35 through 39 years of age; a mammogram every 1 to 2 years, even if no symptoms are present, for women 40 through 49 years of age; an annual mammogram for women 50 years of age or older and when ordered by a Health Care Practitioner for a Female At Risk.
e. Injectable contraceptives, contraceptive implants, and services ordered by a Health Care Practitioner in relation to administration and dispensing of FDA-approved contraceptive Prescription Drugs or injections or the fitting or dispensing of an IUD or diaphragm and the insertion or removal of Norplant or other similar device by a Health Care Practitioner. For other Prescription Drug contraceptives and supplies benefits, see the Outpatient Prescription Drug Benefits section.

Genetic testing or genetic counseling services are not covered, except for BRCA genetic testing, screening, and counseling in accordance with the USPSTF grade A recommendation.

Cost-sharing requirements, such as Your responsibility for paying Deductibles, Coinsurance and or Copayments, will not be required for these preventive benefits when You use a Participating Provider. If You use a Non-Participating Provider for these benefits, You will still be responsible for any applicable Deductible, Coinsurance or Copayment, and any amount that exceeds the Maximum Allowable Amount or Covered Charge as defined in Your plan.

When changes are made to the recommendations and/or guidelines for covered preventive medicine services listed in the A or B recommendations of the USPSTF, covered recommendations for children in HRSA or ACIP, or covered recommendations for women in HRSA, benefits for the new or changed preventive medicine services will be provided for Plan Years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

2. The following preventive services:

a. Prostate specific antigen screening.
b. Complete blood count (or component parts) testing.
c. Urinalysis testing.
d. An annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examinations for covered females age 35 and older at risk for ovarian cancer. At risk means a person who has a family history of relatives with ovarian cancer, breast cancer or nonpolyposis colorectal cancer or who tests positive for BRCA1 or BRCA2 mutations.
e. An annual chlamydia screening test for a woman who is 29 years of age or younger.

Cost-sharing requirements, such as Your responsibility for paying Deductibles and Coinsurance, may apply to these preventive benefits.

Diagnostic Imaging Services and Laboratory Services
Covered Charges Incurred for:

1. Diagnostic Imaging services and laboratory services.

2. Interpretation of Diagnostic Imaging services and laboratory tests if a written report with interpretation is produced directly by the Health Care Practitioner.

Habilitative Services and Rehabilitative Services
Covered Charges Incurred for the following Habilitative Services and Rehabilitative Services:

1. Services provided in the Outpatient department of an Acute Medical Facility, by a licensed therapist, or by a licensed or certified agency in a Covered Person's home or on an Outpatient basis that include, but are not limited to:

   a. Physical Therapy, Occupational Therapy and Speech Therapy.
   b. Pulmonary rehabilitation programs.
   c. Adjustments and manipulations.
   d. Cardiac Rehabilitation Programs.
   e. Services for treatment of Developmental Delay.
   f. Applied behavior analysis therapy for treatment of Autism spectrum disorders.

   Coverage for Outpatient Physical Medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us. For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.

2. Home Health Care services including:

   a. Home Health Care visits by a licensed nurse.
   b. Respiratory therapy.
   c. Intravenous injectable parenteral drug therapy when authorized by Us to be paid under the Medical Benefits section.
   d. Non-intravenous injectable drug therapy when authorized by Us to be paid under the Medical Benefits section.
   e. Postsurgical follow-up visits conducted at home following a mastectomy or lymph node dissection, as determined to be appropriate by the attending physician in consultation with the patient.

   Home Health Care must be provided by a Home Health Care Agency. One visit consists of up to 4 hours of care within a 24-hour period by anyone providing services or evaluating the need for Home Health Care. Services must be included in a plan of treatment established by a Health Care Practitioner. For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.

3. Inpatient Rehabilitative Services including services provided as an Inpatient in an Acute Medical Rehabilitation Facility that include, but are not limited to:

   a. Rehabilitative Services provided for the same or a related Sickness or Injury that required an Inpatient Acute Medical Facility stay.
   b. Treatment of complications of the condition that required an Inpatient Acute Medical Facility stay.
   c. Physical Therapy, Occupational Therapy and Speech Therapy.
   d. Pulmonary rehabilitation programs.
   e. The evaluation of the need for the services listed above.

   Coverage for Inpatient Rehabilitative Services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

4. Subacute Rehabilitation Facility and Nursing Facility Care including services in a Subacute Rehabilitation Facility or Nursing Facility that are:

   a. Provided in lieu of care in an Acute Medical Facility; or
   b. For the same condition that required confinement in an Acute Medical Facility and the Covered Person must enter the Subacute Rehabilitation Facility or Nursing Facility within 14 days after discharge from the Acute Medical Facility after a confinement of at least 3 days.

Coverage for Subacute Rehabilitation Facility or Nursing Facility care will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

Hospice Services
Covered Charges Incurred for:

1. The following Inpatient services when confined in a Hospice facility:

    a. Daily room and board.
    b. Part-time or intermittent nursing care by or under the supervision of a licensed registered nurse.
    c. Other Hospice services and supplies.

2. The following home care services when care is provided by a licensed Hospice:

    a. Part-time or intermittent nursing care by or under the supervision of a licensed registered nurse.
    b. Other Hospice services and supplies.
    c. Counseling services by a licensed Health Care Practitioner for each Immediate Family Member who is a Covered Person prior to another Covered Person's death.
    d. Bereavement counseling by a licensed Health Care Practitioner for each Immediate Family Member who is a Covered Person after another Covered Person's death.

Durable Medical Equipment and Personal Medical Equipment
Covered Charges Incurred for:

1. Rental or purchase, whichever is most cost effective as determined by Us, of the following items when prescribed by a Health Care Practitioner:

    a. A wheelchair.
    b. A basic Acute Medical Facility bed.
    c. Basic crutches.

2. Casts, splints, trusses and orthopedic braces, excluding foot orthotics. Custom knee braces will be covered only when customization is Medically Necessary.

3. The temporary interim and initial permanent basic artificial limb or eye.

4. External breast prostheses needed because of surgical removal of all or part of the breast.

5. Oxygen and the equipment needed for the administration of oxygen.

6. Cochlear implant.

7. The following equipment used in connection with diabetes treatment:
    a. Therapeutic shoes, custom fitted inserts and related orthopedic footwear associated with the prevention and treatment of diabetes and diabetes related conditions.
    b. Injection aids, including those adaptable to meet the needs of the legally blind.
    c. Insulin pumps and insulin pump supplies.
    d. Pen-like insulin injection devices designed for multiple use.
    e. Other medical equipment that is consistent with the current standards of care established by the American Diabetes Association.

8. Other Durable Medical Equipment and supplies that are approved in advance by Us.

Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of wheelchairs will be covered when authorized by Us before any equipment is purchased. Charges for replacement of or maintenance, repair, modification or enhancement to the whole or parts of any of the items listed above, other than wheelchairs, are not covered, regardless of when the item was originally purchased. Replacements due to outgrowing wheelchairs or Durable or Personal Medical Equipment as a result of the normal skeletal growth of a child will be covered when authorized by Us before any equipment is purchased. Charges for duplicate wheelchairs or Durable Medical Equipment, Personal Medical Equipment and supplies are not covered.

Maternity and Newborn Care Services
Covered Charges Incurred for:

1. Prenatal care. Prenatal care in accordance with the A and B recommendations of the United States Preventive Services Task Force are considered under the Preventive Medicine and Wellness Services provision.

2. Delivery for a minimum of 48 hours of Inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of Inpatient care following an uncomplicated caesarean section delivery.

3. Postpartum care, including two follow-up visits if the mother and newborn child are discharged prior to the length of Inpatient care provided in item 2 above. The first visit must occur within 48 hours of discharge by a Health Care Practitioner with experience and training in maternal and child health nursing.

4. Routine well newborn care, including nursery charges, from the moment of birth until the mother is discharged from the Acute Medical Facility. Except for the delivery charge itself, the newborn will be considered distinct from the mother for purposes of benefit eligibility and coverage.

5. Circumcision for newborn males.

6. Complications of pregnancy. Complications of pregnancy are any Sickness associated with a pregnancy, except for hyperemesis gravidarum or a non-emergency caesarean section delivery.

Child Vision Services
This provision provides benefits only for Covered Persons under 19 years of age.

Covered Charges Incurred by Covered Persons under 19 years of age for the following:

1. Routine eye exams, including new and established patient exams and routine ophthalmologic exams with refraction. Includes dilations, if clinically indicated.

2. Eyewear, limited to the Covered Person's choice, per Calendar Year, of either:
   a. One pair of glasses. Benefit includes both frames and lenses, including glass, plastic or polycarbonate lenses, of all lens powers, with or without scratch resistant coating and ultraviolet protective coating; or
   b. Annual supply of contact lenses. Benefits include contact lenses, evaluation, materials, fitting and follow-up care.

   To be considered Participating Provider benefits, eyewear must be purchased from Designated Eyewear Providers and eyewear must be part of the Pediatric Eyewear Collection designated by Our Eyewear Benefit Manager. Charges for eyewear that is purchased from a Designated Eyewear Provider that is not part of the Pediatric Eyewear Collection are considered as Non-Participating Provider benefits and subject to the Maximum Allowable Amount for Non-Participating Provider eyewear benefits. Any eyewear that is purchased from a provider other than a Designated Eyewear Provider is considered as

Non-Participating Provider benefits and subject to the Maximum Allowable Amount for Non-Participating Provider eyewear benefits.

3. Low vision optical devices including low vision services, and an assistive aid when follow-up care is pre-authorized.

4. One comprehensive low vision evaluation every five (5) years.

5. High power spectacles, magnifiers and telescopes if Medically Necessary.

6. Follow up care for low vision services, limited to 4 visits in any 5 year period.

Replacement lenses within the same Calendar Year are not covered. Child vision screening in accordance with the A and B recommendations of the United States Preventive Services Task Force are considered under the Preventive Medicine and Wellness Services provision.

World Wide Coverage
Coverage will be provided for any treatment received outside of the United States, at the Participating Provider benefit level and may be subject to the Maximum Allowable Amount, if such treatment would be covered when rendered in the United States.

An English language translation of the claims, medical records and proof of loss, as outlined in the Proof of Loss provision in the Claims Provisions section must be received by Us. You are responsible for obtaining this information at Your expense.

Benefits are not payable for any services Incurred in a country where travel warnings, issued by the U.S. State Department, exist for visitors from the United States at the time the services are received.

Alternate Medical Care Plan
We may provide benefits for alternate medical care. Alternate medical care is a special arrangement that is made with You, Your Health Care Practitioner and Us to provide services to the Covered Person which may exceed a maximum limit for a specific benefit in exchange for the exhaustion of a specified amount of another benefit that is covered under this plan.

To be considered for alternate medical care, the Covered Person must be participating in case management services provided by Us or Our designee. Alternate medical care must:

1. Be approved in writing by You and the Covered Person's Health Care Practitioner; and

2. Be approved in writing by Us.

We will pay the mutually agreed upon amount for the specified alternate medical care based on the terms set forth in the signed written alternate medical care agreement approved by Us. However, We will not pay for any alternate medical care services Incurred or received prior to Our written approval of the alternate medical care. Any alternate medical care benefits that We pay will apply toward the Covered Person's plan limits.

Providing benefits for alternate medical care in a particular case does not commit Us to do so in another case, nor does it waive or modify the terms and conditions of this plan, render them unenforceable or prevent Us from strictly applying the benefits, limitations and exclusions of this plan at any other time or for any other insured person, whether or not the circumstances are similar or the same.

Specialized Medical Care Plan
We may provide benefits for specialized care approved in advance by Us under Our Specialized Medical Care Program. Benefits under a Specialized Medical Care Plan may be offered on a one-time basis or for a designated period of time. A Specialized Medical Care Plan may provide services or supplies that: 1)

coordinate with a Covered Person's Medically Necessary treatment, and/or 2) facilitate or assist in the support of such treatment. Such benefits may be provided to the Covered Person or the Covered Person's family members or caregivers as outlined in the Specialized Medical Care Plan. A Specialized Medical Care Plan may also include waiver of all or a portion of the Covered Person's cost sharing obligations for such Covered Charges or provide increased benefits.

To be considered for a Specialized Medical Care Plan, the Covered Person must be participating in case management or disease management services provided by Us or Our designee.

We will not pay for any specialized medical care services or supplies Incurred or received prior to Our approval of the Specialized Medical Care Plan or after the designated timeframe in the plan expires.

Providing benefits for specialized medical care in a particular case does not commit Us to do so in another case, nor does it waive or modify the terms and conditions of this plan, render them unenforceable or prevent Us from strictly applying the benefits, limitations and exclusions of this plan at any other time or for any other Covered Person. The specialized medical care program may be discontinued at any time. Any approved benefits will be administered to the end of the period for which they had been approved under the Specialized Medical Care Plan.

Child Dental Services
This provision provides benefits only for Covered Persons under 19 years of age.

If a program of Dental Treatment is already in progress on the Covered Person's Effective Date, only those services and supplies Incurred on or after the Effective Date will be covered by this plan. No payment will be made for Dental Treatment completed after You or a Covered Dependent's coverage under the plan ends, except as otherwise provided by this plan.

Dental Treatment must be:

1. Performed by or under the direction of a Dentist, or performed by a Dental Hygienist or Denturist;
2. Medically Necessary; and
3. Started and completed while You or Your Covered Dependent are covered under the plan, except as otherwise provided by this plan.

We consider Dental Treatment to be started as follows:

1. Full or partial denture	The date the first impression is taken.
2. Fixed bridge, crown, inlay or onlay	The date the teeth are first prepared.
3. Root canal therapy	The date the pulp chamber is first opened.
4. Periodontal surgery	The date the surgery is performed.
5. All other Dental Treatment	The date Dental Treatment is rendered.

We consider Dental Treatment to be completed as follows:

1. Full or partial denture	The date a final completed appliance is first inserted in the mouth.
2. Fixed bridge, crown, inlay or onlay	The date an appliance is cemented in place.

3.	Root canal therapy	The date a canal is permanently filled.

We consider Dental Treatment to be started and completed on the date Dental Treatment is rendered. See Class IV: Orthodontic Dental Services for start and completion dates for Orthodontic Treatment.

Claims submitted to Us must identify the Dental Treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as We see fit, to determine benefits.

We consider a temporary Dental Treatment to be an integral part of the final Dental Treatment. The sum of the fees for temporary and final Dental Treatment will be used to determine whether the charges are above the Maximum Allowable Amount.

Pre-estimate Review
If the charge for any Dental Treatment is expected to exceed $300, We recommend that the Covered Person submit a Dental Treatment Plan to Us before Dental Treatment starts for an estimate of any benefits that would be payable.

In addition to a Dental Treatment Plan, before Orthodontic Treatment begins We may request any of the following information to help determine benefits payable for orthodontic services:
1. Full mouth dental X-rays;
2. Cephalometric X-rays and analysis;
3. Study models; and
4. A statement specifying:
    a. Degree of overjet, overbite, crowding and open bite;
    b. Whether teeth are impacted, in crossbite, or congenitally missing;
    c. Length of Orthodontic Treatment; and
    d. Total Orthodontic Treatment charge.

In estimating the amount of benefits payable, We will consider whether or not an alternate Dental Treatment may accomplish a professionally satisfactory result. If the Covered Person, or legal guardian, and the Dentist agree to a more expensive Dental Treatment than that pre-estimated by Us, We will not pay the excess amount.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets You know in advance approximately what portion of the expenses will be considered Covered Charges by Us.

We will consider benefits only for the following Covered Charges Incurred by Covered Persons who are under 19 years of age. No other routine dental benefits are covered under this provision.

Class I: Preventive Dental Services
1. Periodic or comprehensive oral evaluations, limited to 1 time in any 6-month period.

2. Comprehensive periodontal evaluation, limited to 1 time in any 6-month period.

3. Intra-oral complete series X-rays, including bitewings, and 10 to 14 periapical X-rays, or panoramic film.

4. Bitewing X-rays (one, two or four films), limited to 1 set in any 6-month period.

5. Vertical bitewing X-rays (seven to eight films), limited to 1 set in any 6-month period.

6. Dental prophylaxis, limited to 1 time in any 6-month period.

7. Topical fluoride treatment (excluding prophylaxis) or topical fluoride varnish, limited to 2 times in any 12-month period.

8. Sealant applications made to the Occlusal surface of permanent molar teeth, limited to 1 time per tooth in any 36-month period.

9. Preventive resin restorations for a permanent tooth for Covered Person with moderate to high caries risk, limited to 1 sealant per tooth in any 36-month period.

10. Space maintainers (including re-cementation and all adjustments made within 6 months of installation), limited to Covered Persons 18 years of age or younger.

Class II: Basic Dental Services

1. Limited oral evaluation (problem focused), considered for payment as a separate benefit only if no other Dental Treatment (except X-rays) is rendered during the visit. Limited to 1 time in every 6-month period.

2. Intraoral periapical X-rays.

3. Intraoral occlusal X-rays.

4. Extraoral X-rays, limited to 1 film in any 6-month period.

5. Panoramic film X-ray, limited to 1 film in any 60-month period.

6. Other X-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction).

7. Stainless steel crowns for teeth not restorable by an amalgam or composite filling, limited to: 1 time in any 60-month period and Covered Persons 14 years of age or younger.

8. Pulpotomy.

9. Pulpal therapy (resorbable filling) on either anterior or posterior primary teeth, limited to primary incisor teeth for Covered Persons 5 years of age and under; limited to primary molars and cuspids for Covered Persons 10 years of age and under. Maximum Benefit of one pulpal therapy per tooth, per Covered Person. Excludes final restoration.

10. Oral surgery services as listed below and routine post-operative care:
    a. Surgical extractions (including extraction of wisdom teeth);
    b. Alveoloplasty;
    c. Coronectomy;
    d. Vestibuloplasty;
    e. Removal of exostosis (maxilla or mandible);
    f. Removal of impacted tooth;
    g. Incision and drainage of intraoral soft tissue abscess;
    h. Suture of recent small wounds;
    i. Surgical access of unerupted tooth;
    j. Excision of pericoronal gingiva.

11. Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus.

12. Simple extraction.

13. Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

14. Incision and drainage of abscess.

15. Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other Dental Treatment (except X-rays) is rendered during the visit.

16. General anesthesia and intravenous sedation. Coverage for general anesthesia will be considered for payment based on the benefit allowed for the corresponding intravenous sedation. Coverage is considered for payment as a separate benefit only when Medically Necessary and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the plan.

17. Amalgam restorations, primary or permanent.

    a. Multiple restorations on one surface will be considered a single filling.
    b. Replacement of an existing amalgam restoration.
    c. Mesial, lingual, buccal (MLB) and distal, lingual, buccal (DLB) restorations will be considered single surface restorations.

18. Silicate restorations.

19. Protective restorations.

20. Plastic restorations.

21. Composite restorations, resin-based.

    a. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restoration.
    b. Acid etch is not covered as a separate procedure.
    c. Replacement of an existing composite restoration.

22. Pin retention restorations, covered only in conjunction with an amalgam or composite restoration, limited to 1 time per tooth.

23. Periodontal scaling and root planning (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period.

24. Periodontal Maintenance Procedure (following active Dental Treatment of adult prophylaxis), not to exceed 4 in any 12-month period.

Class III: Major Dental Services

1. Consultation, including specialist consultations:
    a. Coverage is considered for payment only if billed by a Dentist who is not providing operative Dental Treatment.
    b. Coverage will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan.

2. Detailed and extensive oral evaluation (problem focused), considered for payment as a separate benefit only if no other Dental Treatment (except X-rays) is rendered during the visit.

3. Therapeutic drug injections.

4. All benefits for inlays, onlays, crowns, dentures, implants, and fixed bridges include an allowance for all temporary restorations and appliances, and 1 year follow-up care.

5. Root canal therapy (anterior, bicuspid, molar), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

6. Occlusal guard for Covered Persons 13 to 19 years of age, limited to 1 per 12 months.

7. Apexification and recalcification.

8. Pulpal regeneration (regenerative treatment for an immature permanent tooth with necrotic pulp), not including final restoration.

9. Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

10. Root amputation (per root).

11. Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care. Coverage does not include a benefit for root canal therapy.

12. Periodontal related services as listed below, limited to 1 time per 4 or more teeth in any 36-month period, with charges combined for each of these services performed on the same teeth within the same 36-month period:

    a. Gingivectomy or gingivoplasty; gingival flap procedure;
    b. Osseous surgery;
    c. Osseous grafts.

13. Periodontal related services as listed below:
    a. Subepithelial connective tissue graft;
    b. Pedical grafts;
    c. Tissue grafts;
    d. Full mouth debridement for comprehensive evaluation and diagnosis.

14. Periodontal appliances, limited to 1 appliance per Calendar Year.

15. General anesthesia and intravenous sedation, limited as follows: considered for payment as a separate benefit only when Medically Necessary (as determined by Us) and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under this plan. Coverage for general anesthesia will be considered for payment based on the benefit allowed for the corresponding intravenous sedation.

16. Inlays , limited to 1 per tooth every 60 months.

17. Onlays, limited to 1 per tooth every 60 months.

18. Porcelain restorations on anterior teeth.

19. Crowns, limited to 1 per tooth every 60 months.

20. Recementing inlays.

21. Recementing crowns.

22. Crown lengthening when Medically Necessary.

23. Crown build-up, including pins and prefabricated posts; limited to 1 per tooth every 60 months.

24. Post and core, covered only for endodontically treated teeth requiring crowns; limited to 1 per tooth every 60 months.

25. Core buildup, including pins; limited to 1 per tooth every 60 months.

26. Prefabricated abutment; limited to 1 per tooth every 60 months.

27. Implant or abutment supported connecting bars; limited to 1 per tooth every 60 months.

28. Endodontic endosseous implant and endosseous implant; limited to 1 per tooth every 60 months.

29. Implant index and implant removal; limited to 1 every 60 months.

30. Implant maintenance procedures or repair to implant prosthesis; limited to 1 per tooth every 60 months.

31. Full dentures, limited to 1 time per arch every 60 months.

    a. We will not pay additional benefits for personalized dentures or overdentures, or associated Dental Treatment.
    b. We will not pay for any denture until it is accepted by the Covered Person.

32. Partial dentures, including any clasps and rests and all teeth, limited to 1 partial denture per arch every 60 months. Includes precision or semi-precision attachments.

33. Each additional clasp and rest.

34. Retainers, including abutment or implant supported retainers or cast metal or porcelain/ceramic retainers for resin bonded fixed prosthesis; limited to 1 per tooth every 60 months.

35. Denture adjustments, limited to 1 time in any 12-month period and adjustments performed more than 12-months after the initial insertion of the denture.

36. Repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12-months after the initial insertion.

37. Relining, recementing or rebasing dentures, limited to 1 time in any 36-month period and relining or rebasing performed more than 6-months after the initial insertion of the denture.

38. Tissue conditioning.

39. Fixed bridges (pontics), including Maryland bridges, limited to 1 per tooth every 60 months.

    a. Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than 60 months old and cannot be made serviceable.
    b. We will not pay benefits for a fixed bridge replacing the extracted portion of a hemisected tooth.

40. Recementing bridges, limited to repairs or adjustments performed more than 12 months after the initial insertion of the bridge.

41. Non-surgical temporomandibular joint (TMJ) treatment for: myofascial pain syndrome; muscular, neural, or skeletal disorder; and dysfunction or disease of the temporomandibular joint. Benefits include Dental Treatment of the chewing muscles to relieve pain or muscle spasm, X-rays, and occlusal adjustments.

    Benefits do not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing.

Class IV: Orthodontic Dental Services
Orthodontic Treatment is covered only when such treatment is Medically Necessary. Orthodontic Treatment for cosmetic purposes is <u>not covered</u> under this plan.

We will consider benefits only for the following Covered Charges Incurred by Covered Persons who are under 19 years of age:

1. Cephalometric X-rays.
2. Oral or facial photographic images used in Orthodontic Treatment.
3. Diagnostic casts (study models), limited to casts made for orthodontic purposes.
4. Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes.
5. Orthodontic appliances for tooth guidance.
6. Fixed or removable appliances to correct harmful habits.

Benefits for Orthodontic Treatment are not payable for expenses incurred for retention of orthodontic relationships. Benefits for Orthodontic Treatment are payable only for active Orthodontic Treatment for the services listed above.

We will pay benefits for the orthodontic services listed above for those parts of the Dental Treatment Plan Incurred while the Covered Person is insured under the plan. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.

We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered orthodontic services will be paid in equal monthly installments over the course of the remaining Orthodontic Treatment. The benefit consideration for the initial Orthodontic Treatment and monthly installments will be determined as follows:

An initial amount of 25% of the Covered Charges for the Orthodontic Treatment charge will be considered for the initial Orthodontic Treatment. This amount will be considered Incurred as of the date appliances or bands are inserted. The remaining 75% of the benefit consideration will be divided by the number of months that Orthodontic Treatment will continue to determine the amount that We will consider Incurred for each subsequent month of Orthodontic Treatment. The subsequent monthly benefits will be considered only if the Covered Person receiving treatment remains insured under the plan and provides proof to Us that Orthodontic Treatment continues.

If Orthodontic Treatment began prior to the Effective Date of coverage, We will consider benefits only for those portions of Orthodontic Treatment Incurred after the Effective Date.

VII. OUTPATIENT PRESCRIPTION DRUG BENEFITS

Only the Prescription Drugs listed as Outpatient Prescription Drug Benefits in this section of the plan will be considered Covered Charges. How Covered Charges are paid and are shown in the Benefit Summary. Refer to the Exclusions section of the plan for drugs, medications and supplies that are not covered under this plan.

The Covered Person must follow the Utilization Review Provisions section and use the Participating Pharmacy Network or Designated Pharmacy Providers to receive the maximum benefits available under this plan.

Prior authorization may be required for certain Prescription Drugs before they are considered for coverage under the Outpatient Prescription Drug Benefits section. Please call the number listed on the back of the Identification (ID) Card to receive information on which Prescription Drugs require prior authorization, to check Prescription Drug coverage and pricing or to locate a Participating Pharmacy.

After the Covered Person has paid any Ancillary Charge, and/or Ancillary Pharmacy Network Charge, Prescription Drug Copayment, Deductible or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan. Any applicable Prescription Drug Copayment, are shown in the Benefit Summary. Benefits are subject to all the terms, limits and conditions in this plan.

Any Ancillary Charge or Ancillary Pharmacy Network Charge will not count toward satisfying any Emergency Room Access Fee, Coinsurance, Copayment, or Deductible under this plan. Any Prescription Drug Copayment, under this section will not count toward satisfying any Emergency Room Access Fee, Plan Coinsurance, Copayment, or Plan Deductible under the Medical Benefits section in this plan.

Unless a Prescription Drug is specifically listed as a Covered Charge in the Medical Benefits section or on Our Drug List, all Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section.

Specialty Pharmaceuticals are covered under this plan only if they are dispensed through a Designated Pharmacy Provider.

This plan provides benefits only for the following Covered Charges for Prescription Drugs that are received on an Outpatient basis as shown in the Benefit Summary:

1. Prescription Drugs that are fully approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner.

2. Prescription Drugs that are dispensed in accordance with Our Drug List.

3. Up to a 30 consecutive day supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this plan. If a 90-Day Prescription Drug Provider is used, We will pay up to a 90 consecutive day supply for each Prescription Order for Prescription Maintenance Drugs covered by and through a 90-Day Prescription Drug Provider, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan. We will not limit coverage for Prescription Drug inhalants for a Covered Person with asthma or other life-threatening bronchial ailments when the Prescription Drug inhalants are ordered or prescribed by the treating Health Care Practitioner.

4. Up to 3 vials or up to a 30 consecutive day supply of one type of self-injectable insulin for each Prescription Order, whichever is less. If a 90-Day Prescription Drug Provider is used, We will pay up to 9 vials or up to a 90 consecutive day supply of one type of self-injectable insulin for each Prescription Order, whichever is less.

5. Up to 100 disposable insulin syringes and needles, up to 100 disposable blood/urine/glucose/acetone testing agents, or up to 100 lancets, or up to a 30 consecutive day supply for each Prescription Order, whichever is less. If a 90-Day Prescription Drug Provider is used, We will pay up to 300 disposable insulin syringes and needles or up to 300 disposable blood/urine/glucose/acetone testing agents or up to 300 lancets, or up to a 90 consecutive day supply for each Prescription Order, whichever is less.

6. Prescription Drugs, in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of a Sickness or an Injury that is covered under this plan.

7. Prescription Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a Prescription Drug.

8. Prescription Drugs and Prescription Drug products if all active ingredients are covered under this plan.

9. Prescription Drugs used for contraception that are oral contraceptives, contraceptive patches, contraceptive vaginal rings, and diaphragms. For injectable contraceptives and contraceptive implants, see the Preventive Medicine and Wellness Services provision of the Medical Benefits section.

10. Specialty Pharmaceuticals that are identified on Our Drug List as considered under the Outpatient Prescription Drug Benefits section. To be covered under this plan, Specialty Pharmaceuticals must be authorized by Us in accordance with the Utilization Review Provisions section and Our Specialty Pharmacy Program.

11. Prescription Drugs that treat a Covered Person for a life-threatening disease or condition that is covered by the plan if the drug has been approved by the U.S. Food and Drug Administration (FDA) and the Prescription Drug is either: recognized for treatment of the indication for which the drug is being used by at least one standard reference compendium; or the Prescription Drug is recommended for treatment of the condition and was found to be safe and effective in formal clinical studies, the results of which were published in a peer-reviewed professional medical journal published in either the United States or Great Britain.

Manufacturer's Packaging Limits
Some Prescription Drugs may be subject to additional supply, quantity, duration, gender, age, lifetime, cost sharing or other limits based on the manufacturer's packaging, plan limits or the Prescription Order. Examples of these situations are:

1. If a Prescription Drug is taken on an as-needed basis, only enough medication for a single episode of care may be covered per Prescription Drug Copayment; or

2. If two or more covered Prescription Drug products are packaged and/or manufactured together, the Covered Person may be required to pay a Prescription Drug Copayment amount for each of the Prescription Drug products contained in the packaging and/or in the combination Prescription Drug product; or

3. If two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered, then the entire packaged and/or manufactured combination product is not covered under this plan.

Step-Therapy Authorization
We consider Covered Charges for Prescription Drugs in accordance with Our Drug List and for the most cost-effective option if alternative Prescription Drug treatments are available. However, when a Prescription Drug in the same therapeutic class is less efficacious or less cost effective, We may authorize coverage for a different Prescription Drug or drug regimen. The step therapy could include changes to the dosage of the Prescription Drug or substituting the Prescription Drug with a different drug or drug regimen in the same or similar therapeutic classification. Please call Us to discuss alternative coverage options available to You.

PAYMENT OF BENEFITS

Participating Pharmacy
Present the identification (ID) card to the Participating Pharmacy to obtain benefits. The Covered Person must pay any applicable Ancillary Charge, Prescription Drug Copayment to the Participating Pharmacy.

The following additional cost sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

1. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the Prescription Drug Copayment for that Generic Drug as shown in the Benefit Summary.

2. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug as shown in the Benefit Summary.

3. If a Brand Name Drug is received when a Generic Drug or a Bio-Similar Drug is available, the Covered Person pays the Prescription Drug Copayment for that Brand Name Drug plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug or Bio-Similar Drug (referred to as the Ancillary Charge). The Ancillary Charge will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit.

4. When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens or manufacturers' packaging or when more than one covered Prescription Drug may be used to treat a condition that would be covered under this plan, We will consider benefits only for the most cost effective drug, dosage form or packaging that would be a Covered Charge under this plan and that will produce a professionally adequate result.

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable Ancillary Charge, Ancillary Pharmacy Network Charge, Prescription Drug Copayment. Any Ancillary Charge does not count toward satisfying any Emergency Room Access Fee, Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under this plan.

Designated Pharmacy Providers
A Covered Person must obtain authorization from Us before a Specialty Pharmaceutical is considered for possible coverage, as outlined in the Utilization Review Provisions section. If the Specialty Pharmaceutical is authorized, We will advise the Covered Person how the Specialty Pharmaceutical can be obtained from a Designated Pharmacy Provider and how to file a claim with Us.

Non-Participating Pharmacy or Non-Designated Pharmacy Provider
When the Covered Person has prescriptions filled at a Non-Participating Pharmacy or a Non-Designated Pharmacy Provider, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy or a Non-Designated Pharmacy Provider. To receive reimbursement for Covered Charges, the

Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy or Designated Pharmacy Provider for the cost of the covered Prescription Drug minus any applicable Ancillary Charge, Prescription Drug Copayment.

90-Day Prescription Drug Provider
Coverage for 90-day Prescription Orders of selected Outpatient Prescription Maintenance Drugs may be available to You and Your Covered Dependents under this plan as shown in the Benefit Summary. If this service is available, We will advise You of the name and address of the 90-Day Prescription Drug Providers so that You and Your Covered Dependents can take advantage of this service. If required, order forms may be obtained by contacting Us. If the 90-Day Prescription Drug Provider is a Mail Service Prescription Drug Vendor and You choose home delivery of Prescription Maintenance Drugs, the Covered Person must mail the Prescription Order, a completed order form and any required cost sharing amounts to the Mail Service Prescription Drug Vendor.

The following Prescription Drug Copayment cost sharing provisions apply to covered Outpatient Prescription Maintenance Drugs that are obtained through a 90-Day Prescription Drug Provider:

1. When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the 90-Day Prescription Drug Copayment for that Generic Drug as shown in the Benefit Summary.

2. When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the 90-Day Prescription Drug Copayment for that Brand Name Drug as shown in the Benefit Summary.

3. If a Brand Name Drug is received when a Generic Drug or Bio-Similar Drug is available, the Covered Person pays the 90-Day Prescription Drug Copayment for that Brand Name Drug, as shown in the Benefit Summary, plus the Ancillary Charge. The Ancillary Charge will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section or the Medical Benefits section.

4. When a covered Prescription Drug is available under two or more names, dosages, dosage forms, dosage regimens or manufacturers' packaging or when more than one covered Prescription Drug may be used to treat a condition that would be covered under this plan, We will consider benefits only for the most cost effective drug, dosage form or packaging that would be a Covered Charge under this plan and that will produce a professionally adequate result.

When using a Mail Service Prescription Drug Vendor, the vendor will fill the covered Prescription Order and mail it along with a replacement order form to the Covered Person. It will be mailed to the Covered Person's home or another location that is designated by the Covered Person. Some medications may have shipping restrictions.

Identification Cards
In connection with this benefit, You will receive an identification (ID) card or cards for You and Your Covered Dependents to use while covered under this plan.

No benefits are payable for any Prescription Order filled for a Covered Person on or after the date his or her coverage terminates under this plan. Thus, all Covered Persons are required to turn in their ID card or cards at the time of coverage termination. If You fail to do so and any Covered Person uses the ID card after coverage ends, You are responsible for all Prescription Drugs purchased after the termination date. We will recover from You any amounts paid by Us for drugs purchased after coverage terminates under this plan.

How To File A Claim
Present the ID card with the Prescription Order at the Pharmacy each time a Prescription Order is filled at a Participating Pharmacy. Pay the Participating Pharmacy the difference between the charge for the covered

Prescription Drug and the amount We will pay. This applies to each covered Prescription Drug that is filled at a Participating Pharmacy. If the ID card is not used to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay the Participating Pharmacy the entire amount charged for the covered Prescription Drug. Complete a prescription drug claim form. Send it and any Prescription Drug receipts to the Prescription Card Service Administrator (PCSA) at the address shown on the form for reimbursement of Covered Charges. A prescription drug claim form can be obtained from Us.

At a Non-Participating Pharmacy or a Non-Designated Pharmacy Provider, the Covered Person must pay the Pharmacy the entire amount charged for the covered Prescription Drug. Complete a prescription drug claim form. Send it and any Prescription Drug receipts to the address shown on the form for reimbursement of Covered Charges. A prescription drug claim form can be obtained from Us.

We reserve the right to limit Covered Charges under this Outpatient Prescription Drug Benefits section to a single Participating Pharmacy to help ensure that quality services are provided to You and Your Covered Dependents.

Miscellaneous Provisions
The amount paid by Us under this section may not reflect the ultimate cost to Us for the Prescription Drug. Any amounts that the Covered Person is responsible for paying are paid on a per prescription or refill basis and will not be adjusted if We receive any retrospective volume drug discounts or Prescription Drug rebates under any portion of this plan.

Manufacturer product discounts, also known as rebates, may be sent back to Us and may be related to certain drug purchases under this plan. These amounts will be retained by Us.

Payment by Us for a Prescription Drug under this section does not constitute any assumption of liability for coverage of a Sickness or an Injury under the Medical Benefits section. It also does not constitute any assumption of liability for further coverage of the Prescription Drug under this section.

The Covered Person is responsible for any Prescription Drug Copayment that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen or Prescription Order. These charges will not be reimbursed by Us.

VIII. EXCLUSIONS

We will not pay benefits for any of the following:

1. Charges for which Our liability cannot be determined because a Covered Person, Health Care Practitioner, facility, or other individual or entity within 30 days of Our request, failed to:

    a. Authorize the release of all medical records to Us and other information We requested.
    b. Provide Us with information We requested about pending claims, other insurance coverage or proof of creditable coverage.
    c. Provide Us with information as required by any contract with Us or a network including, but not limited to, repricing information.
    d. Provide Us with information that is accurate and complete.
    e. Have any examination completed as We requested.
    f. Provide reasonable cooperation to any requests made by Us.

2. Charges that:

    a. Are not specifically listed as a Covered Charge in the Medical Benefits section or Outpatient Prescription Drug Benefits section.
    b. Are complications of a non-covered service.
    c. Are Incurred before the Covered Person's Effective Date or after the termination date of coverage.
    d. Are not documented in the Health Care Practitioner's or Medical Supply Provider's records.
    e. Are related to the supervision of laboratory services that do not involve written consultation by a Health Care Practitioner including, but not limited to, laboratory interpretation.
    f. Are complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Health Care Practitioner.

3. Charges that are:

    a. Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law. If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, the benefits under this plan will be reduced by any amount that would have been reimbursed by Medicare.
    b. Payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California).
    c. For free treatment provided in a federal, veteran's, state or municipal medical facility.
    d. For free services provided in a student health center.
    e. For services that a Covered Person has no legal obligation to pay or for which no charge would be made if the Covered Person did not have a health plan or insurance coverage.

4. Charges for particular treatment, services, supplies or drugs that are billed by a Non-Participating Provider or a Non-Designated Pharmacy Provider that waives the Covered Person's payment obligation of any Copayment, Coinsurance and/or Deductible amounts for such treatment, services, supplies or drugs, except as provided for under contract or agreement with Us.

5. Charges for work-related Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to any of the following:

    a. The sole proprietor, if the Covered Person's employer is a proprietorship.

b. A partner of the Covered Person's employer, if the employer is a partnership.
c. A Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.

6. Charges caused by or contributed to by:

   a. War or any act of war, whether declared or undeclared.
   b. Participation in the military service of any country or international organization, including non-military units supporting such forces.

7. Charges for: vision care that is routine and glasses, except as otherwise covered for Outpatient diabetic services or Child Vision Services in the Medical Benefits section; contact lenses, except when used to aid in healing an eye or eyes due to a Sickness or an Injury or as otherwise covered for Outpatient diabetic services or Child Vision Services in the Medical Benefits section; vision therapy, exercise or training; surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).

8. Charges for: hearing care that is routine; any artificial hearing device except Medically Necessary cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.

9. Charges for foot conditions including, but not limited to, expenses for:

   a. Flat foot conditions.
   b. Foot supportive devices, including orthotics and corrective shoes, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision in the Medical Benefits section.
   c. Foot subluxation treatment.
   d. Care of corns; bunions, except capsular or bone surgery; calluses; toenails, except for ingrown toenails; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.
   e. Hygienic foot care that is routine, except as otherwise covered for diabetic services in the Medical Benefits section.

10. Charges for: dental care that is routine; dental charges; bridges, crowns, caps, dentures, dental implants or other dental prostheses; dental braces or dental appliances; extraction of teeth; orthodontic charges; odontogenic cysts; any other expenses for treatment or complications of the teeth and gum tissue, except for Outpatient dental services and Child Dental Services listed in the Medical Benefits section.

11. Except as provided in the Child Dental Services provision, charges for any appliance, medical or surgical expenses for:

    a. Malocclusion or Mandibular Protrusion or Recession.
    b. Maxillary or Mandibular Hyperplasia.
    c. Maxillary or Mandibular Hypoplasia.

12. Charges for: any diagnosis, supplies, treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity or morbid obesity, whether or not weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions; weight reduction or weight control surgery, treatment or programs; any type of gastric bypass surgery; suction lipectomy; physical fitness programs, exercise equipment or exercise therapy,

including health club membership fees or services; nutritional counseling, except as otherwise covered in the Outpatient Medical Services and Preventive Medicine and Wellness Services provisions in the Medical Benefits section.

13. Charges for Transplant services that are:

    a. Authorized by Us to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized by Us.
    b. Not specifically listed as a covered transplant in the Inpatient Hospitalization Services provision in the Medical Benefits section.
    c. For multiple organ, tissue and cellular transplants during one operative session, except for a simultaneous heart/lung, double lung or simultaneous kidney/pancreas transplant.
    d. For any non-human (including animal or mechanical) to human organ transplant.
    e. For the purchase price of an organ or tissue that is sold rather than donated.

14. Charges for chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other charges that are primarily a Cosmetic Service, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section.

15. Charges for revision of breast surgery for capsular contraction, removal or replacement of a prosthesis or augmentation or reduction mammoplasty, except as otherwise covered in the Inpatient Hospitalization Services or Outpatient Medical Services provisions in the Medical Benefits section.

16. Charges for prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date, except for prophylactic mastectomy/hysterectomy (oophorectomy) if the Covered Person has tested positive for BRCA gene and the Covered Person meets Our medical policies for prophylactic treatment.

17. Charges for:

    a. A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse or massage therapist; a rolfer; a home health aide or personnel with similar training and experience; a stand-by Health Care Practitioner except as otherwise covered in the Habilitative Services and Rehabilitative Services provision in the Medical Benefits section.
    b. Custodial Care; respite care; rest care; supportive care; homemaker services.
    c. A Health Care Practitioner who is not properly licensed or authorized in the state where services are rendered.
    d. Phone consultations; internet consultations; e-mail consultations, except for covered Telehealth Services and Telemedicine Services in the Outpatient Medical Services provision of the Medical Benefits section.
    e. Health Care Practitioner administrative expenses including, but not limited to, expenses for claim filing, contacting utilization review organizations or case management fees.
    f. Missed appointments.
    g. Sales tax; gross receipt tax.
    h. Living expenses; travel; transportation, except as otherwise covered in the Emergency and Ambulance Services provision, or transplants provision in the Medical Benefits section.
    i. Treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.

18. Charges for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth, except as otherwise covered growth hormone therapy services in the Medical Benefits section.

19. Charges related to non-spontaneous abortion.

20. Charges related to the following conditions, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual energy, performance or desire.

21. Charges for:

    a. Genetic testing or counseling, except for BRCA genetic testing, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chorionic villi testing.
    b. Infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any treatment to promote conception.
    c. Cryopreservation of sperm or eggs.
    d. Surrogate pregnancy.
    e. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury.

22. Charges for treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition.

23. Charges for chelation therapy, except for laboratory proven toxic states as defined by peer-reviewed published studies.

24. Charges to address quality of life or lifestyle concerns and similar charges for non-functional conditions.

25. Charges for: behavior modification or behavioral (conduct) problems; learning disabilities; educational testing, training or materials; cognitive enhancement or training; except as covered in the Habilitative Services and Rehabilitative Services provision.

26. Charges for: vocational or work hardening programs; transitional living.

27. Charges for services provided by or through a school system.

28. Charges for:

    a. Non-medical items, self-care or self-help programs.
    b. Aroma therapy.
    c. Meditation or relaxation therapy.
    d. Naturopathic medicine; homeopathic medicine.
    e. Treatment of hyperhidrosis (excessive sweating).
    f. Acupuncture, except when authorized by Us; biofeedback; neurotherapy; electrical stimulation; or Aversion Therapy.
    g. Inpatient treatment of chronic pain disorders, except as Medically Necessary.
    h. Snoring.
    i. The treatment or prevention of hair loss.

j. Change in skin pigmentation.
k. Stress management.
l. Family counseling; marriage counseling.

29. Charges for: drugs that have not been fully approved by the FDA for marketing in the United States; drugs limited by federal law to investigational use; drugs that are used for Experimental or Investigational Services, even when a charge is made; drugs with no FDA-approved indications for use; FDA approved drugs used for indications, dosage or dosage regimens or administration outside of FDA approval, except as otherwise covered in the Outpatient Prescription Drug Benefits section; drugs that are undergoing a review period, not to exceed 12 months, following FDA approval of the drug for use and release into the market; drugs determined by the FDA as lacking in substantial evidence of effectiveness for a particular condition, disease or for symptom control. This exclusion does not apply to the Routine Patient Costs a Clinical Trial Qualified Individual incurs while participating in an Approved Clinical Trial.

30. Charges for treatment or services Incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged.

31. Charges for Prescription Drugs, medications or other substances dispensed or administered in an Outpatient setting, except as covered under the Outpatient Prescription Drug Benefits section or as otherwise noted as a Covered Charge in the Medical Benefits section. Charges for drugs and medicines prescribed for treatment of a Sickness or an Injury that is not covered under this plan. Charges for drugs, medications or other substances that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state. This includes, but is not limited to, items dispensed by a Health Care Practitioner.

32. Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, or a person who ordinarily resides with a Covered Person.

33. Charges for any amount in excess of any Maximum Benefit for covered services.

34. Charges that do not meet the definition of a Covered Charge in this plan including, but not limited to:

    a. Charges in excess of the Maximum Allowable Amount, as determined by Us under this plan except as otherwise shown in the Benefit Summary.
    b. Charges that are not Medically Necessary.

35. Charges Incurred for Experimental or Investigational Services, except for Routine Patient Costs in an Approved Clinical Trial.

36. Charges Incurred outside of the United States, unless the services would have been covered under this plan if the services had been received in the United States.

37. Charges for drugs obtained from pharmacy provider sources outside the United States, except as otherwise covered in the World Wide Coverage provision in the Medical Benefits section.

38. Charges related to Health Care Practitioner assisted suicide.

39. Charges for vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner except for: a) Legend prenatal vitamin Prescription Drugs when the prenatal vitamins are

prescribed during pregnancy; b) Clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake; or c) vitamins covered in accordance with the Preventive Medicine and Wellness Services provision of the Medical Benefits section

40. Charges for any over-the-counter or prescription products, drugs or medications in the following categories, whether or not prescribed by a Health Care Practitioner:

    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries.
    e. Appetite suppressants.
    f. Dietary or nutritional substances or dietary supplements.
    g. Nutraceuticals.
    h. Tube feeding formulas and infant formulas, except those in accordance with the Preventive Medicine and Wellness Services provision of the Medical Benefits section.
    i. Medical foods.

41. Charges for any over-the-counter drugs or medications in the following categories, whether or not prescribed by a Health Care Practitioner: NSAID's, H2 Antagonists, Laxatives, Protectants, PPI's, and Antihistamines.

42. Charges for cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry, except following cranial surgery.

43. Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered for diabetic services under the Medical Benefits section.

44. Charges for: any injectable medications that are not specifically authorized by Us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

45. Charges for: drugs dispensed at or by a Health Care Practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the Covered Person; amounts above the Contracted Rate for Participating Pharmacy or Designated Pharmacy Provider reimbursement; the difference between the cost of the Prescription Order at a Non-Participating Pharmacy or a Non-Designated Pharmacy Provider and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy or a Designated Pharmacy Provider been used; Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by Us before they are dispensed; any administrative charge for drug injections or administrative charges for any other drugs.

46. Charges for treatment, services, supplies or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person's family member. For purposes of this exclusion, "employer" includes, but is not limited to, any corporation, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

47. Charges for treatment, services, supplies or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit,

including but not limited to an ownership interest in any such entity. For purposes of this exclusion, "entity" includes, but is not limited to, any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

48. Charges for treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to, the following: Participating, or instructing, or demonstrating, or guiding or accompanying others in parachute jumping, or hang-gliding, or bungee jumping, or racing any motorized or non-motorized vehicle, skiing or rodeo activities. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.

In addition to the exclusions listed above, the following additional exclusions apply to the Child Vision Services provision. We will not pay Child Vision Services benefits for any of the following:

1. Charges for visual therapy.
2. Charges for two pairs of glasses in lieu of bifocals.
3. Charges for nonprescription (Plano) lenses.
4. Charges for: lost or stolen eyewear; insurance premium for contact lenses or eyewear.
5. Charges for any vision treatment, service, eyewear, or supply not listed in the Child Vision Services provision.

In addition to the exclusions listed above, the following additional exclusions apply to the Child Dental Services provision. We will not pay Child Dental Services benefits for any of the following:

1. Charges for TMJ Dysfunction arthrogram and other TMJ Dysfunction films; tomographic surveys.
2. Charges for Cone Beam CT, Cone Beam multiple images 2 dimension, and Cone Beam multiple images 3 dimension.
3. Charges for viral culture.
4. Charges for saliva analysis, including chemical or biological diagnostic saliva analysis.
5. Charges for caries testing.
6. Charges for adjunctive pre-diagnostic testing.
7. Charges for: declassification procedures; special stains, either for or not for microorganisms; immunohistochemical stains; tissue in-situ-hybridization.
8. Charges for: electron microscopy; direct immunofluorescence; consultation on slides prepared by another provider; consultation with slide preparation; accession transepithelial.
9. Charges for: nutritional counseling; tobacco counseling; instruction on oral hygiene.
10. Charges for removal of fixed space maintainer.
11. Charges for: screw retained surgical replacement; surgical replacement with or without surgical flap; TMJ Disorder appliances and therapy; sinus augmentation with bone or bone substitutes; appliance removal; intraoral placement of a fixation device.
12. Charges for: gold foil surfaces; provisional crown(s); post removal; temporary crown(s); coping; endodontic implant; intentional re-implantation; surgical isolation of tooth; canal preparation; anatomical crown exposure; splinting, either intracoronal or extracoronal; complete interim denture, either upper or lower; partial interim denture, either upper or lower; precision attachment; replacement precision attachment; fluoride gel carrier; custom abutment; provisional pontic; interim pontic; interim retainer crown; connector bar; stress breaker.

13. Charges for orthodontic services and supplies that are not Medically Necessary; charges for Orthodontic Treatment for cosmetic purposes.
14. Charges for: repair of damaged orthodontic appliances; lost or missing orthodontic appliances or replacement thereof.
15. Charges for equilibration, periodontal splinting, full mouth rehabilitation, restoration for misalignment of teeth, or other orthodontic services that restore or maintain the occlusion or alter vertical dimension.
16. Charges for any other dental or orthodontic treatment, service or supply not listed in the Child Dental Services provision.

In addition to the exclusions listed above, the following additional exclusions apply only to the Outpatient Prescription Drug Benefits section. We will not pay benefits for any of the following:

1. Charges for that part of any Prescription Order exceeding a 30 consecutive day supply per Prescription Order, except as otherwise covered in the Outpatient Prescription Drug Benefits section. Charges for that part of any Prescription Order exceeding a 90 consecutive day supply if the Prescription Drug is dispensed through a 90-Day Prescription Drug Provider, except as otherwise covered in the Outpatient Prescription Drug Benefits section.

2. Charges for that part of any Prescription Order exceeding 3 vials or a 30 consecutive day supply of one type of insulin. Charges for that part of any Prescription Order exceeding 9 vials or a 90 consecutive day supply if it is dispensed through a 90-Day Prescription Drug Provider.

3. Charges for that part of any Prescription Order exceeding 100 disposable insulin syringes or needles, 100 disposable blood/urine/glucose/acetone testing agents or 100 lancets or a 30 consecutive day supply. Charges for that part of any Prescription Order exceeding 300 disposable blood/urine/glucose/acetone testing agents or 300 lancets or a 90 consecutive day supply if the supplies are dispensed through a 90-Day Prescription Drug Provider.

4. Charges for drugs that are paid under another plan sponsor or payor as primary payor.

5. Charges for drugs that are not listed in a Drug List. Charges for any Ancillary Charge or any difference between the cost of the Prescription Order at a Non-Participating Pharmacy or a Non-Designated Pharmacy Provider and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy or Designated Pharmacy Provider been used.

6. Charges for Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin, unless authorized by Us under the Outpatient Prescription Drug Benefits section before they are dispensed. Charges for any injectable Prescription Drugs, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed. Any administrative charge for drug injections or administrative charges for any other drugs.

7. Charges for devices or supplies including, but not limited to, blood/urine/glucose/acetone testing devices, needles and syringes, support garments, bandages and other non-medical items regardless of intended use, except as described under a Prescription Order.

8. Charges for over-the-counter (OTC) medications that can be obtained without a Health Care Practitioner's Prescription Order, except for injectable insulin; or drugs that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us, unless specifically authorized for coverage by Us on Our Drug List.

9. Charges for: Compounded Medications that contain one or more active ingredients that are not covered under this plan; combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this plan; combination drugs or drug products that are manufactured and/or packaged together, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed.

10. Charges for: Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order; amounts above the Contracted Rate for Participating Pharmacy or Designated Pharmacy Provider reimbursement.

11. Charges for: drugs administered or dispensed by an Acute Medical Facility, rest home, sanitarium, extended care facility, convalescent care facility, Subacute Rehabilitation Facility or similar institution; drugs administered or dispensed by a Health Care Practitioner, who is not a Participating Pharmacy, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed; drugs consumed, injected or otherwise administered at the prescribing Health Care Practitioner's office; drugs that are dispensed at or by a Health Care Practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the Covered Person.

12. Charges for: any drug used for Cosmetic Services as determined by Us; drugs used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.

13. Charges for: drugs prescribed for dental services except when covered under the Child Dental Services provision, or unit-dose drugs.

14. Charges for Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne or related conditions for a Covered Person age 30 or older.

15. Charges for: duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates.

16. Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns; anabolic steroids are not excluded if Medically Necessary.

17. Charges for drugs used to treat, impact or influence: obesity; morbid obesity; weight management; sex transformation; gender dysphoric disorder; gender reassignment; sexual function, dysfunction or inadequacy sexual energy, performance or desire; skin coloring or pigmentation; social phobias; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness; dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).

18. Charges for drugs or drug categories that exceed any Maximum Benefit limit under this plan.

19. Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition.

20. Charges for prescriptions, dosages or dosage forms used for the convenience of the Covered Person or the Covered Person's Immediate Family Member or Health Care Practitioner.

21. Charges for drugs obtained from pharmacy provider sources outside the United States, except for Covered Charges that are received for Emergency Treatment.

22. Charges for: postage, handling and shipping charges for any drugs.

23. Charges for: vaccines and other immunizing agents; biological sera; blood or blood products.

24. Charges for drugs for which prior authorization is required by Us and is not obtained.

25. Charges for treatment, services, supplies or drugs provided by or through any employer of a Covered Person or the employer of a Covered Person's family member. For purposes of this exclusion, "employer" includes, but is not limited to, any corporation, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

26. Charges for treatment, services, supplies or drugs provided by or through any entity in which a Covered Person or their family member receives, or is entitled to receive, any direct or indirect financial benefit including, but not limited to, an ownership interest in any such entity. For purposes of this exclusion, "entity" includes, but is not limited to, any corporation, organization, partnership, sole-proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

IX. CLAIM PROVISIONS

Proof of Loss
Most providers will file claims directly with Us. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with Us.

We must receive written or electronic notice of the services that were received due to a condition, preventive service, Sickness or Injury for which the claim is made. Notice must be provided to Us within 90 days after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, proof of loss must be sent to Us within 12 months of the date of loss.

The proof of loss must include all of the following:

1. Your name and Policy number.

2. The name of the Covered Person who Incurred the claim.

3. The name and address of the provider of the services.

4. An itemized bill from the provider of the services that includes all of the following as appropriate:

    a. International Classification of Diseases (ICD) diagnosis codes.
    b. International Classification of Diseases (ICD) procedures.
    c. Current Procedural Terminology (CPT) codes.
    d. Healthcare Common Procedure Coding System (HCPCS) level II codes.
    e. National Drug Codes (NDC).
    f. Current Dental Terminology (CDT) codes.

5. A statement indicating whether the Covered Person has coverage for the services under any other insurance plan or program. If the Covered Person has other coverage, include the name and certificate or policy number of the other coverage.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

Right to Collect Information
To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within 90 days of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.

2. Provide Us with information We requested about pending claims, other insurance coverage or proof of creditable coverage.

3. Provide Us with information as required by any contract with Us or a network including, but not limited to, repricing information.

4. Provide Us with information that is accurate and complete.

5. Have any examination completed as requested by Us.

6. Provide reasonable cooperation to any requests made by Us.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.

Physical Examination
We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits or when authorization is requested under the Utilization Review Provisions section. These exams will be paid by Us. We also have the right, in case of death, to have an autopsy done where it is not prohibited by law.

Payment of Benefits
When We receive due written proof of loss, benefits will be paid to the Covered Person unless they have been assigned to a Health Care Practitioner, facility or other provider. We pay Participating Providers directly for Covered Charges. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate or the providers of the services.

We will pay medical and dental claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual, Current Dental Terminology (CDT), or International Classification of Diseases (ICD) manual. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Submitted charges may be applied to the Covered Person's Deductible without review. Application of the charges to the Deductible does not guarantee future coverage of similar expenses. We reserve the right to review any and all claims for eligibility for coverage at the time each claim is submitted. You may request a review while claims are being applied to the Deductible by calling Our Home Office or writing to Us.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.

When We receive due written proof of loss, We will process the claim within 15 working days for claims received electronically and within 30 calendar days after receipt of paper claims. If additional information is required after receiving due written proof of loss, We will mail a notice to the Covered Person which states the reasons for not paying the claim and provide a written itemization of any documents or other information needed to process the claim within 15 working days for claims received electronically and within 30 calendar days after receipt of paper claims. When We have received all of the listed documents or other information needed to process the claim, We will process the claim within 15 working days for claims received electronically and within 30 calendar days after receipt of paper claims. If benefits due are not paid within this timeframe after due written proof of loss and all requested documents and other information needed to determine our liability is received, We will pay interest equal to 12 percent per annum on the benefit amount due under this plan.

Rights of Administration
We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

Claims Involving Fraud or Misrepresentation
Claims will be denied in whole or in part in the event of intentional misrepresentation of material fact or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is

later shown the claims for these benefits involved fraud or intentional misrepresentation of material fact, We will be entitled to a refund from You, the beneficiary or the person receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly file a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

Claim Appeal
You may appeal any coverage or claim determination made by Us to deny, reduce, or terminate the provision or payment for health care services under Your plan. A review must be requested in writing within 180 days following Your receipt of the notice that the claim was denied or reduced.

When we have made an adverse claim determination based on a judgment as to Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, You have the right to have Our decision reviewed by an independent review organization external to Us. A request for an external independent review must be submitted within 4 months from the date You received notice of the adverse determination through Our internal appeal process. Except when a Covered Person's life or health would be seriously jeopardized, You must first exhaust Our internal appeal process before we will grant Your request for an external independent review. Appeals must be submitted in accordance with Our appeal policy and required timeframes, as set forth in Your plan documents.

X. PREMIUM PROVISIONS

Consideration
This plan is issued based on the statements and agreements in the Covered Person's enrollment form, any exam of a Covered Person that is required, any other amendment or supplements to the enrollment form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

Premium Payment
The initial premium must be paid on or before the Effective Date for this coverage to be in force. Subsequent premiums are due as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received in cash or check at Our office on the date due. We may agree to accept premium payment in alternative forms, such as credit card or automatic charge to a bank account. We reserve the right to dishonor any such agreement for payment of premium during the grace period if We tried to obtain payment for the amount due using the alternative method but were unsuccessful.

With advance notice to the Policyholder, We may adjust the premium amount upon any annual renewal date. Your premium may be adjusted from time to time, or on any premium due date, based on changes to Your geographic area, or Your addition or removal of Dependents. The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.

Grace Period
There is a grace period of 31 days for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the last day of the grace period. Coverage will continue during the grace period unless You call Our office or give Us written notice to terminate the coverage. If a claim is payable for charges Incurred during the grace period, any unpaid premiums due will be deducted from the claim payment.

Grace Period for Recipients of Advance Payment of the Premium Tax Credit
If You receive advance payment of the premium tax credit, there is a grace period of 3 months for the payment of each premium due if You have previously paid at least one full month's premium during the Plan Year. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the last day of the first month of the grace period. Coverage will continue during the first month of the grace period unless You call Our office or give Us written notice to terminate the coverage.

Reinstatement
If any premium is not paid within the required time period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than 61 days and has not occurred previously in the same Calendar Year.

2. You submit a supplemental enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.

3. We approve Your enrollment form for reinstatement.

The coverage will be reinstated on the date We approve Your enrollment form for reinstatement.

If the coverage is reinstated, loss resulting from an Injury or Sickness will be covered only for Covered Charges Incurred on or after the date of reinstatement. No benefits will be paid for treatment or services Incurred during the time between the lapse date and the reinstatement date. In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.

XI. RECOVERY PROVISIONS

Overpayment
If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You, the Beneficiary or the provider of the medical treatment, services or supplies. We may offset the overpayment against future benefit payments.

Right of Recovery
If You or Your Covered Dependents have a claim for damages or a right to recover damages from a third party or parties for any Sickness or Injury for which benefits are payable under this plan, We may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical Covered Charges under this plan, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. You or Your attorney must inform Us of any legal action or settlement agreement at least ten days prior to settlement or trial. We will then notify You of the amount We seek to recover for Covered Charges paid by Us. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

Workers' Compensation Not Affected
Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.

XII. CONVERSION

Enrollment, Premium and Effective Date for Conversion Coverage
An eligible person who wants to obtain conversion coverage must submit a written enrollment form and the required premium to Us within 60 days after coverage under this plan terminates. Evidence of insurability will not be required. However, rates may be affected.

If written enrollment is not made within 60 days following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates.

Covered Dependent Conversion
In the event of the Policyholder's death, a Covered Dependent spouse, or eldest Covered Dependent child if no spouse is covered, becomes the Policyholder. A Covered Dependent may be eligible to convert to another plan of medical insurance We offer if the Covered Dependent's insurance terminates due to a valid decree of divorce between the Policyholder and the Covered Dependent.

XIII. OTHER PROVISIONS

Entire Contract
This Policy is issued to the Policyholder. The entire contract of insurance includes the Policy, a Covered Person's enrollment form, and any riders and endorsements.

Policy Changes
The Policy may be changed. We will give the Policyholder at least 30 days notice prior to any change, unless the Policyholder agrees to such changes prior the expiration of such time. No change in the Policy will be valid unless approved by one of Our executive officers and included with or issued as a supplement to this Policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

Clerical Error
If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this Policy.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

Changes to Coverage Required by Law
Coverage under this plan may be changed as required by applicable law as of the first day of the Plan Year, or other date, specified by law or an endorsement or amendment to the Policy.

Conformity with State Statutes
If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

Enforcement of Plan Provisions
Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

Extension of Benefits
If the Covered Person is Totally Disabled on the date this coverage terminates, We will extend benefits for the Sickness or Injury that caused the Total Disability. Benefits are subject to all the terms, limits and conditions in this plan. Premium payment will not be required during the extension of benefits period.

Medical documentation verifying the Covered Person's Total Disability must be submitted to Us within 60 days of termination. The extension will end when the Covered Person is no longer Totally Disabled, or at the end of a 365-day period after the date the Covered Person's coverage terminated, whichever occurs first.

Incentives, Rebates and Contributions
We may elect to furnish or participate in programs with other organizations that furnish individual applicants for coverage or Covered Persons that meet common criteria or requirements determined by Us with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted or where other gifts or items of value may be offered or provided to You at no charge or a discount at a time or times or for a period determined by Us.

Discounted or Free Non-Insurance Programs
We may elect to furnish or participate in programs with other organizations that furnish Policyholders who meet common criteria or requirements determined by Us with discount cards, vouchers, coupons, or other goods, services or programs that may be offered or provided to Covered Persons at no charge or a reduced charge for a period of time determined by Us. We may provide You with access to discounts with certain health care providers and suppliers negotiated by Us.

Family Support Services
We may elect to furnish or participate in programs with other organizations that furnish family support services and goods to You at no charge or at a discount. Family support services are services designed to assist the Covered Person's family or other caregivers with facilitating delivery of or access to covered treatment.

Representations
All statements made by the Covered Person during enrollment are considered to be representations, not warranties.

Misstatements
If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

Rescission of Insurance and/or Denial of Claim
Within the first two years after the Effective Date of coverage, We have the right to modify Your Policy of insurance coverage and/or deny a claim for a Covered Person if the enrollment form contains an intentional omission or misrepresentation which We determine to be material. We also reserve the right to rescind a Policy of insurance and/or deny a claim if a Covered Person has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact at any time during the coverage period. We will give the Policyholder 30 days notice prior to such a rescission of the Policy.

Legal Action
You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the plan. You may want to submit any dispute through Our claims review process prior to filing a suit or legal action. No suit or action at law or in equity can be brought later than 3 years from the date the expenses were Incurred.

Modification of Your Coverage
We may modify the health insurance coverage for You and Your Covered Dependents. This modification will be consistent with state law and will apply uniformly to all Policies with Your plan of coverage. You will be notified of any change. If the change involves a material modification, as defined by federal law, that affects the content of the summary of benefits and coverage (SBC), and does not coincide with the renewal or reissuance of coverage, We will give You 60 days notice prior to the date on which the modification will become effective.

XIV. DEFINITIONS GLOSSARY

When reading this Policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the Policy carefully.

90-Day Prescription Drug Provider
A licensed pharmacy including, but not limited to, a mail order service, that has agreed to Our terms and conditions, including reimbursement amounts, to provide 90-day supplies of covered Prescription Drugs under this plan.

Accident or Accidental
Any event that meets all of the following requirements:
1. It causes harm to the physical structure of the body.
2. It results from an external agent or trauma.
3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
4. It is definite as to time and place.
5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness.

Administrator
An organization or entity designated by Us to manage the benefits provided in this plan. The designated Administrator will have the discretionary authority to act on Our behalf in the administration of this plan. The Administrator may enter into agreements with various providers to provide services covered under this plan.

Ancillary Charge
The difference in cost between a Brand Name Drug and what We will pay for a Generic Drug when a Generic Drug substitute exists but the Brand Name Drug is dispensed. A Covered Person must pay any applicable Ancillary Charge directly to the Participating Pharmacy or Designated Pharmacy Provider.

Ancillary Charge also includes the difference in cost between a Brand Name Drug and a Bio-Similar Drug when a Bio-Similar Drug substitute exists but the Brand Name Drug is dispensed.

The Ancillary Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under this plan.

Ancillary Pharmacy Network Charge
The difference in cost between the actual charge and the maximum amount that a Participating Pharmacy or Designated Pharmacy Provider has agreed to accept as total payment for the cost of a Prescription Drug. The Covered Person must pay any applicable Ancillary Pharmacy Network Charge directly to the Pharmacy. An Ancillary Pharmacy Network Charge may apply if the Covered Person does not use his or her identification (ID) card to obtain Prescription Drugs at a Participating Pharmacy or Designated Pharmacy Provider or if Prescription Drugs are purchased at a Non-Participating Pharmacy or a Non-Designated Pharmacy Provider.

The Ancillary Pharmacy Network Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section or the Medical Benefits section.

Approved Clinical Trial
A clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

1. Federally funded trials: The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a. The National Institutes of Health.
   b. The National Cancer Institute.
   c. The Centers for Disease Control and Prevention.
   d. The Agency for Health Care Research and Quality.
   e. The Centers for Medicare & Medicaid Services.
   f. Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
   g. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   h. The Department of Veterans Affairs, if the conditions for department are met.
   i. The Department of Defense, if the conditions for department are met.
   j. The Department of Energy, if the conditions for department are met.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Assistant Surgeon
A Health Care Practitioner who is qualified by licensure, training and credentialing to perform the procedure in an assistant role to the primary surgeon in the state and facility where the procedure is performed.

Autism
A developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

Average Sales Price
A published cost of a Prescription Drug as listed by Our national drug data bank or by a federal or other national source on the date the Prescription Drug is purchased.

Average Wholesale Price
A published cost of a Prescription Drug that is paid by a Pharmacy to a wholesaler as listed by Our national drug data bank on the date the Prescription Drug is purchased.

Aversion Therapy
A series of procedures, medications or treatments that are designed to reduce or eliminate unwanted or dangerous behavior through the use of negative experience, such as pairing the behavior with unpleasant sensations or punishment.

Behavioral Health
Any condition classified as a mental disorder in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us, including Autism.

Behavioral Health Facilities and Programs
The following Behavioral Health Facilities and Programs are defined in this plan:

1. **Acute Behavioral Health Inpatient Facility:** A facility that provides acute care or Subacute Medical Care for Behavioral Health or Substance Abuse on an Inpatient basis. This type of facility must meet all of the following requirements:

    a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care or Subacute Medical Care for Behavioral Health or Substance Abuse.
    b. Be staffed by an on duty licensed physician 24 hours per day.
    c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
    d. Maintain daily medical records that document all services provided for each patient.
    e. Provide a restrictive environment for patients who present a danger to self or others.
    f. Provide alcohol and chemical dependency detoxification services.
    g. Handle medical complications that may result from a Behavioral Health or Substance Abuse diagnosis.
    h. Not primarily provide Rehabilitative Services, residential, partial hospitalization or intensive Outpatient services although these services may be provided in a distinct section of the same physical facility.

2. **Behavioral Health Rehabilitation and Residential Facility:** A facility that provides care for Behavioral Health or Substance Abuse on an Inpatient basis. This type of facility may also be referred to as a residential facility and must meet all of the following requirements:

    a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide residential care for Behavioral Health or residential/rehabilitation care for Substance Abuse.
    b. Be staffed by an on call physician 24 hours per day.
    c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
    d. Provide an initial evaluation by a physician upon admission and ongoing evaluations for patients on a regular basis.
    e. Provide a restrictive environment for patients who present a danger to self or others.
    f. Provide at least 3 hours per day of individual or group psychotherapy by an appropriately licensed Health Care Practitioner 6 days per week. Recreational therapy, educational therapy, music and dance therapy and similar services may be provided but are not included in the 3 hour minimum per day requirement of psychotherapy.
    g. Be able to handle medical complications that may result from a Substance Abuse diagnosis.
    h. Not primarily provide partial hospitalization or intensive Outpatient services although these services may be provided in a distinct section of the same physical facility.

3. **Intensive Outpatient Behavioral Health Program:** A program that provides care for Behavioral Health or Substance Abuse on an Outpatient basis. Room and board and overnight services are not covered. This type of program must meet all of the following requirements:

    a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide care for Behavioral Health or Substance Abuse.
    b. Provide at least 6 hours of therapeutic intervention per week. Therapeutic intervention consists of at least 2 hours per week of individual or group psychotherapy by an appropriately licensed Health Care Practitioner. Chemical dependency support, medication, education and similar services may be provided but are not included in the 2 hour minimum requirement of psychotherapy.

4. **Partial Hospital and Day Treatment Behavioral Health Facility or Program:** A program that provides care for Behavioral Health or Substance Abuse on an Outpatient basis. Room and board and overnight services are not covered. This type of program must meet all of the following requirements:

    a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide care for Behavioral Health or Substance Abuse.
    b. Provide at least 3 hours of individual or group psychotherapy by an appropriately licensed Health Care Practitioner 1 to 5 days per week. Recreational therapy, educational therapy, music and dance therapy and similar services may be provided but are not included in the 3 hour minimum requirement of psychotherapy.

Benefits Deductible for Other Insurance
The value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis including, but not limited to, any government program (except Medicare and Medicaid). "Benefits Deductible" does not mean the value of benefits provided with respect to medical or liability insurance offered under either a general liability insurance policy or an auto insurance policy.

Bio-Similar Drug
An FDA-approved biological product that is nearly the same as another US-licensed reference biological product except for differences in clinically inactive components and for which there are no clinically meaningful differences in safety and potency between the biological product and the reference product.

Brand Name Drug
A Prescription Drug for which a pharmaceutical company has received a patent or trade name.

Calendar Year
The period beginning on January 1 of any year and ending on December 31 of the same year.

Cardiac Rehabilitation Program
An Outpatient program that is supervised by a Health Care Practitioner and directed at improving the physiological well-being of a Covered Person with heart disease.

Clinical Trial Qualified Individual
A Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition and either:

1. The referring Health Care Practitioner is a Participating Provider and has concluded that the Covered Person's participation in such trial would be appropriate based on the trial protocol; or

2. The Covered Person provides medical and scientific information establishing that participation in such trial would be appropriate based upon the trial protocol.

Coinsurance
Coinsurance is the dollar amount or percentage of Covered Charges that must be paid by a Covered Person after any Emergency Room Access Fee, Copayment and Deductible are satisfied. Coinsurance applies separately to each Covered Person, except as otherwise provided by this plan.

The Benefit Summary will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which it applies.

Compounded Medication
A drug product made up of two or more active parts or ingredients which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered to be Non-Preferred Brand Name Drugs.

Contracted Rate
The amount a Health Care Practitioner, facility, Participating Pharmacy, Designated Pharmacy Provider or supplier that has a contract with Us or Our Network Manager, as identified for this plan, has agreed to accept as total payment for the treatment, services, supplies or Prescription Drugs provided.

Copayment
A Copayment is the dollar amount that a Covered Person must pay to a Health Care Practitioner or facility each time certain visits or services are received. This amount does not count toward satisfying any Emergency Room Access Fee, Deductible, or Coinsurance. Covered Charges in the Medical Benefits section that require a Copayment are not subject to any Deductible.

A Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.

Cosmetic Services
A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Covered Charge
An expense that We determine meets all of the following requirements:
1. It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.
2. It is Incurred by a Covered Person while coverage is in force under this plan as the result of a Sickness or an Injury or for preventive medicine services as outlined in the Medical Benefits section.
3. It is Incurred for services or supplies listed in the Medical Benefits section or Outpatient Prescription Drug Benefits section.
4. It is Incurred for treatment, services or supplies which are Medically Necessary.
5. It is not in excess of the Maximum Allowable Amount.

Charges from the Covered Person's Non-Participating Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by Us.

Covered Dependent
A person who meets the definition of a Dependent and is enrolled and eligible to receive benefits under this plan.

Covered Person
A person who is eligible to receive benefits under this plan.

Custodial Care
Care, regardless of setting, that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient. Custodial Care:

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or
2. Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or

preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or
3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.

Deductible or Plan Deductible
A Deductible is the dollar amount of Covered Charges that must be paid before benefits are paid by Us.

This plan has varying types of Deductibles. This may depend on whether the Covered Person's Health Care Practitioner belongs to a particular network or not. A Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Deductibles are along with the Covered Charges to which they apply.

The Deductible is the larger of:

1. The Deductible amount shown in the Benefit Summary; or

2. Benefits Deductible for Other Insurance. If the Covered Person receives coverage under Other Insurance, We will consider benefits under this Policy only after benefits are paid under all other plans. If the Benefits Deductible for Other Insurance is used as the Deductible for Covered Charges, We will pay the balance of those Covered Charges at 100% minus any applicable Access Fee or Copayment, but Our payment will not exceed the amount that would have been paid if the Covered Person did not have Other Insurance.

One or more of the following Deductibles may apply to Covered Charges as shown in the Benefit Summary:

1. **Carryover Deductible:** Covered Charges Incurred by a Covered Person during the last 3 months of a Calendar Year, that count toward satisfying a Covered Person's Individual Deductible, will also count toward satisfying the Covered Person's Individual Deductible for the next Calendar Year. This Carryover Deductible does not count toward satisfying the Child Dental Services Deductible or Family Deductible. For the purpose of determining whether a Carryover Deductible applies, Covered Charges will be considered to apply toward the Individual Deductible in the order the Covered Charges are processed.

2. **Family Deductible:** The Individual Deductibles that all Covered Persons may have to pay are limited to the Family Deductible amount. When the Family Deductible amount is reached, We will consider the Deductible requirements for all Covered Persons in Your family to be satisfied for the remainder of the Calendar Year.

3. **Individual Deductible:** The dollar amount of Covered Charges each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Individual Deductible have been Incurred and processed by Us, the Individual Deductible for that Covered Person will be satisfied for the remainder of the Calendar Year.

4. **Integrated Deductible:** Covered Charges Incurred by all Covered Persons count toward satisfying a single Deductible. When Covered Charges equal to the Integrated Deductible have been Incurred and processed by Us, the Integrated Deductible for all Covered Persons will be satisfied for the remainder of the Calendar Year.

5. **Participating Provider Deductible:** The dollar amount of Covered Charges received from providers in the Participating Provider Network that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Participating Provider Deductible have been Incurred and

processed by Us, the Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the Calendar Year.

6. **Non-Participating Provider Deductible:** The dollar amount of Covered Charges received from Non-Participating Providers that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Non-Participating Provider Deductible have been Incurred and processed by Us, the Non-Participating Provider Deductible for that Covered Person will be satisfied for the remainder of the Calendar Year.

Dental Hygienist
A person licensed by the state or other geographic area in which the Covered Charges are rendered to practice dental hygiene under the supervision of a Dentist. The Dental Hygienist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Dental Injury
Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.

Dental Treatment
Any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Dental Treatment Plan
A dentist's report of recommended treatment, or orthodontist's report of recommended Orthodontic Treatment, on a form satisfactory to Us that:
1. Itemizes the dental procedures and charges required for care of the mouth; and
2. Lists the charges for each procedure; and
3. Is accompanied by supporting preoperative imaging tests and any other appropriate diagnostic materials required by Us.

Dentist
A person licensed by the state or other geographic area in which the Covered Charges are rendered to practice dentistry. The Dentist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Denturist
A person licensed by the state or other geographic area in which the Covered Charges are rendered to make dentures. The Denturist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Dependent
A Dependent is:

1. The Policyholder's lawful spouse; or
2. The Policyholder's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder, a stepchild or a child for which the Policyholder is the legal guardian, or a child for whom the Policyholder is required to provide coverage by a court or administrative order or a National Medical Support Notice, a Title IV-D support case of the Social Security Act, who is under 26 years of age at the time of enrollment in this plan.

If Your child is age 26 or older, the child will be considered a Dependent if You give Us proof that the child is not capable of self-sustaining employment because of mental retardation or physical disability as determined by the Georgia Department of Human Resources. The child must also be chiefly dependent on

the Policyholder for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan or within 31days after the child reaches the normal age for termination. Additional proof may be requested periodically but not more often than annually after the 2-year period following the date the child reaches the limiting age for termination.

If this is a child-only plan, the youngest child will be considered the Policyholder. All siblings of the Policyholder will be considered Covered Dependents if they meet the requirements above.

Designated Eyewear Provider
An eyewear supplier under contract with Us or Our Eyewear Benefit Manager to distribute covered Pediatric Eyewear Collection under the Child Vision Services provision of this plan.

Designated Pharmacy Network
A Prescription Drug delivery system for Specialty Pharmaceuticals that is established by Us or the Network Manager in which Designated Pharmacy Providers are under contract with Us or Our Network Manager. The list of Designated Pharmacy Providers is subject to change at any time without notice.

Designated Pharmacy Provider
A Pharmacy under contract with Us or Our Network Manager to distribute specific Specialty Pharmaceuticals to the Covered Person through Our Designated Pharmacy Network. A Pharmacy will only be considered a Designated Pharmacy Provider when they are designated as such by Us for the specific Specialty Pharmaceutical being obtained. This list is subject to change at any time without notice.

Designated Transplant Provider
A Health Care Practitioner, facility or supplier, as determined by Us, that a Covered Person must use to obtain the maximum benefits available under the transplant provision in the Medical Benefits section.

Developmental Delay
A child who has not attained developmental milestones for the child's age, adjusted for prematurity, in one or more of the following areas of development: cognitive; physical (including vision and hearing); communication; social-emotional; or adaptive development. A Developmental Delay is a delay that has been measured by qualified personnel using informed clinical opinion and appropriate diagnostic procedures and/or instruments. A Developmental Delay must be documented as:

1. A 12 month delay in one functional area; or
2. A 33% delay in one functional area or a 25% delay in each of two areas (when expressed as a quotient of developmental age over chronological age); or
3. A score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas if appropriate standardized instruments are individually administered in the evaluation.

Diagnostic Imaging
Procedures and tests including, but not limited to, x-rays, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition or determine the nature of a condition.

Drug List
The lists of Prescription Drugs that We designate as eligible for benefit consideration under this plan. There may be more than one Drug List including, but not limited to, a separate list for Specialty Pharmaceuticals. The Drug Lists are subject to change at any time without notice.

Durable Medical Equipment
Equipment that meets all of the following requirements:

1. It is designed for and able to withstand repeated use.
2. It is primarily and customarily used to serve a medical purpose.
3. It is used by successive patients.
4. It is suitable for use at home.
5. It is normally rented.

Effective Date
The date coverage under this plan begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time at the Policyholder's state of residence.

Emergency Confinement
An Inpatient stay for a medical condition that requires Emergency Treatment.

Emergency Room
A place affiliated with and physically connected to an Acute Medical Facility and used primarily for short term Emergency Treatment.

Emergency Room Access Fee
The initial dollar amount that must be paid directly to the facility for an Emergency Room visit. Deductible and Coinsurance apply to the remaining Covered Charges for Emergency Treatment after the Emergency Room Access Fee has been assessed. We will waive an Emergency Room Access Fee if the Covered Person is admitted for an Inpatient stay immediately following the Emergency Room visit. The Emergency Room Access Fee will not be reimbursed by Us nor does it count toward satisfying any Deductible or Coinsurance.

Emergency Treatment
Treatment, services or supplies that are provided for a Sickness or an Injury that is of recent onset and sufficient severity including, but not limited to, severe pain that would lead a prudent person, possessing an average knowledge of medicine and health, to believe that the condition is of such a nature that failure to obtain medical care immediately or within 72 hours after the onset of symptoms could result in:

1. Placing the person's health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Essential Health Benefits
Benefits, consistent with those set forth in PPACA, included in the following categories: ambulatory patient services, hospitalization, emergency services, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, Preventive Benefits and chronic disease management and pediatric services, including oral and vision care.

Experimental or Investigational Services
Treatment, services, supplies or equipment which, at the time the charges are Incurred, We determine are:

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or
5. Medications used for non-FDA approved indications and/or dosage regimens.

For any device, drug, or biological product, final approval must have been received to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption, is not sufficient.

Only We can make the determination as to whether charges are for Experimental or Investigational Services based on the following criteria:

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:
   a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
   b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.

2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:
   a. The American Medical Association Drug Evaluations; or
   b. The American Hospital Formulary Service Drug Information; or
   c. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.

3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:
   a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
   b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
   c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.

Eyewear Benefit Manager
Us or an entity designated by Us to maintain the Pediatric Eyewear Collection. The collection list is subject to change at any time without notice. The Eyewear Benefit Manager may also distribute child eyewear, including glasses (frames and lenses) or contact lenses. Call Us to verify the name of the Eyewear Benefit Manager.

Family Plan
A plan of insurance covering the Policyholder and one or more of the Policyholder's Dependents.

Female At Risk
A woman:

1. Who has a personal history of breast cancer; or

2. Who has a personal history of biopsy proven benign breast disease; or

3. Whose grandmother, mother, sister or daughter has had breast cancer; or

4. Who has not given birth prior to age 30.

Generic Drug
A Prescription Drug that:
1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

It must be listed as a Generic Drug by Our national drug data bank on the date it is purchased. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by Our national drug data bank on the date it is purchased and it must be approved by Us.

Habilitative Services
Specialized treatment for a disabling condition, including developmental delay, which meets all of the following requirements:
1. Is a program of services provided by one or more members of a multi-disciplinary team.
2. Is designed for the Covered Person to attain and maintain a skill or function and independence that was never learned or acquired.
3. Is under the direction of a qualified Health Care Practitioner.
4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.
5. May be provided in either an Inpatient or Outpatient setting.

Health Care Practitioner
A person licensed by the state or other geographic area in which the Covered Charges are rendered to treat the kind of condition, Sickness or Injury or provide preventive or wellness services for which a claim is made. This term includes, but is not limited to, services of a licensed dentist, psychologist, chiropractor, optometrist and a qualified athletic trainer when performing services otherwise covered under this plan. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Health Care Provider Network
The group of Health Care Practitioners, facilities and suppliers, identified by Us or the Network Manager for this plan, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies, except for Specialty Pharmaceuticals. For Specialty Pharmaceuticals, only Designated Pharmacy Providers identified by Us for this plan, who have agreed to accept a Contracted Rate as payment in full for specific Specialty Pharmaceuticals are considered members of the Health Care Provider Network. This list is subject to change at any time without notice.

Home Health Care
Services provided by a state licensed Home Health Care Agency as part of a program for care and treatment in a Covered Person's home.

Home Health Care Agency
An organization:
1. Whose primary purpose is to provide Home Health Care; and
2. That is certified by Medicare; and

3. That is licensed as a Home Health Care Agency by the state in which it provides services.

Home Office
Our office in Milwaukee, Wisconsin or other administrative offices as indicated by Us.

Hospice
An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of 6 months or less as certified by a physician. A Hospice must meet all of the following requirements:
1. Comply with all state licensing requirements.
2. Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
3. Provide a treatment plan and services under the direction of a physician.

An Inpatient Hospice facility must meet all of the following requirements in addition to the requirements above:
1. Be a dedicated unit within an Acute Medical Facility or a Subacute Rehabilitation Facility or a separate facility that provides Hospice services on an Inpatient basis.
2. Be licensed by the state in which the services are rendered to provide Inpatient Hospice services.
3. Be staffed by an on call physician 24 hours per day.
4. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
5. Maintain daily clinical records.
6. Admit patients who have a terminal illness.
7. Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided

Immediate Family Member
An Immediate Family Member is:
1. You or Your spouse or
2. The children, brothers, sisters and parents of either You or Your spouse; or
3. The spouses of the children, brothers and sisters of You and Your spouse or
4. Anyone with whom a Covered Person has a relationship based on a legal guardianship.

Incur or Incurred
The date services are provided or supplies are received.

Injury
Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Inpatient
Admitted to an Acute Behavioral Health Inpatient Facility, an Acute Medical Facility or other licensed facility for a stay of at least 24 hours for which a charge is Incurred for room and board or observation.

Mail Service Prescription Drug Vendor
A Participating Pharmacy that is under contract with Us or Our Network Manager through Our Participating Pharmacy Network. The Mail Service Prescription Drug Vendor dispenses selected Prescription Maintenance Drugs to Covered Persons through the mail.

Malocclusion
Teeth that do not fit together properly which creates a bite problem.

Mandibular Protrusion or Recession
A large chin which causes an underbite or a small chin which causes an overbite.

Maxillary or Mandibular Hyperplasia
Excess growth of the upper or lower jaw.

Maxillary or Mandibular Hypoplasia
Undergrowth of the upper or lower jaw.

Maximum Allowable Amount
The maximum amount of a billed charge We will consider when determining Covered Charges, as determined by Us. Benefit payments of Covered Charges are not based on the amount billed but, rather, they are based on what We determine to be the Maximum Allowable Amount. Amounts billed in excess of the Maximum Allowable Amount by or on behalf of a Health Care Practitioner, facility or supplier are not payable by Us under this contract. Please see the Provider Charges and Maximum Allowable Amount Provisions section for the method(s) We use to determine the Maximum Allowable Amount.

Maximum Allowable Cost (MAC) List
A list of Prescription Drugs that are considered for reimbursement at a Generic Drug product level that is established by Us. This list is subject to change at any time without notice.

Maximum Benefit
The maximum amount, as shown in the Benefit Summary, that We will consider as Covered Charges Incurred by each Covered Person under this plan. This maximum will apply even if coverage under this plan is interrupted. When the Maximum Benefit has been reached, no other benefits are considered as Covered Charges for that Covered Person for the treatment, services or supplies to which the maximum applies.

Medical Emergency
The sudden and unexpected onset of a condition with severe symptoms, requiring medical care which is secured immediately after the onset or within 72 hours after the onset of symptoms. The Sickness or condition as finally diagnosed must be one which would require immediate medical, not surgical, care. Sudden, unexpected, severe medical conditions or symptoms are those which are or which give evidence of being life threatening. Previously diagnosed chronic conditions in which subacute symptoms have existed over a period of time are not considered as a Medical Emergency unless symptoms suddenly become so severe as to require immediate medical aid.

The following conditions qualify as a Medical Emergency provided the requirements stated above are met:

1. Appendicitis.
2. Acute asthma.
3. Breathing difficulties or shortness of breath.
4. Severe bronchitis.
5. Severe onset of bursitis.
6. Severe chest pain.
7. Choking.
8. Coma.
9. Convulsions or seizures.
10. Cystitis.
11. Dermatitis or hives (resulting from internal or unknown causes).
12. Diabetic coma.
13. Severe diarrhea.
14. Drug reaction.
15. Epistaxis (nosebleed).
16. Fainting.
17. Severe fecal impaction.

18. Food poisoning.
19. Frostbite.
20. Acute attack of gall bladder.
21. Gastritis.
22. Acute gastrointestinal conditions.
23. Severe headache.
24. Suspected heart attack.
25. Hemorrhage.
26. Hysteria.
27. Insertion of catheter (for acute retention).
28. Insulin shock (overdose).
29. Kidney stone.
30. Maternity complication such as a suspected miscarriage.
31. Sudden or severe onset of pain.
32. Pleurisy.
33. Pneumonitis.
34. Poisoning (including overdoses).
35. Pyelitis.
36. Pyelonephritis.
37. Shock.
38. Cerebral or cardiac spasms.
39. Spontaneous pneumothorax.
40. Severe stomach pains.
41. Strangulated hernia.
42. Stroke.
43. Sunstroke.
44. Swollen ring finger.
45. Tachycardia.
46. Thrombosis or phlebitis.
47. Unconsciousness.
48. Acute urinary retention.
49. Sudden onset of vision loss.
50. Severe vomiting.

Medical Facilities
The following Medical Facilities are defined in this plan:

1. **Acute Medical Facility (Hospital):** A facility that provides acute care or Subacute Medical Care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long term acute care facility and must meet all of the following requirements:
    a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care or Subacute Medical Care.
    b. Be staffed by an on duty physician 24 hours per day.
    c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
    d. Maintain daily medical records that document all services provided for each patient.
    e. Provide immediate access to appropriate in-house laboratory and imaging services.

f. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility.
g. Provide care in an intensive care unit (ICU), a neonatal intensive care unit (NICU), a coronary intensive care unit (CICU) and step-down units.

2. **Acute Medical Rehabilitation Facility:** A facility that provides acute care for Rehabilitative Services for a Sickness or an Injury on an Inpatient basis. A distinct section of an Acute Medical Facility solely devoted to providing acute care for Rehabilitation Services would also qualify as an Acute Medical Rehabilitative Facility. These types of facilities must meet all of the following requirements:
   a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF) to provide acute care for Rehabilitative Services.
   b. Be staffed by an on duty physician 24 hours per day.
   c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
   d. Provide an initial, clearly documented care plan upon admission and ongoing care plans for patients on a regular basis that include reasonable, appropriate and attainable short and intermediate term goals.
   e. Provide a total of at least 3 hours per day of any combination of active Physical Therapy, Occupational Therapy and Speech Therapy by an appropriately licensed Health Care Practitioner to each patient at least 6 days per week. A Covered Person must be able and willing to participate actively in these services for at least the above referenced time frames. Cognitive therapy, counseling services, passive range of motion therapy, respiratory therapy and similar services may be provided but are not included in the 3 hour minimum per day requirement of active Physical Therapy, Occupational Therapy and Speech Therapy.
   f. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility.

3. **Free-Standing Facility:** A facility that provides interventional services, on an Outpatient basis, which require hands-on care by a physician and includes the administration of general or regional anesthesia or conscious sedation to patients. This type of facility may also be referred to as an ambulatory surgical center, an interventional diagnostic testing facility, a facility that exclusively performs endoscopic procedures or a dialysis unit. A designated area within a Health Care Practitioner's office or clinic that is used exclusively to provide interventional services and administer anesthesia or conscious sedation is also considered to be a Free-Standing Facility. Room and board and overnight services are not covered. These facilities must meet all of the following requirements:

   a. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
   b. Not primarily provide care for Behavioral Health or Substance Abuse or be an Urgent Care Facility.

4. **Nursing Facility:** A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility must meet all of the following requirements:
   a. Be licensed by the state to provide skilled nursing services.
   b. Be staffed by an on call physician 24 hours per day.
   c. Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day.
   d. Maintain daily clinical records.
   e. Not primarily be a place for rest, for the aged or for Custodial Care or provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same

physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this plan.

5. **Subacute Rehabilitation Facility:** A facility that provides Subacute Medical Care for Rehabilitative Services for a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of the following requirements:
   a. Be licensed by the state in which the services are rendered to provide Subacute Medical Care for Rehabilitative Services.
   b. Be staffed by an on call physician 24 hours per day.
   c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
   d. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this plan.

6. **Urgent Care Facility:** A facility that is attached to an Acute Medical Facility but separate from the Emergency Room or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:
   a. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
   b. Be staffed by an on duty physician during operating hours.
   c. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.
   d. Provide immediate access to appropriate in-house laboratory and imaging services.

Medical Review Manager
Our Company or an organization or entity, designated by Us, which may:
1. Review services as required by the Utilization Review Provisions section; or
2. Perform discharge planning and case management services; or
3. Evaluate the Medical Necessity of treatment, services or supplies; or
4. Administer treatment for Behavioral Health or Substance Abuse through Health Care Practitioners, facilities or suppliers; or
5. Review a Covered Person's Behavioral Health or Substance Abuse condition and evaluate the Medical Necessity of referral treatment.
6. Review and administer authorization under Our Specialty Pharmacy Program.

The Medical Review Manager's name is shown on the insurance coverage identification (ID) card.

Medical Supplies
Disposable medical products or Personal Medical Equipment that are used alone or with Durable Medical Equipment.

Medical Supply Provider
Agencies, facilities or wholesale or retail outlets that make medical supplies available for use.

Medically Necessary or Medical Necessity
For medical treatment:
Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury, and that We determine:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

For dental treatment:
For purposes of dental coverage under this plan, Medically Necessary means Dental Treatment or Orthodontic Treatment rendered to diagnose or treat a dental or orthodontic condition that left untreated would likely result in medical or functional impairment, and that We determine:
1. Is essential for the care of the teeth and supporting tissues; and
2. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis and treatment of the condition; and
3. Is commonly accepted as proper care or treatment of the condition in accordance with United States dental standards and federal government guidelines; and
4. Can reasonably be expected to result in or contribute substantially to the improvements of a condition; and
5. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of care provided; and
6. Is rendered for non-cosmetic reasons.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

For vision treatment:
For purposes of vision coverage under this plan, Medically Necessary means vision services rendered to diagnose or treat a vision condition, and that We determine:
1. Is essential for the care of the eyes and sight; and
2. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis and treatment of the condition; and
3. Is commonly accepted as proper care or treatment of the condition in accordance with United States ophthalmologic standards and federal government guidelines; and
4. Can reasonably be expected to result in or contribute substantially to the improvements of a condition; and
5. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Medicare
Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.

Negotiated Rate
The amount negotiated between Us, or on behalf of Us, and the Health Care Practitioner, facility or supplier as total payment for the services or supplies provided, except for Specialty Pharmaceuticals, where it is the amount negotiated only between Us and a Designated Pharmacy Provider, Health Care Practitioner, facility or supplier as total payment for the Specialty Pharmaceuticals. The Negotiated Rate may include any discount arrangement We may have with the Designated Pharmacy Provider, Health Care Practitioner, facility or supplier.

Network Manager
An organization or entity, designated by Us, which may administer the Health Care Provider Network, Participating Provider Network, Participating Pharmacy Network or Designated Pharmacy Network. The Network Manager's name is shown on the insurance coverage identification (ID) card.

Non-Designated Pharmacy Provider
Any Health Care Practitioner, facility or supplier, not identified for this plan by Us or the Network Manager, as participating when obtaining Specialty Pharmaceuticals. Any provider that is not a Designated Pharmacy Provider by Us for the specific Specialty Pharmaceutical being dispensed is considered a Non-Designated Pharmacy Provider. Benefits for a Specialty Pharmaceutical that is obtained from a Non-Designated Pharmacy Provider are paid the same as if the drug was obtained from a Designated Pharmacy Provider. However, You will have to pay any difference between the Non-Designated Pharmacy Provider's billed charge and the Contracted Rate.

Non-Participating Pharmacy
A Pharmacy that is not under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network or Designated Pharmacy Network.

Non-Participating Provider
Any Health Care Practitioner, facility or supplier, not identified for this plan by Us or the Network Manager, as participating. When obtaining Specialty Pharmaceuticals, any provider not designated by Us as a Designated Pharmacy Provider for the specific Specialty Pharmaceutical being dispensed is considered a Non-Participating Provider or a Non-Designated Pharmacy Provider.

Occupational Therapy
The treatment of Sickness or Injury, by a Health Care Practitioner who is an occupational therapist, using purposeful activities or assistive devices that focus on all of the following:

1. Developing daily living skills.
2. Strengthening and enhancing function.
3. Coordination of fine motor skills.
4. Muscle and sensory stimulation

Office Visit
An in-person meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury, including Behavioral Health and Substance Abuse disorders, as defined in the most recent edition of the Current Procedural Terminology (CPT) or provides preventive medicine services. Office Visit does not include service of Physical therapy, Speech Therapy, or Occupational therapy, even if rendered in an office setting.

Orthodontic Treatment
The corrective movement of teeth through the bone by means of an active appliance to correct a handicapping Malocclusion (a malocclusion severely interfering with a person's ability to chew food) of the mouth. We will make the determination of the severity of the Malocclusion.

Other Insurance
Any plan that provides benefits on an expense incurred basis for services that are also covered by this policy. If coverage is provided on a service basis instead of cash payments, We will determine a reasonable charge for the service and that amount will be considered the amount paid by the Other Insurance plan. Other Insurance will not include benefits provided by medical or liability insurance offered under either a general liability policy or an auto insurance policy.

Out-of-Pocket Limit
The Out-of-Pocket Limit is the sum of the Covered Charges each Calendar Year for which We do not pay benefits. When Covered Charges equal to the Out-of-Pocket Limit have been Incurred and processed by Us, the Out-of-Pocket Limit will be satisfied for the remainder of the Calendar Year. The Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this plan.

The following do not count toward satisfying any Out-of-Pocket Limit:
1. All penalties applied under the Utilization Review Provisions section.
2. Amounts in excess of the Maximum Allowable Amount.
3. Charges Incurred after the Maximum Benefit has been paid for a benefit under this plan.
4. All Ancillary Charges and Ancillary Pharmacy Network Charges**.**
5. All charges for Specialty Pharmaceuticals obtained from a provider that is not a Designated Pharmacy Provider.
6. All Non-Participating Provider charges for which the Benefit Summary states Coinsurance does not apply to the Out-of-Pocket Limit.
7. All charges that are not Covered Charges.

The Benefit Summary identifies the following Out-of-Pocket Limits, if applicable.

1. **Individual Out-of-Pocket Limit:** The dollar amount of Covered Charges that must be paid by each Covered Person before the Out-of-Pocket Limit is satisfied for that Covered Person for the remainder of the Calendar Year.
2. **Family Out-of-Pocket Limit:** The total dollar amount of Covered Charges that must be paid by You and Your Covered Dependents before We will consider the Out-of-Pocket Limit for all Covered Persons under the same Family Plan to be satisfied for the remainder of the Calendar Year.
3. **Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from providers in the Participating Provider Network that must be paid by each Covered Person before the Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person for the remainder of the Calendar Year.
4. **Non-Participating Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from Non-Participating Providers that must be paid by each Covered Person before the Non-Participating Provider Out-of-Pocket Limit is satisfied for that Covered Person for the remainder of the Calendar Year.

Outpatient
Treatment, services or supplies received at a licensed medical facility, Health Care Practitioner’s office or dispensary on other than an Inpatient basis for a stay of less than 24 hours.

Participating Pharmacy
A Pharmacy that is under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network or Designated Pharmacy Network.

Participating Pharmacy Network
A Prescription Drug delivery system established by Us or the Network Manager in which Participating Pharmacies are under contract with Us or Our Network Manager. For purposes of obtaining Specialty Pharmaceuticals, only Designated Pharmacy Providers are considered members of the Participating Pharmacy Network. The list of Participating Pharmacies is subject to change at any time without notice.

Participating Provider
Any Health Care Practitioner, facility or supplier that is:

1. Identified for this plan by Us or the Network Manager, as participating; and
2. Who has agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies, except that in the case of Specialty Pharmaceuticals only Designated Pharmacy Providers are considered Participating Providers for purposes of this plan. For purposes of Child Vision Services eyewear benefits, only Designated Eyewear Providers are considered Participating Providers under this plan and only when the eyewear dispensed to the Covered Person is part of Our Pediatric Eyewear Collection.

This list is subject to change at any time without notice. The Health Care Provider Network may be made up of various levels of provider networks.

Participating Provider Network
The group of Participating Providers within the Health Care Provider Network, identified for this plan by Us or the Network Manager, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. For purposes of obtaining Specialty Pharmaceuticals, only Designated Pharmacy Providers are considered members of the Participating Provider Network. This list is subject to change at any time without notice. For purposes of Child Vision Services eyewear benefits, only Designated Eyewear Providers are considered members of the Participating Provider Network under this plan and only when the eyewear dispensed to the Covered Person is part of Our Pediatric Eyewear Collection.

Pediatric Eyewear Collection
The collection of eyewear, including glasses, lenses, frames and contact lenses designated by Our Eyewear Benefit Manager for coverage under the Child Vision Services provision of this plan.

Period of Confinement
The initial and subsequent Inpatient stays resulting from the same or a related Sickness or Injury and/or any complications unless the current Inpatient stay begins more than 30 days after the date of discharge from the most recent Inpatient stay.

Periodontal Maintenance Procedure
The recall procedures for Covered Persons who have undergone either surgical or non-surgical Dental Treatment for periodontal disease. The procedures may include Medically Necessary examination, periodontal evaluation, and any further scaling and root planning.

Personal Medical Equipment
Equipment, such as a prosthesis, that meets all of the following:

1. Is designed for and able to withstand repeated use; and
2. Is primarily and customarily provided to serve a medical purpose; and
3. Is not intended for use by successive patients.

Pharmacy
A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

Physical Medicine
Treatment of physical conditions relating to bone, muscle or neuromuscular pathology. This treatment focuses on restoring function using mechanical or other physical methods.

Physical Therapy
The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and alleviating pain. Physical Therapy also includes massage therapy as part of an approved Physical Therapy regimen.

Plan Year or Policy Year
The 12-month period beginning on January1st of any year while coverage is inforce and ending on December 31st of the same calendar year.

Policy
This contract issued by Us to the Policyholder providing benefits for Covered Persons.

Policyholder
The person to whom the Policy is issued as shown in the Benefit Summary.

Prescription Card Service Administrator (PCSA)
An organization or entity that administers the processing of claims under the Outpatient Prescription Drug Benefits section. This organization or entity may be changed at any time without notice.

Prescription Drug
Any medication that:
1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States; and
2. Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws; and
3. Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or “Rx Only” on the manufacturer's label, or similar wording as designated by the FDA.

Prescription Drug Copayment
A Prescription Drug Copayment is the dollar amount of Covered Charges that a Covered Person pays each time a Prescription Order is received that is covered under the Outpatient Prescription Drug Benefits section after any applicable Prescription Drug Deductible is satisfied. The Covered Person must pay any applicable Prescription Drug Copayment directly to the Participating Pharmacy or Designated Pharmacy Provider.

A Prescription Drug Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Copayments are.

Prescription Maintenance Drugs
Prescription Drugs that are:
1. Drugs that are taken regularly to treat a chronic health condition; and
2. Covered under the Outpatient Prescription Drug Benefits section; and
3. Approved by Us for coverage under the 90-Day Prescription Drug Provider provision in this section.

Prescription Order
The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill; or
2. Insulin only by prescription; or
3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:
   a. Disposable insulin syringes and needles; or
   b. Disposable blood/urine/glucose/acetone testing agents or lancets.

Primary Care Practitioner
A Health Care Practitioner who is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) whose practice predominantly includes pediatrics, internal medicine, family practice, general practice or obstetrics/gynecology. A Health Care Practitioner who primarily treats Behavioral Health and Substance Abuse disorders is also considered a Primary Care Practitioner under this plan.

Rehabilitative Services
Specialized treatment for a Sickness or an Injury which meets all of the following requirements:

1. Is a program of services provided by one or more members of a multi-disciplinary team.
2. Is designed to improve the patient's function and independence.
3. Is under the direction of a qualified Health Care Practitioner.
4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.
5. May be provided in either an Inpatient or Outpatient setting.

Retail Health Clinic
A facility that meets all of the following requirements:
1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or part of a store or retail facility;
4. Is separate from an Acute Medical Facility, Emergency Room, Acute Medical Rehabilitation Facility, Free-standing Facility, Nursing Facility, Subacute Rehabilitation Facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein, even when services are performed after normal business hours;
5. Provides general medical treatment or services for a Sickness or Injury, or provides preventive medicine services;
6. Does not provide room and board or overnight services; and
7. Does not include Telehealth Services or Telemedicine Services.

Routine Patient Costs
Covered Charges associated with participation in an Approved Clinical Trial. Routine Patient Costs do not include:
1. The investigational item, device, or service, itself;
2. Treatment, services and supplies that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Service Area
The geographic area, as defined by Us, served by Participating Providers. Contact the Network Manager or Us to determine the precise geographic area serviced by Participating Providers. The Service Area is subject to change at any time without notice.

Sickness
A disease or illness of a Covered Person. For purposes of this plan, Sickness includes Behavioral Health and Substance Abuse disorders. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.

Single Plan
A plan of insurance covering only the Policyholder.

Specialized Medical Care Program
Our program and guidelines providing Specialized Medical Care Plans to Covered Persons.

Specialized Medical Care Plan
A special arrangement by which We may provide benefits to the Covered Person to assist with treating, controlling or managing certain conditions or encouraging healthy outcomes by improving the quality of life while Medically Necessary treatment is received.

Specialty Care Provider
A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties or who is designated by the Network Manager as a Specialty Care Provider. A Specialty Care Provider cannot be a Primary Care Practitioner.

Specialty Pharmaceuticals
Drugs that are defined by Us in the Benefit Summary or in a Drug List as Specialty Pharmaceuticals. These types of Prescription Drugs may include:
1. Drugs used to treat rare or certain chronic diseases.
2. Drugs that have a highly targeted, cellular mechanism of action.
3. Drugs that may require injection or other parenteral or unique method of administration.
4. Drugs that may require special administration and monitoring.
5. Drugs that are regularly supplied by Designated Pharmacy Providers.

Specialty Pharmacy Program
Program(s) created and/or administered by Us or by one or more of Our Designated Pharmacy Providers in order to effectively manage the distribution of Specialty Pharmaceuticals and treatment, services and supplies related to such drugs. These programs will include, but are not limited to, pre-authorization requirements, patient and pharmacy audits, ongoing review for continued Medical Necessity and supply limitations of 7 days for the first treatment under the program and 30days for subsequent treatments, or as otherwise authorized by Us or Our designee.

Stabilize
With respect to a medical condition requiring Emergency Treatment or Emergency Confinement, such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Covered Person from a facility (or, with respect to a pregnant woman, to deliver, including the placenta).

Speech Therapy
The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.

Subacute Medical Care
A short-term comprehensive Inpatient program of care for a Covered Person who has a Sickness or an Injury that:
1. Does not require the Covered Person to have a prior admission as an Inpatient in a licensed medical facility; and
2. Does not require intensive diagnostic and/or invasive procedures; and

3. Requires Health Care Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

Substance Abuse
Abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us.

Surgical Assistant
A Health Care Practitioner who is licensed to assist at surgery in the state and credentialed at the facility where the procedure is performed but who is not qualified by licensure, training and credentialing to perform the procedure as a primary surgeon at that facility.

Telehealth Services
The use of modern telecommunication and information technologies by a Health Care Practitioner in the treatment of his or her established patient.

Telemedicine Services
A medical inquiry initiated by a Health Care Practitioner for the purpose of assistance with a patient's assessment, diagnosis, consultation, treatment or the transfer of medical data that requires the use of modern telecommunications technology.

Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction
TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing:
1. Clicking and/or difficulties in opening and closing the mouth.
2. Pain or swelling.
3. Complications including arthritis, dislocation and bite problems of the jaw.

Total Disability/Totally Disabled
You or Your spouse are unable to perform the essential duties of any occupation for which reasonably fitted by education, training or experience, whether performed for financial gain or not. Retired individuals and homemakers shall not be considered unable to perform an occupation solely because they are unemployed. A Covered Dependent child is Totally Disabled only if confined as a patient in an Acute Medical Facility or Behavioral Health Facility.

Urgent Care
Treatment or services provided for a Sickness or an Injury that:
1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and
2. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.

We, Us, Our, Our Company
Time Insurance Company or its Administrator.

You, Your, Yours
The person listed on the Benefit Summary as the Policyholder.

Statement of rights under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers of facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Notice of privacy practices

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

(effective date April 14, 2003)

Assurant Health is required by law to maintain the privacy of protected health information and to provide individuals with this notice of our legal duties and privacy practices. Assurant Health is required to abide by the terms of the Notice.

Who we are

In business since 1892, Assurant Health provides health insurance coverage nationwide to individuals, families and small businesses. Assurant Health develops and provides a wide range of individual medical, small group, short term and student health insurance products, as well as non-insurance products. Assurant Health also provides consumer choice products such as Health Savings Accounts and Health Reimbursement Arrangements. Assurant Health is headquartered in Milwaukee, Wis., with operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, John Alden Life Insurance Company and Union Security Insurance Company. The Assurant Health website is **www.assuranthealth.com**. Assurant Health is part of Assurant, which offers specialized insurance products and related services in North America and selected other markets.

Information we collect

To serve your health insurance needs, Assurant Health collects information about you. We may collect this information directly from you orally or on applications or other forms. We also collect information from third parties such as your agent or broker, your current or former health care providers and consumer reporting agencies. In addition, this information may include your transactions with Assurant Health, its affiliates and others. It is impossible to describe every type of information that we collect, but here are some examples: your name, age, address, Social Security number, telephone number, occupation and other demographic information about you and your family; whether you are a past or present customer with us, or if you ever applied for an insurance product or service from us, as well as your history of other insurance coverage and applications (if you apply online, information is collected through an Internet "cookie," an information-collecting device from a web server); your past, present or future physical, mental or behavioral health or condition; your health care history; your history of insurance coverage, premiums, claims and payments through Assurant Health; prescription information; information from consumer reporting agencies and data collection agencies.

How Assurant Health may use and disclose information about you

We use and disclose information about you in serving your health insurance needs. It is impossible to describe every type of information that we use or disclose but we have provided some examples of how we use this information to provide services to you and your dependents. Other types of use or disclosure of your protected health information that are not categorized in this notice including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information may only be made with your written authorization, which you may revoke at any time by writing us at the address identified on the authorization.

Treatment: Your health care provider may ask us to use or disclose protected health information in connection with treatment, including the provision, coordination, or management of health care and related services.

Payment: We may use and disclose protected health information for payment purposes, including billing, review of health care services, determining whether a service is "medically necessary" and for utilization review. For instance, a doctor or health facility involved in your care may forward a claim to us with your protected health information. Assurant Health must have this health information to process your claims.

Health care operations: Assurant Health may use and disclose protected health information as part of our health care operations. For example, we may use and disclose information in the underwriting process, renewal process, quality assessment activities or accreditation and certification. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes.

Plan sponsors: If you are enrolled in a group health plan, Assurant Health may provide protected health information to the plan sponsor. For instance, we may share enrollment or disenrollment information with your employer.

Health-related benefits and services: We may, from time to time, contact you about treatment alternatives or other health-related benefits, products or services that may be of interest to you, and for case management or care coordination.

Business associates: Assurant Health works with companies and consultants who perform a wide variety of functions on our behalf. For example, we work with financial institutions such as agents, brokers, insurance distributors, reinsurers and excess loss insurers, non-financial institutions such as health care providers, detectors of fraud, auditors, insurance support organizations, claims handlers, underwriters, and others such as information technology specialists and consultants. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our

health care operations. In all cases, we require these business associates to provide written assurances to us that they will appropriately safeguard the privacy of your protected health information.

Individuals involved in your care or payment: We may use or disclose protected health information to you or other family members who are covered under your health insurance policy regarding your care or payment related to your care. If you object to our use or disclosure of your protected health information in communications with other family members covered under your health insurance policy, please contact our customer service department and ask for the Right to Restrictions form, or visit our website at www.assuranthealth.com. This request must be made in writing and signed by you or your legally authorized representative.

Permitted or required by law: Assurant Health may release information when requested by law enforcement officials or when permitted or required by law. If you are involved in a lawsuit or dispute, Assurant Health may need to disclose protected health information in response to a court or administrative order.

More stringent laws: Assurant Health offers health coverage in many states across the nation. In some cases we may be required to follow the state law provisions on use and disclosure of your protected health information, which may be more stringent than those outlined in this notice. Assurant Health has established safeguards to ensure the security and confidentiality of information about you. These safeguards include protection against any anticipated threats or hazards to the security or integrity of the information, as well as protection against the unauthorized access to or use of this information. We restrict access to your information to those employees "who need to know that information" to provide products or services to you or on your behalf. You have the following rights regarding protected health information we maintain about you:

Right to access: You have the right to request to access, inspect or copy your protected health information in a designated record set. A designated record set could include information related to enrollment, premium payment, claims adjudication and medical management.

Right to amend: If you feel that the information we have about you is incorrect, you may ask to have protected health information in a designated record set amended. You have the right to request an amendment as long as the information is kept and created by Assurant Health.

Right to an accounting of disclosures: You have the right to receive an accounting of disclosures of your protected health information made by us in the preceding six years from the date of your request. The accounting will not include disclosures made for purposes of treatment, payment or health care operations, disclosures permitted or required by law, or disclosures to you or to third parties to whom you have authorized disclosure.

Right to request restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to a requested restriction.

Right to confidential communications: If you feel that your life may be in danger if Assurant Health contacts you at the address or phone number maintained in our records, you may request that we contact you in a different way or at a different location.

Right to be notified of a breach: You will be notified in the event that your unsecured protected health information is compromised.

If you would like to request to access or amend your personal health information, to request restrictions on use or disclosure, to request confidential communications, or to request an accounting of disclosures, please visit our website at www.assuranthealth.com or contact our Customer Service Department at the number

listed below and ask for the appropriate form. Each form must be signed by you or your legally authorized representative. Each of the forms provides additional information relating to your rights.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Assurant Health or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. You will not be retaliated against for filing a complaint.

Changes to this notice

We reserve the right to make changes to this notice and to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive or create in the future. Any changes to this notice will be posted on our website, and if we make substantial material changes to the notice, we will distribute the revised notice to you or your plan sponsor via mail. You may view a copy of this notice at any time at our website www.assuranthealth.com or you may receive another copy of the notice, or receive further information about this notice, by calling our Customer Service Department. For Time Insurance Company and Union Security Insurance Company, call 800.800.1212. For John Alden Life Insurance Company, call 800.328.4316.

Women's Health and Cancer Rights Act notice

Effective October 21, 1998, the federal Women's Health and Cancer Rights Act requires all health insurance plans that provide coverage for a mastectomy must also provide coverage for the following medical care: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Covered benefits are subject to all provisions described in your plan, including but not limited to deductible, copayment, rate of payment, exclusions and limitations.

Members' Rights and Responsibilities

You have the right to:

- Voice concerns about the service and care you receive without penalty or disenrollment
- Register complaints and appeals concerning your health plan or the care provided to you
- Receive timely responses to your concerns
- Participate in decisions regarding your health care treatment options related to your condition
- Choose physicians, health care professionals and other health care facilities who will participate in your care
- Choose an Advance Directive to designate the kind of care you wish to receive should you be unable to express your wishes
- Privacy and confidentiality for treatments, tests and procedures you receive
- Obtain information regarding Assurant Health's criteria for case closure
- Receive notification and a rationale when case management services are changed or no longer needed
- Refuse treatment or services, including case management services
- Have coverage decisions and claims processed according to regulatory and contractual standards, when applicable
- Ask questions regarding your medical plan coverage, the preadmission, authorization process or claims payment
- Receive information about the participating providers within the company's networks
- Receive information regarding your prescription drug benefits and the Drug Formulary Program
- Receive a certificate outlining the coverage which you and your family members are entitled, and to whom benefits are paid
- Request information on types of provider payment arrangements
- Request the Quality Assurance Program Report

You have the responsibility to:

- Read your certificate carefully
- Know and confirm your benefits before receiving treatment
- Review the Pre-existing Conditions Limitation in your policy certificate
- Contact an appropriate health care professional when you have a medical need or concern
- Keep scheduled appointments
- Show your ID card before receiving health care services
- Provide information needed for your care
- Pay your financial obligations under the benefit plan

Form-30565 (Rev. 08/2013)

You have the responsibility to:

- Participate in understanding your health problems and developing mutually agreed upon treatment goals
- Follow agreed upon instructions and guidelines of physicians and health care professionals
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- Know if you are covered by a PPO plan
- Verify the medical care and treatment you receive is through participating doctors and hospitals if you are covered by a PPO plan and wish to receive maximum benefits. Please note that providers may move in and out of the network; also, a hospital or clinic may use both in-network and out-of-network providers. To ensure your chosen provider is in network each time you seek care, verify the provider's participation by calling the network or visiting the network's website, listed on your medical ID card
- Present your drug ID card each time a prescription is filled
- Obtain preauthorization for services indicated in your certificate
- Notify Assurant Health and your providers of changes in your address or family status

Members' Rights and Responsibilities apply only to current Assurant Health customers. The relevance of each right and responsibility may vary, depending on plan benefits.

Questions regarding the above can be submitted by writing or calling:

Customer Service Department
Assurant Health
501 W. Michigan Street
Milwaukee, WI 53201
800.800.1212

We accept TTY (text telephone) calls if you are hearing or speech impaired. If English is not your primary language and you do not have an interpreter available, or if you have special needs, please let us know you need assistance.

Form-30565 (Rev. 08/2013)

Time Insurance Company
Authorization for Credit Card Billing

Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

*******ATTACH THIS TO YOUR POLICY*******

0062481938
Policy Number

I authorize Time Insurance Company to withdraw funds/charge my account as directed in my Payment Information. I agree subsequent payments can be withdrawn/charged until Time Insurance Company has received written notification from me to stop future charges and has a reasonable opportunity to act on the notification.

Signature: Signature On File

This transaction has been conducted electronically.