The Provident™
MAKING A DIFFERENCE SINCE 1889

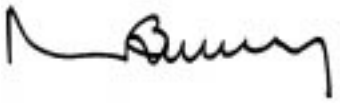
PROVIDENT INDEMNITY
Life Insurance Company

2500 DeKalb Pike, P.O. Box 511 · Norristown, PA 19404
610-279-2500

This Coverage is subject to renewal at your option.

Provident Indemnity Life Insurance Company (hereinafter referred to as *Us*) having issued Group Policy No. TW 2000-0001 (hereinafter referred to as the *policy*) to Consumer Benefits of America Association (hereinafter referred to as the *Policyholder*) HEREBY CERTIFIES that the person named in the certificate schedule to whom this certificate is issued (hereinafter referred to as the *covered member*) and a *covered spouse* or *covered dependents*, if any, and for whom coverage has been requested, are insured for the benefits provided subject to all of the provisions, definitions, exclusions, limitations and conditions of the *policy* on and after the *effective date* shown in the certificate schedule. All periods of insurance coverage begin and end at 12:01 A.M., Standard Time, at the address of the *covered member*. The *policy* may be inspected during regular business hours at the office of the *policyholder* or *our* office.

This certificate replaces any certificate previously provided under the *policy*.



Secretary President

NOTICE OF TEN DAY RIGHT TO EXAMINE

We want the *covered member* to fully understand and be satisfied with the insurance coverage. If for any reason, the *covered member* is not satisfied, the *member* may return this certificate to the agent or the *our* home office within ten days of the *effective date* and the *premium* will be fully refunded. Coverage will then be void from the beginning.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE *APPLICATION*

The *covered member* should review the *application* attached to this certificate. Omissions or misstatements in the *application* can cause *rescission*, *reformation of coverage under the policy* and/or denial of an otherwise valid claim. The *application* should be carefully checked so that if any information shown on the *application* is not correct or complete, or if any medical history has not been included, the *covered member* should write to *us* at *our* home office address within 10 days of receipt of this certificate. The *application* is part of the *policy*. The coverage under the *policy* is issued on the basis that the answers to all questions and any other information requested in the *application* is correct and complete. No agent or employee, except one of *our* executive officers has the authority to waive any of the requirements within the *application* or waive any of the provisions of the *policy*.

ASSOCIATION CERTIFICATE
MAJOR MEDICAL & OPTIONAL INSURANCE COVERAGE
INDEMNITY/PREFERRED PROVIDER PLAN FOR MAJOR MEDICAL BENEFITS

Table of Contents

Introduction to Your Coverage

The *policy* provides insurance benefits for *the covered member*, *the covered spouse*, and/or *covered dependents*. It contains different levels of benefits based upon whether care is provided by *participating providers* or *nonparticipating providers*.

The *policy* also requires *precertification* authorization for certain services. A *precertification* penalty will be assessed if *precertification* authorization is not obtained before a *covered person* receives certain *covered expenses*. *The provider* may be willing to obtain *precertification,* however, *the covered person* is ultimately responsible for obtaining *precertification*. Please refer to the *Precertification* of Care section for more information.

The highest level of benefits are available under the *policy* when a *participating provider* is used. *Participating providers* agree to provide health care services at negotiated prices and agree not to bill more than the *negotiated fee*. *The covered person* will be responsible for the *deductible, coinsurance,* and *co-payment* amounts. *The coinsurance* amount is based upon the *negotiated fee*. Please refer to *the* Schedule of Benefits page for the *benefit percentage*. *Participating providers* agree to file claims for the *covered person* and reimbursement is made directly to the *participating provider*.

The *policy* will pay a lower level of benefits when a *nonparticipating provider* is used. These *nonparticipating providers* have not signed contracts with *us* and do not provide services at agreed upon prices. When a *covered person* receives services from a *nonparticipating provider*, *covered expenses* are limited to the *usual, reasonable and customary charge*. *The covered person* will be responsible for the *deductible*, *coinsurance*, *co-payment*, any amount of the billed charges that exceed the *usual, reasonable and customary charge,* and all paperwork regarding the claim. Please refer to *the* Schedule of Benefits page for the *benefit percentage.* At *the covered person's* request, payment may be made directly to the *provider*.

If a *medically necessary* service is not available from a *participating provider, our* network *provider* may refer a *covered person* to a *nonparticipating provider* and the *covered expenses* will be considered for payment at the *participating provider* benefit level.

All medical benefits for *emergency* services will be considered for payment at the *participating provider* benefit level. *Emergency* services are those medical services provided within 72 hours following an *injury* or a medical *emergency*.

Call the number listed on *the covered member's* identification card to verify whether a *provider* is a member of *our preferred provider network*. Some individual *providers* enter or leave the network. Some individual *providers* practice in more than one location. On occasion, an individual *provider* will be a *participating provider* at one location, but a *nonparticipating provider* at another location. Be sure to check the *provider's* participating status before services are rendered and at the location where the *covered person* is seeking care.

Having a procedure *precertified* verifies *medical necessity*. *Precertification* does not guarantee that a procedure is covered under the *policy*. All other terms and conditions of the *policy* must be satisfied before the payment of benefits.

SCHEDULE OF BENEFITS

Member:
Covered Persons:
Group Policy No.: TW 2000-0001
Certificate No:
Coverage Effective Date:
Life Insurance Amount: $7,500 *Covered Member*

Not Available for *Covered Dependent Children*

A.D. & D. Amount: $7,500 *Covered Member*

Not Available for *Covered Dependent Children*

HEALTH INSURANCE BENEFITS

Deductible: Per *Covered Person*

Deductible Accumulation Period: Each *Calendar Year*

Lifetime Maximum Benefit
Each *Covered Person*: $5,000,000

Prescription Drug Card Benefit:
Separate Rx Deductible per *Covered Person*;
Calendar Year Maximum Benefit per *Covered Person*
Co-Payment Amount: for *Generic Drugs*
for *Named Brand Drugs*

Pre-certification Penalty for *Hospital* Admissions and Certain Outpatient Services and Procedures: $500

Optional Maternity Expense Benefits:

Optional Supplemental

Optional Dental Rider:
Annual Deductible: [N/A] OR [$50]

Health Insurance Portability and Accountability Act Rider

Initial Monthly *Premium*:
Monthly *Premium*:

SCHEDULE OF BENEFITS PLAN A1
ANY HEALTH PROVIDER

Benefit Percentage for Covered Expenses: Once *deductible* has been met, this plan will pay 80% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year.*

Physician Office Visit Co-payments: $20.00 *co-payment* required of *covered person*. Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. The *physician office visit co-payment* does not apply to satisfying the *calendar year deductible*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to: Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentages.*

SCHEDULE OF BENEFITS PLAN A2
ANY HEALTH PROVIDER

Benefit Percentage for Covered Expenses:

Once *deductible* has been met, this plan will pay 50% of the next $2,500 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year.*

Physician Office Visit Co-payments:

$20.00 *co-payment* required of *covered person*. Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. The *physician office visit co-payment* does not apply to satisfying the *calendar year deductible*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to:

Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentages.*

SCHEDULE OF BENEFITS PLAN B1
PARTICIPATING HOSPITAL PROVIDERS/NON-PARTICIPATING
PHYSICIAN OR OTHER HEALTH PROVIDER

Hospital
***Service Deductible*:** $1,500 per *covered person* per hospital admission. This *service deductible* shall apply to each *hospital confinement* in a *non-participating provider hospital*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Benefit Percentage for
Covered Expenses: Once *deductible* has been met, this plan will pay 80% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*. However, for *non-participating* hospitals, this plan will pay 60% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year.*

Physician Office
Visit Co-payments: $20.00 *co-payment* required of *covered person*. Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to: Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentages.*

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SCHEDULE OF BENEFITS PLAN B2
PARTICIPATING HOSPITAL PROVIDERS/NON-PARTICIPATING
PHYSICIAN OR OTHER HEALTH PROVIDER

Hospital
***Service Deductible*:** $1,500 per *covered person* per hospital admission. This *service deductible* shall apply to each *hospital confinement* in a *non-participating provider hospital*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Benefit Percentage for
Covered Expenses: Once *deductible* has been met, this plan will pay 90% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*. However, for *non-participating* hospitals, this plan will pay 70% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year.*

Physician Office
Visit Co-payments: $20.00 *co-payment* required of *covered person*. Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to: Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentages.*

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SCHEDULE OF BENEFITS PLAN B3
PARTICIPATING HOSPITAL PROVIDERS/NON-PARTICIPATING
PHYSICIAN OR OTHER HEALTH PROVIDER

Hospital
***Service Deductible*:** $1,500 per *covered person* per hospital admission. This *service deductible* shall apply to each *hospital confinement* in a *non-participating provider hospital*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Benefit Percentage for
Covered Expenses: Once *deductible* has been met, this plan will pay 50% of the next $2,500 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*.

Physician Office
Visit Co-payments: $20.00 *co-payment* required of *covered person*. Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to: Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentages.*

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SCHEDULE OF BENEFITS PLAN C1
PARTICIPATING HOSPITAL, PHYSICIAN AND OTHER HEALTH PROVIDERS

Hospital *Service Deductible*:

$1,500 per *covered person* per *hospital* admission. This *service deductible* shall apply to each *hospital confinement* in a *non-participating provider hospital.*

Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Outpatient *Ambulatory Surgical Facility Service Deductible:*

$500 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *non-participating provider ambulatory surgical facility.*

Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Outpatient Testing *Service Deductible*:

$100 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *non-participating provider.*

Once the *service deductible* s been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*. This *service deductible* does not apply to charges subject to the Physician Office Visit X-Ray, Lab and Diagnostic Tests *Co-payment*.

Benefit Percentage for Covered Expenses:
Once Deductible has been met, this plan will pay:

For Participating Providers	**For Non-Participating Providers**
80% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred, during the *calendar year.*	60% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*

Physician Office Visit Co-payment Amount:

$15.00 *co-payment* required of *covered person* for *participating providers.*	$40.00 *co-payment* required of *covered person* for *non-participating providers.*

Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to:

Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to the Physician Office Visit X-ray, Lab and Diagnostic Tests *Co-payment* amount.

Physician Office Visit X-Ray, Lab and Diagnostic Tests

Co-payment Amount:	**For Participating Providers**	**For Non-Participating Providers**
	$15.00 *co-payment* required of *covered person* for *participating providers*. Plan will then pay 100% of *covered expenses* incurred subject to a *maximum benefit* of $200 per visit. Expenses incurred in excess of the $200 *maximum benefit* will be subject to any applicable *deductibles* and *benefit percentages.*	No *co-payment*, subject to *deductible* and *benefit percentage* for *non-participating providers*.

Applies to: Charges for x-rays, lab and diagnostic tests performed in a *physician's* office during a *physician office visit* and which are billed by the *physician.* All other covered services, regardless of whether they are performed in or outside of the *participating physician's* office, including x-rays, lab and diagnostic tests performed, and/or billed outside the *participating physician's* office are subject to *deductible* and *benefit percentage.* For plans with a *deductible* of $2500 or more there is no Physician Office Visit X-ray, Lab and Diagnostic Tests *Co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance..*

SCHEDULE OF BENEFITS PLAN C2
PARTICIPATING HOSPITAL, PHYSICIAN AND OTHER HEALTH PROVIDERS

Hospital *Service Deductible*:

$1,500 per *covered person* per *hospital* admission. This *service deductible* shall apply to each *hospital confinement* in a *non-participating provider hospital.*

Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Outpatient *Ambulatory Surgical Facility Service Deductible:*

$500 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *non-participating provider ambulatory surgical facility.*

Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Outpatient Testing *Service Deductible*:

$100 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *non-participating provider.*

Once the *service deductible* s been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*. This *service deductible* does not apply to charges subject to the Physician Office Visit X-Ray, Lab and Diagnostic Tests *Co-payment*.

Benefit Percentage for Covered Expenses:
Once Deductible has been met, this plan will pay:

For Participating Providers	**For Non-Participating Providers**
90% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred, during the *calendar year.*	70% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*

Physician Office Visit Co-payment Amount:

$15.00 *co-payment* required of *covered person* for *participating providers.*	$40.00 *co-payment* required of *covered person* for *non-participating providers.*

Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to:

Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to the Physician Office Visit X-ray, Lab and Diagnostic Tests *Co-payment* amount.

Physician Office Visit X-Ray, Lab and Diagnostic Tests

Co-payment Amount:	**For Participating Providers**	**For Non-Participating Providers**
	$15.00 *co-payment* required of *covered person* for *participating providers*. Plan will then pay 100% of *covered expenses* incurred subject to a *maximum benefit* of $200 per visit. Expenses incurred in excess of the $200 *maximum benefit* will be subject to any applicable *deductibles* and *benefit percentages.*	No *co-payment*, subject to *deductible* and *benefit percentage* for *non-participating providers*.

Applies to: Charges for x-rays, lab and diagnostic tests performed in a *physician's* office during a *physician office visit* and which are billed by the *physician.* All other covered services, regardless of whether they are performed in or outside of the *participating physician's* office, including x-rays, lab and diagnostic tests performed, and/or billed outside the *participating physician's* office are subject to *deductible* and *benefit percentage.* For plans with a *deductible* of $2500 or more there is no Physician Office Visit X-ray, Lab and Diagnostic Tests *Co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance..*

SCHEDULE OF BENEFITS PLAN C3
PARTICIPATING HOSPITAL, PHYSICIAN AND OTHER HEALTH PROVIDERS

Hospital *Service Deductible*:

$1,500 per *covered person* per *hospital* admission. This *service deductible* shall apply to each *hospital confinement* in a *non-participating provider hospital.*

Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Outpatient *Ambulatory Surgical Facility Service Deductible:*

$500 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *non-participating provider ambulatory surgical facility.*

Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.

Outpatient Testing *Service Deductible*:

$100 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *non-participating provider.*

Once the *service deductible* s been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*. This *service deductible* does not apply to charges subject to the Physician Office Visit X-Ray, Lab and Diagnostic Tests *Co-payment*.

Benefit Percentage for Covered Expenses: Once Deductible has been met, this plan will pay:	**For Participating Providers**	**For Non-Participating Providers**
	50% of the next $2,500 of *covered expenses* and then 100% of additional *covered expenses* incurred, during the *calendar year.*	50% of the next $2,500 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*
Physician Office Visit Co-payment Amount:	$15.00 *co-payment* required of *covered person* for *participating providers.*	$40.00 *co-payment* required of *covered person* for *non-participating providers.*

Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*. For plans with a *deductible* of $2500 or more there is no *physician office visit co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

Applies to:

Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to the Physician Office Visit X-ray, Lab and Diagnostic Tests *Co-payment* amount.

Physician Office Visit X-Ray, Lab and Diagnostic Tests

Co-payment Amount:	**For Participating Providers**	**For Non-Participating Providers**
	$15.00 *co-payment* required of *covered person* for *participating providers*. Plan will then pay 100% of *covered expenses* incurred subject to a *maximum benefit* of $200 per visit. Expenses incurred in excess of the $200 *maximum benefit* will be subject to any applicable *deductibles* and *benefit percentages.*	No *co-payment*, subject to *deductible* and *benefit percentage* for *non-participating providers*.

Applies to: Charges for x-rays, lab and diagnostic tests performed in a *physician's* office during a *physician office visit* and which are billed by the *physician.* All other covered services, regardless of whether they are performed in or outside of the *participating physician's* office, including x-rays, lab and diagnostic tests performed, and/or billed outside the *participating physician's* office are subject to *deductible* and *benefit percentage.* For plans with a *deductible* of $2500 or more there is no Physician Office Visit X-ray, Lab and Diagnostic Tests *Co-payment* and *covered expenses* are subject to the *deductible* and *benefit percentage*.

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance..*

SCHEDULE OF BENEFITS PLAN D1
ANY HEALTH PROVIDER

Hospital **Service Deductible:**	$500 per *covered person* per hospital admission. This *service deductible* shall apply to any *hospital confinement*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage.*
Outpatient ***Ambulatory Surgical Facility Service Deductible*:**	$250 per *covered person* per outpatient treatment in an *ambulatory surgical facility*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage.*
Outpatient Testing Facility *Service* Deductible:	$50 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing in an *outpatient testing facility*. This *service deductible* is only required for services rendered by an *outpatient testing facility*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage.*
Benefit Percentage for Covered Expenses:	Once *deductible* has been met, this plan will pay 80% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year.*
Physician Office Visit Co-payment:	There is no *physician office visit co-payment. Covered expenses* are subject to the *deductible* and *benefit percentage.*
NOTE:	*Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SCHEDULE OF BENEFITS PLAN D2
ANY HEALTH PROVIDER

Hospital **Service Deductible:**	$500 per *covered person* per hospital admission. This *service deductible* shall apply to any *hospital confinement*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage.*
Outpatient ***Ambulatory Surgical Facility Service Deductible*:**	$250 per *covered person* per outpatient treatment in an *ambulatory surgical facility*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage.*
Outpatient Testing Facility *Service* Deductible:	$50 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing in an *outpatient testing facility*. This *service deductible* is only required for services rendered by an *outpatient testing facility*. Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage.*
Benefit Percentage for Covered Expenses:	Once *deductible* has been met, this plan will pay 50% of the next $2,500 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year.*
Physician Office Visit Co-payment:	There is no *physician office visit co-payment. Covered expenses* are subject to the *deductible* and *benefit percentage.*
NOTE:	*Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SCHEDULE OF BENEFITS PLAN E1
PARTICIPATING HOSPITAL, PHYSICIAN AND OTHER HEALTH PROVIDERS

	For Participating Providers	**For Non-Participating Providers**
Hospital *Service Deductible*:	\$500 per *covered person* per *hospital* admission for each *hospital confinement* in a *participating provider hospital*.	\$2,000 per *covered person* per *hospital* admission for each *hospital confinement* in a *non-participating provider hospital.*
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	
Outpatient *Ambulatory Surgical Facility Service Deductible:*	\$250 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *participating provider ambulatory surgical facility*.	\$1,000 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *non-participating provider ambulatory surgical facility.*
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	
Outpatient Testing *Service Deductible*:	\$50 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *participating provider.*	\$200 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *non-participating provider*.
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	

Benefit Percentage for Covered Expenses:	**For Participating Providers**	**For Non-Participating Providers**
Once Deductible has been met, this plan will pay:	90% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred, during the *calendar year.*	70% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*
Physician Office Visit Co-Payment Amount:	$25.00 *co-payment* required of *covered person* for *participating providers.*	$50.00 *co-payment* required of *covered person* for *non-participating providers.*

Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*.

Applies to: Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentage*.

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SCHEDULE OF BENEFITS PLAN E2
PARTICIPATING HOSPITAL, PHYSICIAN AND OTHER HEALTH PROVIDERS

	For Participating Providers	**For Non-Participating Providers**
Hospital *Service Deductible*:	\$500 per *covered person* per *hospital* admission for each *hospital confinement* in a *participating provider hospital*.	\$2,000 per *covered person* per *hospital* admission for each *hospital confinement* in a *non-participating provider hospital.*
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	
Outpatient *Ambulatory Surgical Facility Service Deductible:*	\$250 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *participating provider ambulatory surgical facility*.	\$1,000 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *non-participating provider ambulatory surgical facility.*
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	
Outpatient Testing *Service Deductible*:	\$50 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *participating provider.*	\$200 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *non-participating provider*.
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	

Benefit Percentage for Covered Expenses:	**For Participating Providers**	**For Non-Participating Providers**
Once Deductible has been met, this plan will pay:	80% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred, during the *calendar year.*	60% of the next $5,000 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*
Physician Office Visit Co-Payment Amount:	$25.00 *co-payment* required of *covered person* for *participating providers.*	$50.00 *co-payment* required of *covered person* for *non-participating providers.*

Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*.

Applies to: Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentage*.

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SCHEDULE OF BENEFITS PLAN E3
PARTICIPATING HOSPITAL, PHYSICIAN AND OTHER HEALTH PROVIDERS

	For Participating Providers	**For Non-Participating Providers**
Hospital *Service Deductible*:	\$500 per *covered person* per *hospital* admission for each *hospital confinement* in a *participating provider hospital*.	\$2,000 per *covered person* per *hospital* admission for each *hospital confinement* in a *non-participating provider hospital.*
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	
Outpatient *Ambulatory Surgical Facility Service Deductible:*	\$250 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *participating provider ambulatory surgical facility*.	\$1,000 per *covered person* for each outpatient treatment in a *surgical facility*. This *service deductible* is only required for services rendered by a *non-participating provider ambulatory surgical facility.*
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	
Outpatient Testing *Service Deductible*:	\$50 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *participating provider.*	\$200 per *covered person* per visit for outpatient x-rays, laboratory and diagnostic testing. This *service deductible* is only required for services rendered by a *non-participating provider*.
	Once the *service deductible* has been satisfied, *covered expenses* will then be subject to the *deductible* and *benefit percentage*.	

Benefit Percentage for Covered Expenses:	**For Participating Providers**	**For Non-Participating Providers**
Once Deductible has been met, this plan will pay:	50% of the next $2,500 of *covered expenses* and then 100% of additional *covered expenses* incurred, during the *calendar year.*	50% of the next $2,500 of *covered expenses* and then 100% of additional *covered expenses* incurred during the *calendar year*
Physician Office Visit Co-Payment Amount:	$25.00 *co-payment* required of *covered person* for *participating providers.*	$50.00 *co-payment* required of *covered person* for *non-participating providers.*

Plan will then pay 100% of *covered expenses* incurred during the *physician office visit*.

Applies to: Each *physician office visit*. Additional charges, including charges for x-rays, lab and diagnostic tests, are not covered under the *physician office visit co-payment* and will be subject to any applicable *deductible* and *benefit percentage*.

NOTE: *Co-payments* and *service deductibles* do not apply towards satisfying *calendar year deductibles* or *coinsurance.*

SECTION I - DEFINITIONS

Many words used in the *policy* have special meanings. These words appear in italics and are defined in this section.

Ambulatory Surgical Center or Facility

An institution which provides health care treatment or surgery on an outpatient basis and is licensed as required by applicable law.

Application

The form(s) completed to apply for coverage which provide *us* with relevant information used to make the decision whether to issue or amend a *certificate*.

Amendment

A formal document signed by one of *our* executive officers and attached to the *policy* that changes the provisions of the *policy*.

Benefit Percentage

The percentage, as shown in the Schedule of Benefits page, that will be paid on *covered expenses* after the *deductible* and *co-payment*, if any, have been satisfied.

Brand Name Drug

A prescription drug that is protected by a patent or a trademark registration.

Calendar Year

The period from January 1st of any year through December 31st of the same year.

Certificate

The document that details provisions of the *policy* that is given to the *covered member* to evidence insurance coverage under the *policy*.

Class

Class is the group of *eligible members* who share certain characteristics. These characteristics include age, gender, state of residence, and tobacco use.

Coinsurance

The percentage of *covered expenses* to be paid by a *covered person* after the *deductible* has been satisfied.

Complications of Pregnancy

Complications of pregnancy include:

1. conditions requiring *hospital confinement* (when the pregnancy is not terminated) which are caused by pregnancy or are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to:

   - severe dehydration requiring intravenous (IV) therapy;
   - acute nephritis or nephrosis;
   - cardiac decompensation;
   - premature labor or threatened abortion requiring intravenous (IV) therapy;
   - eclampsia; and
   - abrupto previa.

2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a live birth is not possible.

   Complications of pregnancy shall not include conditions which do not require *hospital confinement* nor conditions associated with the management of a difficult pregnancy, including but not limited to:

   - elective cesarean section;
   - antepartum or postpartum bleeding;
   - premature labor;
   - morning sickness;
   - genetic testing;
   - placenta previa;
   - abortion.

Complications of the fetus shall not be considered *complications of pregnancy* unless there are also *complications of pregnancy* arising out of the same condition. Normal deliveries and associated services, even if following *complications of pregnancy*, are not considered *complications of pregnancy* for purposes of this section.

Confinement

A *hospital* stay as a registered inpatient on the advice of the *covered person(s) physician*.

Co-payment

The payment, as required by the terms of the *policy*, which must be made by a *covered person* at the time of service for *Physician Office Visits*, X-ray and Laboratory tests, and Prescription Drug Card benefits. The Schedule of Benefits page describes which services are subject to a *co-payment*. Co-payments do not apply towards calendar year *deductible* or *coinsurance*.

Convalescent Nursing Facility, Skilled Nursing Facility, Extended Care Facility (or other institutions with similar nomenclature)

A lawfully operating institution engaged mainly in providing 24 hour nursing and rehabilitative treatment, on an inpatient basis, of people convalescing from *illness* or *injury*. It must have:

- organized facilities for medical services;
- 24-hour nursing service by licensed Registered Nurses under the direction of a full-time *physician*;
- daily medical records for each patient; and
- a *physician* available at all times

A *Convalescent Nursing Facility* does not include: rest homes, homes for the aged, places for custodial or educational care, places for *confinement* or treatment of alcoholism, drug addiction or chemical dependency, or care of *nervous or mental disorders*.

Covered Dependents

Eligible dependents who are named in the *eligible members application* and approved by *us,* or subsequently have been provided coverage through a validly executed endorsement, provided coverage under the *policy* has not been terminated.

Covered Expense(s)

The expenses payable under the *policy*, based upon either the *usual, reasonable and customary charges* from *nonparticipating providers* or the *negotiated fee* amounts from *participating providers* for *medically necessary* services or supplies prescribed or provided by a *physician* for treatment of a covered *injury* or *illness*. *Covered expenses* are listed under the Covered Expense section of the *policy*.

Covered Member

The *eligible member* as shown in the *application* and approved by *us*, provided coverage under the *policy* has not been terminated.

Covered Person(s)

The *covered member's*, *covered spouse,* and/or *covered dependents*, as approved by *us*, or as added to coverage by endorsement, provided coverage has not been terminated.

Covered Spouse

The *eligible spouse*, as named in the *application* and approved by *us*, or as added to coverage by endorsement, provided coverage under the *policy* has not been terminated.

Creditable Coverage

Coverage of a *covered person* under any of the following that is regulated by the Louisiana Department of Insurance, but not limited to:

- a group health plan;
- health insurance coverage;
- Medicare coverage provided under 42 USC 1395, et seq;
- Medical assistance coverage provided under 42 USC 1396, et seq;
- medical insurance coverage under the General Military Law;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health plan offered for federal employees;
- a public health plan, as defined in regulations promulgated by the commissioner of insurance; or
- a health benefit plan provided to members of the Peace Corps.

Custodial Care

Supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to: bathing, dressing, feeding, routine skin care, bladder care and administration of routine oral medications or eye drops.

Deductible

The amount of *covered expense* each *Covered Person* must first incur each *calendar year* before this *policy* will begin payment for *covered expenses.* The *deductible* is shown on the Schedule of Benefits page.

Deductible Carryover

Covered expenses incurred in the last three months of a calendar year and used to meet the *deductible* for the calendar year in which they were incurred, will also apply toward meeting the *covered person's deductible* for the next *calendar year*.

Deductible Family Maximum

When three *covered person*s under this *policy* have each satisfied their *deductible* in any given *calendar year*, no further *deductibles* will apply for the remainder of that *calendar year*.

Dental Treatment or Care

Treatment or care of any condition involving and/or originating in one or more teeth, the tissue or structure around them, the alveolar process or the gums.

Disabled Dependent

A *covered dependent* who is all of the following:

- incapable of self-sustaining employment by reason of disability (including mental retardation, *nervous or mental disorder*, and/or physical handicap other than pregnancy) which came into existence prior to age 21 (or age 25 in the case of a full-time student);
- beyond the age coverage would otherwise terminate;
- unmarried; and
- chiefly dependent upon the *covered member* for support and maintenance.

The *covered member* must request in writing for continued coverage of a *disabled dependent*. The request must include written proof of disability and dependency. *We* must receive the request no later than 31 days after a *covered dependent* has reached the age at which coverage would otherwise terminate. The request must be approved by *us* in writing. Proof of continued dependency and disability may be requested by *us.* Once a dependent has been covered for two years as a *disabled dependent*, w*e* will not review disability more frequently than annually.

Durable Medical Equipment

Equipment which is able to withstand repeated use; primarily and customarily used to serve a medical purpose; and is not generally useful to a person in the absence of an *illness* or *injury*.

Effective Date

The date which the *eligible member* requests in the *application*, or a later date as assigned by *us*, provided the *application* is approved by *us*.

Eligible Dependents

Individuals who are:

- the *eligible member's* natural or legally adopted child(ren);

- child(ren) for whom the *eligible member* or *eligible member's spouse* is the legal guardian, provided the child(ren) are chiefly dependent upon the *eligible member* or *eligible member's* spouse for support and maintenance;

- *the eligible member's* stepchild(ren), provided the child(ren) are chiefly dependent upon the *eligible member* for support and maintenance;

- child(ren) for whom there is a medical child support order which is enforceable against the *eligible member;*

- the *eligible member's* grandchild(ren), provided the grandchild(ren) are in the legal custody of and residing with the *eligible member*, and *we* receive the required *premium*.

- the *eligible member* or *the eligible member's* spouse's *newborn* child(ren) are covered, provided *we* receive the required *premium*.

  If *we* receive notice and the required *premium* within 31 days of birth, *newborn* child(ren) will be provided coverage under the *policy* without requiring evidence of good health. If coverage is not added within 31 days, evidence of good health may be required.

- newly adopted child(ren) of the *eligible member* and/or children placed with the *eligible member* for adoption are covered regardless of whether adoption of the child is final, provided *we* receive the required *premium*, starting from the earlier of:

  - the date the *eligible member* acquires physical custody of the child(ren); or

  - the date of birth, if adoption procedures have been approved prior to birth and placement, and the *eligible member* is legally obligated to provide coverage for such child(ren).

  If we receive notice and the required *premium* within 31 days, newly adopted child(ren) will be provided coverage without requiring evidence of good health. If coverage is not added within 31 days, evidence of good health may be required.

  For the purposes of this section, the term "placed for adoption" shall mean circumstances under which the *eligible member* assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates. In no event shall coverage be denied or restricted if the adopted child would otherwise be eligible for coverage and the adoption or placement occurs while the adoptive parent or parent with whom the child is placed is covered under this *policy*.

Eligible dependents must be unmarried and either:

- under 21 years of age;

- under 25 years of age and actively pursuing a full-time course of study at an accredited 2 year or 4 year *college*, *university*, vocational, technical, vocational-technical or trade school or institute.

Eligible Member

An individual who is a dues paying member, ages 18 to 64, of the *policyholder*.

Eligible Spouse

The *eligible member's* lawful spouse, ages 18 to 64.

Emergency

A condition that arises suddenly and unexpectedly and requires immediate medical treatment to prevent permanent bodily impairment or jeopardy to life. The symptoms must be severe and occur suddenly. Medical attention and surgery must be provided within 72 hours following the onset of an *injury* or *illness*.

Experimental, Investigational, or Unproven

Charges incurred for services, supplies, devices, treatments, procedures, and/or drugs that have not been recognized as generally accepted medical treatments. *Our* determination will be based on, but not limited to, the approval of treatments from: The American Medical Association, the U.S. Food and Drug Administration, Administrative Procedure Act, and treatments that have not been demonstrated through sufficient peer-reviewed medical literature to be safe and effective for the proposed use.

Generic Drug

A prescription drug that is not protected by a patent or a trademark registration and which the prescribing *physician* has either prescribed by its generic name or has approved its use as a substitute for a drug protected by a patent or a trademark registration.

Grace Period

After the initial *premium* payment the 31 day period immediately following the *premium* due date. Coverage under the *policy* stays inforce during the *grace period*. No benefits are payable for expenses incurred during the *grace period* if the *premium* has not been received by the end of the *grace period*. If the *premium* has not been received by the end of the 31 day *grace period*, coverage under the *policy* will lapse. The *grace period* does not apply if coverage under the *policy* terminates for reasons other than nonpayment of *premium*.

Group Master Application

The application by the *policyholder* for the *policy* which caused the *policy* to be issued.

Home Health Care

The care and treatment of a *covered person* under a written home health care plan that has been approved by *us* and is reviewed and approved by *us* at least every two months.

Home Health Care Agency

An agency or organization that specializes in providing medical care and treatment in the home. Such *provider* must meet all of the following conditions:

- is licensed, if required, by the appropriate licensing authority to provide home health services and supplies;
- is primarily engaged in nursing and other therapeutic services;
- has policies established by a professional group associated with the agency or organization;
- includes at least one *Physician* and at least one *registered nurse* to govern the services provided, and it must provide for full-time supervision of such services by a *Physician* or *registered nurse*;
- maintains a complete medical record on each person served; and
- has a full-time administrator.

Home Health Care Visit(s)

A *home health care visit* is up to four consecutive hours of *home health care* services in a 24-hour period. Each *home health care visit* during which *home health care* services are provided or planned shall be considered a minimum of one *home health care visit*. If a *home health care visit* extends beyond four hours, each additional four hour increment into which that *home health care visit* extends will be considered an additional *home health care visit*.

Hospice

Care given to a terminally ill (diagnosed as having a life expectancy of six months or less to live) *covered person*, by a *hospice* care agency licensed or certified as required by the state where the service is rendered.

Hospital(s)

An institution which:

- is licensed as a *hospital*, if required by law;
- has facilities for diagnosis and surgery, or a reciprocal agreement with another

hospital to perform such surgery;

- is accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals (JCAH);
- has 24 hour nursing service by graduate registered nurses (RNs); and
- is not primarily a place for rest or *custodial care*, a place for *confinement* or treatment of drug addiction, chemical dependency or alcoholism, homes for the aged, or nursing homes.

Illness

A sickness or disease, including all related conditions and occurrences, requiring medical treatment except as otherwise specifically provided in this *policy*.

Immediate Family

The *covered member*, *covered member's* spouse, the children, brothers, sisters, and parents or step parents of either the *covered member* or *covered member's* spouse; and the spouses of the children, brothers, and sisters of either the *covered member* or *covered member's* spouse.

Injury

Bodily damage caused by an accident to the human body that results from a sudden, unplanned or unexpected event and requires medical attention. The bodily damage must result from the accident directly and independently of all other causes. Bodily damage caused by chewing is not considered an *injury*.

Licensed Practical Nurse

An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such service.

Lifetime Maximum

The total amount *we* will pay for all *covered expenses* for each *covered person* insured under this *policy*. The *lifetime maximum* on this *policy* is stated in the Schedule of Benefits page. On each *renewal date*, the balance of the *lifetime maximum*, for each *covered person* is increased by the lesser of:

- $10,000; or
- the amount needed to restore the full *lifetime maximum*.

Medical Necessity or Medically Necessary

Services or supplies provided by a *hospital*, *physician*, or other licensed *provider* of health

care services to diagnose or treat an *illness* or *injury* that *we* determine to be:

- appropriate for the *covered person's* condition, diagnosis, ailment, *illness*, or *injury*;
- recognized as *usual and customary* treatment of a given condition and as meeting generally accepted medical standards of care;
- not primarily for the convenience of the *covered person*, the *physician*, or the *hospital*;
- not *experimental, investigational or unproven*; and
- performed in the least costly setting required by the medical condition.

Medicare

Title XVIII of the Social Security Act of 1965, or as later amended.

Mental Hospital

A facility which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of *nervous or mental disorders*. Such services are provided by or under the supervision of an organized staff of *physicians*. Continuous nursing services are provided under the supervision of a *registered nurse*.

Negotiated Fees

The amount agreed to by a *participating provider* for medical procedures, services and supplies.

Nervous or Mental Disorders

Conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, DSM IV, or current edition, whether or not such conditions are treated with *physician* prescribed medications.

Newborn

An infant from the moment of birth until the initial *hospital* discharge or until the infant is thirty-one (31) days old, whichever occurs last.

Nonparticipating Provider

A *provider* of health care services or supplies who is not a member of *the covered member's immediate family* and who has not agreed to participate in *our preferred provider network*.

Outpatient Mental Health Treatment Center

A treatment facility organized to provide care and treatment for *nervous or mental disorders* through multiple modalities or techniques pursuant to a written plan approved and monitored by a *physician* or a psychologist licensed to practice. The facility shall be licensed, funded or eligible for funding under federal or state law and be affiliated with a *hospital* under a contractual agreement with an established system for patient referral.

Participating Provider

A *provider* of health care services or supplies, who is not a member of *the covered member's immediate family* and has agreed to participate in *our preferred provider network*.

Physician

Physician means a person who is not a member of *the covered member's immediate family*, but is one of the following:

- a Doctor of Medicine or a Doctor of Osteopathy;
- a Doctor of Podiatry or a Doctor of Chiropractic; or
- any other licensed health care practitioner who is required to be recognized as a *physician* by state law and acts within the scope of his/her license to treat an *illness* or *injury*.

Physician Office Visit

A visit with a *physician*, due to a covered *illness* or *injury*, which occurs in a *physician's* office. *Physician office visit co-payments* do not apply to *physician* visits elsewhere, including, but not limited to visits made in an *ambulatory surgical facility*, *convalescent nursing facility*, *hospice*, or in a place of residence.

Physician Office Visit Co-payment

A *physician office visit co-payment* is the payment which must be made by the *covered person* at the time of service for the *physician office visit*. Additional charges, such as charges for x-rays, laboratory and diagnostic tests, are not covered under the *physician office visit co-payment*, unless specifically provided for on the Schedule of Benefits page. *Covered expenses* in excess of the *physician office visit co-payment* will be payable, subject to any applicable *deductibles* and *benefit percentages* and maximum benefits, including *usual, reasonable and customary charges*.

Policy/Policies

The group master policy, issued to the *policyholder* which includes a copy of the *group master application*, endorsements, any attached papers, and/or rider(s).

Policyholder

The legal entity named in the *group master application* to which the *policy* is issued.

Precertification/Precertified/Precertify

A screening process to determine if the proposed medical procedures, services and supplies are *medically necessary*. *Precertification* does not guarantee payment of benefits.

Preexisting Condition

A condition, whether physical or mental, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period ending on the *covered person's effective date* under the *policy*. In no event shall an exclusion or limitation with respect to a preexisting condition, unless the condition is specifically excluded by an allowed endorsement or rider attached to the *policy*, apply to a loss incurred or a disability commencing more than twelve (12) months after the *covered person's effective date* under the *policy*.

Preferred Provider Network

A selected network of *physicians*, *hospitals*, and other health care *providers*. These *providers* have an agreement with *us* to deliver health care services at negotiated prices.

Premium

The periodic payment necessary to keep coverage under the *policy* inforce.

Prescription Medication(s)

A drug, including its administration, which has been approved by the U.S. Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescribed order made by a *physician*. The drug can be *generic* or *brand name* and must be listed as an appropriate treatment in standard medical reference texts.

Proof of Loss

An itemized bill on an industry standard form or any other documentation or information *we* request. If requested by *us, proof of loss* may include an examination. The exam will be at *our* expense. This information will be used to determine benefits payable under the *policy*.

Prophylactic Treatment

Treatment to prevent the occurrence of an *illness* or *injury* in a *covered person* who does not already manifest the symptoms of that *illness* or *injury*.

Provider

A supplier of health care services and/or supplies.

Psychiatric Care

Diagnostic measures or treatment for a *nervous or mental disorders* which shall include physiological or psychological dependence upon alcohol or drugs.

Reformation of coverage under the Policy

Changing coverage under the *policy* by issuing an exclusionary rider retroactive to the *effective date*. *Reformation of coverage under the policy* will occur if an omission or misstatement in *the application* for the *covered person* caused *us* to issue coverage under the *policy* without the rider which *we* would have otherwise issued had *we* known the correct information. If the *covered member* accepts an allowable exclusionary rider, *we* may request a refund for claims paid which would not have been eligible under the exclusionary rider. If the *covered member* does not accept the exclusionary rider, *we* will proceed with *rescission of coverage* under the *policy*.

Registered Nurse

An individual who has received specialized nursing training, is authorized to use the designation of "R.N." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitative Treatment

Treatment for purposes of restoring bodily function which has been lost due to *illness* or *injury*. Care ceases to be *rehabilitative treatment* when either:

- the patient can perform the activities which are normal for someone of the same age and gender; or

- the patient has reached maximum therapeutic benefit and further treatment cannot restore bodily function beyond the level the patient currently possesses.

Renewal Date

Each anniversary of the *covered member's effective date.*

Rescission of coverage under the Policy

Cancellation of coverage under the *policy* back to the *effective date* due to an omission or misstatement in *the application for the covered member* which caused *us* to issue coverage under this *policy* when *we* would not have done so had *we* known the correct information. *We* will refund *premiums* received for any coverage *we* rescind; however, *we* will subtract total claim payments from this *premium* refund. If *we* have paid claims in excess of the amount of *premium* received, *we* may request a refund. *We* may cancel the coverage of a *covered dependent* back to the *effective date* due to an omission or misstatement in the *application* which caused *us* to issue coverage for the *covered dependent* when *we* would not have done so had *we* known the correct information. If only a *covered spouse* or *covered dependent's* coverage is rescinded, *premiums* received for that coverage only, minus any claim payments,

will be refunded.

Routine Physical Exam

A *routine physical exam* consists of physical history which includes a review of past medical and surgical history, review of medications, social habits, occupation and family history; the *routine physical exam* would include vital signs, height and weight and a general exam of all external and internal organs and systems. A *routine physician exam* does not focus on a specific organ or system.

Separate Drug Deductible

The payment, as required by the terms of the *policy*, which must be made by a *covered person* at the time of service for Prescription Drug Card Benefits. The *separate drug deductible* does not apply towards the calendar year *deductible*, *co-payments* or *coinsurance.*

Service Deductible

The payment, as required by the terms of the *policy*, which must be made by a *covered person* at the time of service for *hospital confinement*, outpatient *ambulatory surgical center or facility* and outpatient testing. The Schedule of Benefits page describes which services are subject to a *service deductible*. *Service deductibles* do not apply towards the calendar year *deductible*, *co-payments* or *coinsurance*.

Total Disability, Totally Disabled

With respect to the *covered member's* coverage *total disability* means the *covered member* is unable to perform the material and substantial duties of his/her occupation as a direct result of an *illness* or *injury*. After the *covered member* has been *totally disabled* for twelve consecutive months, *total disability* means the *covered member* is unable to perform the material and substantial duties of any occupation for which the *covered member* is or may become qualified by education, training or experience.

With respect to a *covered dependent total disability* means the inability to perform the normal substantial activities of a person of like age and sex in good health.

Urgent Care

Medical services and supplies necessary for conditions that are not life threatening but which require treatment which cannot wait for a regularly scheduled clinical appointment because of the prospect of the conditions worsening without timely medical intervention.

Urgent Care Facility

A free-standing facility, by whatever actual name it may be called, which is engaged primarily in providing minor *emergency* and episodic medical care to a *covered person.* A *physician*, a *registered nurse* and a registered X-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. However, a facility located on the premises of or physically a part of a

hospital shall be excluded from this definition. The facility must be licensed by the state in which it is located and be accredited by the appropriate regulatory authority.

University or College

An institution offering a two year or four-year educational program leading to a degree and shall also include any graduate school, vocational school, technical school, vocational-technical school or trade school or institute offering a degree or certification.

Usual, Reasonable and Customary Charges

The fees charged for medical procedures, services and supplies up to the lesser of:

- the *provider's* usual charge; or
- the amount *we* determine to be within the range of fees charged by most *providers* in the geographic area as determined by *us* for the same medical procedures, services and supplies, with consideration given to unusual circumstances involving medical complications requiring additional time, skill, and experience.

We, Our, Us

Provident Indemnity Life Insurance Company.

SECTION II - HEALTH INSURANCE BENEFITS

Covered Expenses

Covered expenses mean the *usual, reasonable and customary charges* from *nonparticipating providers* or *negotiated fee* amounts from *participating providers* for *medically necessary* services or supplies prescribed or provided by a *physician* for treatment of a covered *injury* or *illness*. A *covered expense* will be considered incurred on the date the service or treatment is performed or the date supplies are purchased. *Covered expenses* will first be applied to the *calendar year deductible* as shown in the Schedule of Benefits page, unless otherwise specified. All *covered expenses* are subject to annual and *service deductibles*, *coinsurance* and *policy lifetime maximums,* unless otherwise specified.

Only One Deductible is Applied in Same Accident Situations

If two or more *covered persons* under this *policy* sustain *injury* in the same accident, only one *deductible* will be applied to all eligible medical expenses arising out of that accident, subject to the following conditions:

- *we* must be informed with the first claim arising out of the accident that this is a multiple *covered person*/same accident situation;
- the one *deductible* applied to the accident will be the largest remaining *deductible* of all the *covered persons* involved in the accident; and
- all benefits are subject to any *coinsurance* and *lifetime maximum* benefit limits.

Covered Hospital Charges Include:

1. room, board, and general nursing care, not to exceed the semi-private room rate. The most common semi-private room rate will be covered for *confinement* in a private room. If a facility contains only private rooms, coverage will be limited to 90% of the private room rate;
2. *confinement* in an intensive or specialized care unit which provides four or more hours of nursing care per day; *covered expenses* are limited to an amount not greater than 3 times the *hospital's* semi-private room rate;
3. emergency room treatment, services, and supplies; and
4. miscellaneous medical services and supplies provided on an inpatient basis.

Covered Treatment Provided by:

1. a *physician*; and
2. a therapist for diagnosis and treatment performed for *rehabilitative treatment*.

Other Covered Charges Include:

1. any *preexisting condition* after twelve (12) months from the *covered person's effective date* under the *policy*;

   A *preexisting condition* will also be considered a covered charge if it is duly disclosed in the *application* for coverage of the *covered person* and otherwise covered by this *policy*, unless the condition is specifically excluded by allowed endorsement or rider attached to the *policy*.

   A preexisting condition limitation shall be reduced by any waiting periods and the aggregate of any periods of creditable coverage which are applicable on the *covered person's effective date* under the *policy*. A period of creditable coverage shall be counted with respect to the enrollment of a *covered person* if, during such period and before the *covered person's effective date*, there was a 63 day period during all of which the *covered person* was covered under creditable coverage.

   The period of creditable coverage shall be counted without regard to the specific benefits covered during the period and shall not include a waiting period. A period of creditable coverage shall not be counted with respect to the enrollment of a *covered person* if, after such period and before the *covered person's effective date*, there was a 63 day period during all of which the *covered person* was not covered under any creditable coverage.

2. outpatient x-ray and laboratory tests;

   Outpatient testing shall include the following benefits for lead poisoning screening:

   - one baseline lead poisoning screening test for children at or around twelve months of age; and

   - lead poisoning screening and diagnostic evaluations for children under the age of six years who are at high risk for lead poisoning in accordance with guidelines and criteria set forth by the Office of Public Health.

3. anesthetics and their administration;

4. treatment in an *urgent care facility*;

5. blood or blood plasma and its administration, if not replaced;

6. artificial limbs, eyes, larynx and orthotic appliances; however, replacements are only covered for children needing replacements due to growth and when prescribed by a *physician*;

7. *medically necessary* supplies, including casts, non-dental splints, trusses, crutches or non-orthodontic braces;

8. oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment;

9. *complications of pregnancy;*

10. *durable medical equipment*, including rental of a wheelchair, *hospital*-type bed or iron lung, not to exceed the purchase price of such equipment. At *our* option, benefits may be available for purchase of such equipment payable in monthly installments while coverage under the *policy* remains inforce;

11. local licensed ground ambulance service or air ambulance service within the 48 contiguous states (certified as *medically necessary* by a *physician*) to the nearest *hospital* that *we* determine is qualified to treat the covered *injury* or *illness*; benefits will be limited to a maximum of $600 per occurrence;

    Coverage shall also be provided for transportation by professional ambulance services of the temporarily medically disabled mother of an ill *newborn* when accompanying the ill *newborn* to the nearest available *hospital* or neonatal special care unit. The mother's need for professional ambulance service must be certified by her attending *physician*.

    For the purposes of this benefit, the term "temporarily medically disabled mother" means a woman who has recently given birth and whose *physician* has advised that normal travel would be hazardous to her health.

12. treatment or service in a state approved freestanding *ambulatory surgical center or facility*, which is not part of a *hospital*;

13. *dental treatment or care* required as a result of a covered *injury* to sound natural teeth occurring within 6 months of the *injury*;

14. open cutting operations to the feet; the removal of all or part of one or more nail roots; and services in connection with the treatment of metabolic or peripheral vascular disease;

15. any charge for cosmetic or reconstructive purposes, or complications of cosmetic procedures, when such service is:

    · incidental to or follows a covered *injury* or *illness* occurring while this *policy* is inforce;

    · performed on a *covered dependent* because of congenital disease or anomaly that resulted in a functional defect as determined by the attending *physician*. If a *covered member* has received credit for time covered under a previous plan of health insurance, the time credited will also extend to the member's *covered dependent.*

      Charges for cosmetic purposes to treat a congenital disease or anomaly shall include *medically necessary* oral surgery in connection with the repair of cleft lip and cleft palate. Charges for the following secondary conditions and treatment are also covered if *medically necessary* for cleft lip and palate:

- facial surgery, surgical management and follow-up care;
- prosthetic treatment such as obturators, speech appliances and feeding appliances;
- orthodontic treatment and management;
- preventive and restorative dentistry to insure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy;
- speech-language evaluation and therapy;
- audiological assessments and amplification devices;
- otolaryngology treatment and management;
- psychological assessment and counseling; and
- genetic assessment and counseling for the patient and his or her parents.

Coverage for mastectomy surgery shall include coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. The coverage for reconstructive surgery shall only be required if the reconstructive surgery is performed under the same plan under which the mastectomy was performed.

16. Spinal manipulation, manual or electrical muscle stimulation, and other manipulative or ultra sound therapy when performed by a *physician.* Coverage will be provided for *medically necessary* services.

17. charges for the following transplants and replacements shall be included as any other *illness* or *injury*:

    a. cornea, artery or vein, and kidney transplants,

    b. joint and heart valve replacements,

    c. implantable prosthetic lenses in connection with cataracts,

    d. prosthetic by-pass or replacement vessels,

    e. bone marrow transplants,

    f. skin grafts,

    g. heart, heart and lung, liver, and pancreas transplants.

All organ transplants are subject to the *precertification* requirement.

The *policy* does not cover organ transplants which:

- are animal to human transplants;
- use artificial and/or mechanical organs;
- are *experimental, investigational or unproven*; or
- are not generally accepted by the general medical community as an effective treatment for a covered *injury* or *illness*.

18. Charges for the treatment of *psychiatric care* as an inpatient in a *mental* or general *hospital* or for chemical dependency, substance abuse, alcohol and drug rehabilitation in a general *hospital* or licensed drug and alcohol rehabilitation facility. Coverage is provided to restore any *covered person* to satisfactory emotional and physical health, however, benefits are limited in a calendar year to either: a) 55 days of active treatment, or b) $2,000, whichever occurs first.

19. Charges for the treatment as an outpatient in an *outpatient mental health treatment center* subject to a 50% *benefit percentage* and a maximum benefit of $20 per visit for a maximum of 55 visits per calendar year. Charges shall include:

- charges made by a *hospital* for the necessary care and treatment of *nervous or mental disorders* furnished to a *covered person* while not confined as a *hospital* inpatient;
- charges for services rendered or prescribed by a *physician*, psychologist or clinical social worker licensed to practice for the necessary care and treatment of *nervous or mental disorders* furnished to a *covered person* while not confined to a *hospital* as an inpatient; or
- charges made by an *outpatient mental health treatment center* for the necessary care and treatment of a *covered person* provided in the *treatment center*.

20. *home health care*. This benefit will cover up to 40 *home health care visit*s in each *calendar year*, not to exceed the *usual, reasonable and customary* weekly cost for care in a *convalescent nursing facility*. *Covered expenses* include:

- part-time or intermittent home nursing care by, or under the direction of, a graduate *registered nurse* (RN);
- part-time or intermittent home health aide services that consist only of care for the *covered person*, and which are *medically necessary*, as part of the *home health care* plan. The services must be under the direction of a graduate *registered nurse* (RN);

- physical, respiratory or speech therapy performed for *rehabilitative treatment*;

- nutrition counseling provided by or under the direction of a registered dietitian as part of the *home health care* plan; or
- medical supplies, drugs and medicines prescribed by a *physician* and laboratory services provided by or on behalf of a *hospital* but only to the extent that they would have been covered under the *policy* if the *covered person* had remained in the *hospital*; or

- the evaluation of the need for, and development of, a plan by a *physician or a* graduate *registered nurse* (RN). Such services must be requested by the *physician* and approved by *us*.

Home health care services must be:

· approved through *our precertification* process. Review of *medical necessity* may be periodically required;

· provided in lieu of *confinement* in a *hospital* or *skilled nursing facility* which would otherwise be *medically necessary*; and

· provided or coordinated by a state licensed or *Medicare* certified *home health care* agency or certified rehabilitation agency;

Specifically excluded from coverage under this benefit are the following:

- services of a social worker;

- transportation services; and

- meals.

21. *hospice* care. This benefit will cover charges incurred for up to six months, limited by a lifetime maximum benefit of $5,000 per *covered person. Covered expenses* include charges incurred for the following *hospice* services:

- part-time intermittent home nursing care by, or under the direction of, a graduate *registered nurse* (RN);

- physical, respiratory or speech therapy;

- medical supplies, including drugs and biologicals and the use of appliances, but only to the extent they would have been covered under the *policy* if the *covered person* had remained in the *hospital*;

- nutrition counseling provided by or under the direction of a registered dietitian as part of the active *hospice* management plan; and

- counseling services by a licensed clinical social worker, pastoral counselor, or counselor for an *immediate family member*, the primary care giver and individuals with significant personal ties to a *covered person* who is terminally ill;

Hospice services must be:

· approved through *our precertification* process. Review of *medical necessity* may be periodically required;

· under active management through a *hospice* which is responsible for coordinating all *hospice* care services;

· provided only if the *physician* submits written certification to *us* that the insured is terminally ill with a life expectancy of six months or less.

Bereavement counseling services by a licensed clinical social worker, pastoral counselor, or counselor for an *immediate family member* are covered for up to a period of three months after the *covered person's* death, up to a maximum of $500. Bereavement counseling services are not subject to the *deductible* or *coinsurance* provisions.

This *policy* does not cover *hospice* benefits that include the services of social workers, volunteers or persons who do not regularly charge for their services;

22. Convalescent nursing facility care. This benefit is payable for charges related to convalescent *confinement* which:

a. follows a *hospital confinement* for which at least three consecutive days of daily room and board charges were *covered expenses* under the *policy*; and

b. begins within 14 days after the *covered person* is released from such *hospital confinement*.

Only charges for the following services and supplies furnished by the *convalescent nursing facility* during the convalescent *confinement* are *covered expenses*:

a. room and board, including charges made by the *convalescent nursing facility* as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily room and board charge allowed will not exceed the *convalescent nursing facility's* average semi-private charges or an average semi-private rate made by a representative cross section of similar institutions in the area;

b. medical services customarily provided by the *convalescent nursing facility* with the exception of private duty or special nursing services and *physician's* fees; and

b. drugs, biologicals, solutions, dressings and casts, but no other supplies;

23. low dose mammography as follows:

- Age 35-39 -- a single baseline mammography;
- Age 40-49 -- every two years or more frequently as recommended by a *physician*;
- Age 50 and older -- yearly;

Benefits payable for this covered charge shall not be subject to any *deductible* requirements under the *policy*.

24. *emergency* treatment received outside of the United States;

25. Fees of *registered nurses* or *licensed practical nurses* for private duty nursing while not confined in a *hospital,* up to a maximum benefit of $2,000 per *covered person* per *calendar year;*

26. Chemotherapy and radiation therapy or treatment;

27. Physical, respiratory or speech therapy when rendered by a licensed therapist;

28. *Routine physical exams* after *the covered person* has been covered under the *policy* for 24 consecutive months. Benefits are limited to $100 per examination for each *covered person* per *benefit period. Benefit period* is defined as every two years. Satisfaction of the *deductible* is not required for this benefit, however, the *coinsurance* will apply;

29. Medical treatment, services or supplies rendered to a *newborn covered dependent* solely for the purpose of health maintenance and not for the treatment of a an *illness* or *injury*. Included are charges for physicians, medical examinations, special studies, x-rays and laboratory tests, immunizations and supplies for preventative health care and circumcision and for routine care furnished from the moment of birth. *Hospital* room and board nursery charges are covered. This benefit ends when the *newborn covered dependent* is discharged from the *hospital*;

30. Pap smears for the detection of cervical and endometrial cancer, and the *physician's* office visit in connection with the pap smear. Benefits payable for this covered charge shall not be subject to any *deductible* requirements under the *policy*. There is no *physician's office visit co-payment*, and the *benefit percentage* applies.

31. Outpatient services which provide for CA-125 for monitoring ovarian cancer subsequent to treatment; however, such charges shall not be payable if such treatment is for routine screening only;

32. Routine prostate preventive care, including digital rectal examination and Prostate Specific Antigen (PSA) testing for males age 50 and over, and as *medically necessary* and appropriate for males age 40 and over. Benefits payable for this covered charge

shall not be subject to any *deductible* requirements under the *policy*.

For the purposes of this benefit, "routine prostate preventive care" means a minimum of one routine annual visit, provided that a second visit shall be permitted based upon medical need and follow-up treatment within 60 days after either visit if related to a condition diagnosed or treated during the visits.

33. homeopathic treatment rendered by a licensed homeopathist, subject to a maximum benefit of $50 per visit and $500 per *calendar year* per *covered person.* This benefit does not include coverage for supplies used by the provider. This benefit is not subject to the *co-payment,* and *coinsurance* requirements.

34. Child health supervision services for the periodic examination of *covered dependent* children. Benefits are payable for the following age intervals: birth, one month, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years and six years. This benefit is not subject to the *co-payment, deductible* and *coinsurance* requirements.

    Child health supervision services means the periodic review of a child's physical and emotional status by a licensed and qualified *physician* or pursuant to a *physician's* supervision. A review shall include, but not be limited to, a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards. Child health supervision services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single *physician* during the course of one visit.

35. Charges for expenses incurred for services performed by a qualified interpreter/transliterator, when such services are used by the *covered person* in connection with medical treatment or diagnostic consultations performed by a *physician*, dentist, chiropractor or podiatrist, provided the medical treatment or consultation is covered under the *policy* and the services are required because of a hearing impairment of the *covered person* or the failure of the *covered person* to understand or otherwise communicate in spoken language.

36. Charges for expenses incurred for the diagnosis and treatment of attention deficit/hyperactivity disorder as provided herein.

    Benefits shall be payable for expenses incurred when rendered or prescribed by a *physician* or other appropriate health care provider licensed in the State of Louisiana and received in any *physician's* or other appropriate health care provider's office, any licensed *hospital*, or in any other licensed public or private facility or portion thereof, including but not limited to clinics and mobile screening units.

    However, benefits for attention deficit/hyperactivity disorder provided for an initial diagnosis shall not exceed $600. Services rendered on an out-patient basis shall not exceed $50 per visit with a *physician* or other appropriate health care provider.

    The total benefits payable under this item 36. shall be limited to $2,500 per *calendar*

year, with a maximum lifetime benefit of $10,000 per *covered person*.

37. Charges for outpatient self-management training and education, including nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a *physician*, or if applicable, the patient's primary care *physician*.

    A one-time program of evaluation and training will be covered when *medically necessary* as determined by a *physician*, when provided by a licensed health care professional, and upon certification by the health care professional providing the training that the covered patient has successfully completed the training. Programs of diabetes self-management shall be provided by a health care professional in compliance with the National Standards for Diabetes Self-Management Education Program, as developed by the American Diabetes Association. Benefits payable for a one-time program of diabetes self-management shall not exceed $500.

    Additional coverage for diabetes self-management training will be provided if prescribed by a *physician* and *medically necessary* due to a change in the covered patient's symptoms or conditions. The total benefits payable for this additional coverage shall be limited to $100 per *calendar year*, with a maximum lifetime benefit of $2,000 per *covered person*.

    Diabetes self-management training shall be provided by a health care professional within the scope of his or her practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his/her licensing board, when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Exclusions

The following exclusions are applicable to all Health Insurance Benefits.

Except as specifically provided for in the *policy*, the *policy* does not cover:

1. *preexisting condition*s;

2. expenses incurred before the *effective date*;

3. expenses incurred after coverage under the *policy* terminates, regardless of when the condition originated;

4. expenses covered by any optional benefits attached to the *policy* providing additional benefits;

5. any conditions specifically excluded by riders or exclusions that *we* are allowed to issue and attach to the *policy*;

6. expenses incurred to treat complications resulting from treatment or conditions which are not covered under the *policy*;

7. *experimental, investigational, or unproven* services;

8. expenses reasonably determined by *us* to be educational;

9. amounts in excess of the *usual, reasonable and customary charges* made for services or supplies covered under the *policy*;

10. expenses *the covered person* is not required to pay, which are covered by other insurance, or which would not have been billed if no insurance existed, except in public hospitals and clinics;

11. care in federal government institutions unless *the covered person* is obligated to pay for such care;

12. expenses which are payable under workers' compensation or employers' liability laws;

13. treatment received outside of the United States, except for emergency treatment received outside the United States;

14. charges incurred by a *covered person* while on active duty in the Armed Services. Upon written notice to *us* of entry into such active duty, the unused *premium* will be returned on a pro-rated basis;

15. expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection;

16. expenses incurred or expense related thereto, while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony;

17. pregnancy or childbirth, except for *complications of pregnancy*;

18. charges incurred for voluntary termination of pregnancy;

19. any drug, including birth control pills, supply, treatment or procedure that prevents conception and/or childbirth;

20. diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method other than by natural means; in vitro fertilization, artificial insemination or similar procedures whether the *covered person* is the donor, recipient or surrogate;

21. sex transformation, sexual dysfunctions or sexual inadequacies; or reversal of sterilization;

22. physical exams or other services or supplies not needed for medical treatment;

23. *prophylactic treatment*, including surgery or diagnostic testing;

24. outpatient treatment of alcoholism;
25. outpatient treatment of chemical dependency, substance abuse and/or drug addiction;

26. programs, treatment, or procedures for tobacco use cessation;

27. expenses resulting from suicide or attempted suicide, whether sane or insane;

28. charges incurred which result from: (a) the voluntary taking of drugs, except those taken as prescribed by a *Physician*, (b) the voluntary taking of poison, (c) the voluntary inhaling of gas, or (d) being under the influence of alcohol;

29. expenses resulting from intentional self-inflicted *injury*;

30. *dental treatment or care*;

31. orthodontia or other treatment involving the teeth and supporting structures;

32. nonsurgical treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone (mandible) and skull and the complex of muscles, nerves and other tissues related to the joint;

33. radial keratotomy or surgical correction of refractive error; eye refractions; vision therapy; routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses; the purchase, fitting or adjustment of eyeglasses or contact lenses; frames or contact lenses for the treatment of aphakia;

34. routine hearing exams to assess the need for or change to hearing aids; the purchase, fittings or adjustments of hearing aids;

35. cosmetic or reconstructive procedures, services or supplies;

36. charges for breast reduction unless *medically necessary*, or complications arising from these procedures;

37. Charges for breast augmentation, or complications arising from these procedures;

38. medications and drugs, including vitamins and vitamin mineral supplements, available over-the-counter (OTC) whether or not by a *physician's* prescription order;

39. any drug or other item used for the treatment of hair loss;

40. treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions or the removal of one or more corns, calluses or toenails;

41. charges for blood or blood plasma that has been replaced;

42. treatment of autism;

43. treatment of acne;

44. weight loss programs, diets, or treatment of obesity, including surgery for reconstruction or repair of a gastric bypass as a result of such condition;

45. transportation charges;

46. rest and/or recuperation cures or care in an *convalescent nursing home or facility, extended care facility, skilled nursing facility*, or home for the aged, whether or not part of a *hospital*, unless specifically provided for in the *policy*;

47. services or supplies for personal comfort or convenience, including *custodial care* or homemaker services;

48. services and/or supplies furnished and/or provided by a member of the *covered member's immediate family* or a person who ordinarily resides in the home of the *covered person*;

49. any charges incurred in connection with a *hospital* admission on Friday or Saturday unless the attending *physician* states in writing that the admission was an *emergency* and *medically necessary*;

50. Immunizations not necessary for the treatment of an *illness* or *injury*; or

51. expenses incurred for occupational therapy; or

52. acupuncture unless the charges incurred are in lieu of anesthesia.

Precertification of Care

Precertification is a screening process to determine if medical procedures, services, or supplies are *medically necessary*.

Having a procedure *precertified* verifies *medical necessity*. *Precertification* does not guarantee that a procedure is covered under the *policy*. All other terms and conditions of the *policy* must be satisfied before the payment of benefits.

The following medical procedures, services or supplies require *precertification* authorization before a *covered person* receives them:

- all medical, surgical, or maternity inpatient *hospital* admissions;
- the following medical, surgical, or diagnostic procedures, while not *hospital* confined: arthroscopic knee surgery, MRI's, cardiac therapy, pulmonary rehabilitative therapy and home infusion therapy;
- the purchase or rental of *durable medical equipment* including, but not limited to, *hospital* beds, a dextrometer, oxygen tanks/cylinders plus mask and regulator, or apnea monitors, etc.;
- skilled nursing facility, *hospice* or *home health care*;

- organ transplants; and

- high risk maternity care.

It is the *covered person's* responsibility to *precertify. Precertification* is required each time a *covered person* expects to incur an expense for one of the above listed items. The *covered person's provider* may be willing to obtain *precertification* for the *covered person,* however, the *covered person* is ultimately responsible for obtaining *precertification*. To *precertify*, the *covered person* should call the telephone number listed on the back of the *covered member's* identification card or in the *provider* directory.

If the *covered person* fails to obtain *precertification* authorization, *we* will make a determination of the *medical necessity* of the treatment when *we* receive the claim for benefits. **If the treatment is determined to have been *medically necessary*, the *precertification* penalty as stated in the Schedule of Benefits will be assessed and the *covered person* will be responsible for the *precertification* penalty in addition to the applicable *deductible* and *coinsurance*. If the treatment is determined not to have been *medically necessary*, benefits will not be provided under the *policy*.**

All requests for nonemergency *precertification* must be received by *us* at least two working days before the services are received. If the *covered person* has requested *precertification* as required in the *policy*, and *we* do not respond within two working days, the *precertification* penalty as shown in the Schedule of Benefits page will not be assessed.

All *emergency* and maternity *hospital* admissions must be *precertified* within 24 hours following admission, or as soon as reasonably possible. *Emergency* room visits where an admission to the *hospital* does not take place do not require *precertification*.

Precertified medical procedures, services, and supplies are only *precertified* for the time period indicated in the *precertification* notice.

Second Surgical Opinion

Prior to a *hospital confinement* for a non-emergency surgical procedure, a second surgical opinion may be required to verify such procedure as *medically necessary*. Any required Second Surgical Opinion will be paid for by *us*. If the second surgical opinion does not confirm the *medical necessity* of the surgery, a third surgical opinion may be required and paid for by *us*.

If the second surgical opinion confirms the *medical necessity* of the surgery, or if such second surgical opinion does not confirm, but a third surgical opinion does, the expense of such surgery will be considered a *covered expense* subject to all conditions, exclusions and limitations of the *policy*. If neither the second or third opinions confirm the *medical necessity* of the surgery and the *covered person* has the surgery, the expenses incurred with the surgery are not a *covered expense*.

If the surgery is *medically necessary* on an *emergency* basis, a second or third surgical opinion is not required.

The *physicians* rendering the second and third surgical opinions must be approved by *us* as qualified to render such a service, either through conference, specialist training or education,

or similar criteria, and must not be affiliated in any way with each other or the *physicians* who will perform the actual surgery.

Case Management Program

The *covered person* may be offered *our* Case Management Program if a *covered person* is suffering from a complex *illness* or *injury* requiring ongoing medical care. The program provides a trained medical staff to work with the *covered person* and/or the *physician*.

A Case Management Consultant will coordinate services, resources, and information with a *covered person* and/or the *physician*. Alternate forms of care, treatment, or facilities may be recommended as part of the program.

The alternate care, treatment, or facilities may not be covered under the otherwise applicable provisions of the *policy*. When this happens, subject to approval by *us*, these expenses will be covered on the same basis as the care, treatment, or facilities for which they are substituted.

Prescription Drug Card Benefit

Charges for covered prescription drugs provided to a *covered person* through participating pharmacies will be paid subject to a *co-payment* and a *Separate Drug Deductible*, per *calendar year*, as shown on the Schedule of Benefits page. A *calendar year* maximum benefit will apply and will also be shown on the Schedule of Benefits page. Charges for covered prescription drugs provided to a *covered person* through a non-participating pharmacy will be reimbursed to the *covered member* when a claim form for direct reimbursement is sent to the Prescription Drug Card Administrator. Reimbursement will be made directly to the *covered member* based on 90% of the average wholesale price of the drug less the *covered person's co-payment* and *Separate Drug Deductible*.

Prescription Drug Card Benefits are paid for drugs requiring written prescription and taken as directed by a *physician*. Benefits will not be payable for more than:

1. a quantity in excess of a 34 day supply; or

2. a quantity in excess of 100 units, whichever is greater

Prescription Drug Card Benefits will not be paid for:

1. drugs taken by or administered to a *covered person* while he or she is a patient in a:
   - A. *Hospital*;
   - B. Skilled Nursing Facility;
   - C. Convalescent *Hospital*;
   - D. Nursing Home;
   - E. Rest Home;
   - F. Sanitarium; or
   - G. any similar institution as named above.

2. Contraceptive devices or supplies and drugs for contraception (unless prescribed by a Doctor for therapeutic purposes) or drugs for fertilization;

3. Experimental drugs, even though a Charge is made to the *covered person*;

4. Drugs purchased without a prescription (over the counter);

5. Any drug labeled, "Caution - Limited by Federal law to Investigation Use";

6. Drugs delivered, administered or injected by the prescriber to the *covered person*;

7. Immunization agents, biological sera, blood or blood plasma;

8. Services or appliances; therapeutic devices including hypodermic needles; syringes; support garments; other non-medical items, regardless of their intended use;

   However, benefits will be paid for *medically necessary* equipment and supplies required for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if prescribed by a *physician* or, if applicable, the patient's primary care *physician*.

9. Charges incurred for prescriptions payable under Workers' Compensation insurance or employer's liability laws;

10. Growth hormones; drugs prescribed for weight control; smoking deterrents; Rogaine; Retin A (covered for *covered persons* under age 25); drugs prescribed for cosmetic purposes; Vitamins and Minerals regardless of the purpose for which prescribed (except prescribed prenatal vitamins are covered); and

11. Charges incurred during the balance of the *calendar year* after the Prescription Drug Card Calendar Year Maximum Benefit has been paid.

12. The use of a drug which the United States Food and Drug Administration has determined to be contra-indicated for the treatment of the current indication;

    A drug prescribed for the treatment of cancer will not be excluded on the ground that it is not approved by the United States Food and Drug Administration for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature.

13. Drugs or services which are furnished in a research trial, if the sponsor of the research trial furnishes the drug or service without charge to participants in the research trial.

Payment of any *prescription medication* charge for a condition does not waive *our* rights to deny coverage for that condition if *we* determine it was a *pre-existing condition* on the *covered persons's effective date* or if *we* determine the condition is otherwise not covered under the *policy*.

Participating Pharmacy: Any pharmacy having legal authority to fill prescriptions and which has a service agreement with the Prescription Drug Card Administrator.

With respect to the payment of benefits, the following definitions apply:

The term “medical literature” means scientific studies published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861 (t)(2)(B) of the Social Security Action, 107 Stat. 591 (1993), 42 U.S.C. 1395x (t)(2)(B), as amended; and

The term “standard reference compendia” means the United States Pharmacopeia Drug Information, or the American Hospital Formulary Service Drug Information.

SECTION III - COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when the *covered person* entitled to medical benefits under the *policy* is also covered by another Plan or Plans of health care benefits. The purpose of this provision is to prevent the payment of benefits under the *policy* which, when added to the benefits payable by other Plans, will exceed 100% of allowable expense. This provision applies whether or not a claim is filed under the other Plan or Plans. If required by *us*, authorization shall be given to *us* by the *covered member* or other appropriate person to obtain information concerning benefits or services available from the other Plan or Plans, or to recover overpayments.

1. Definitions

A. "Plan" as used in this provision will be expanded to include the *policy* and any other plan providing benefits or services for medical treatment when such benefits or services are provided by:

(1) Group or blanket insurance or any other arrangement of coverage for persons in a group whether on an insured, partially insured or uninsured basis;

(2) *Hospital* or medical service organizations on a group basis, group practice and other group pre-payment plans;

(3) Plans designed to pay a fixed dollar benefit per day while the *covered person* is *hospital* confined. COB will be applied only to the portion of the daily benefit which exceeds a minimum of $300 per day;

(4) A licensed Health Maintenance Organization (H.M.O.);

(5) Any group coverage for students which is sponsored by, or provided through, a school or other educational institution;

(6) Any coverage under a Governmental program except for Medicaid, and any coverage required or provided by any state or federal statute that is subject to coordination of benefits;

(7) Group automobile insurance;

(8) Individual automobile insurance coverage on an automobile leased or owned by the *covered person*;

(9) Individual automobile insurance coverage based upon the principles of “no-fault” coverage; or

(10) The medical care components of a group long term care plan, such as skilled nursing home care.

The term "Plan" in this provision will be construed separately herein with respect to

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

B. "Allowable Expense" means a charge for a medical treatment, service, supply or an expense (including *deductibles*, *coinsurance* or *co-payments*), at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both a medical expense and a benefit paid.

C. "Claim Determination Period" means a *calendar year* or that portion of a *calendar year* during which the *covered person* for whom claim is made has been covered under the Plan.

2. Coordination Procedures

Notwithstanding other provisions of the *policy*, benefits that would otherwise be payable under the *policy* will be reduced so that the sum of the benefits payable under all Plans will not exceed the total of Allowable Expenses incurred during any Claim Determination Period with respect to the *covered person*.

3. Payments

Each Plan will make its claim payment according to where it falls in the following order.

A. A Plan which contains no provision for coordination of benefits pays before all other Plans.

B. The Plan which covers the claimant as an employee (or named Insured) pays as though the Plan described in A. above existed; remaining recognized charges are paid under a Plan which covers the claimant as a dependent.

C. The Plan which covers the claimant, other than a child whose parents are separated or divorced, as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a *calendar year* will be paid prior to the benefits of a Plan which covers such claimant as a dependent of another person with a birthday later in a *calendar year*. If either Plan does not contain this item C. which results in the inability to determine priority of benefits, the provisions of this item C. shall not apply, and the rule set forth in the other Plan shall determine the order of benefits.

D. The following rules will apply when the claimant is a dependent child whose parents are separated or divorced:

(1) If the parent with legal custody of the child has not remarried, the benefits of the Plan covering the child as a dependent of that parent will be determined

prior to the benefits of the Plan covering the child as a dependent of the parent who does not have custody.

(2) If the parent with legal custody of the child has remarried, the benefits of the Plan covering the child as a dependent of the parent with custody will be determined prior to the benefits of a Plan covering the child as a dependent of the stepparent. The benefits of the Plan covering the child as a dependent of the stepparent will be determined prior to the benefits of a Plan covering the child as a dependent of the parent without custody. The benefits of the Plan covering the child as a dependent of the parent without custody will be determined prior to the benefits of a Plan covering the child as a dependent of the spouse of the parent without custody.

(3) Items (1) and (2) above will not apply when the financial responsibility for medical care expenses is established by a court decree. In such case, the benefits of the Plan covering the child as a dependent of the parent with such responsibility will be determined prior to the benefits of any other Plan.

E. When the above rules do not establish the order of benefits determination, the benefits of the Plan which has covered the person for the longer period of time shall be determined first, except that:

(1) The benefits of a Plan covering the person as a terminated, laid-off or retired employee, or by virtue of the previous employment of a terminated, laid-off, retired or deceased employee, shall be determined after the benefits of another Plan covering such person as an employee, other than a terminated, laid-off or retired employee, or a dependent of such person; and

(2) If either Plan does not have a provision regarding terminated, laid-off or retired employees, which results in an inability to establish priority of benefits, then item I. above shall not apply.

(3) The benefits of a Plan covering the person under a right of continuation provided by federal or state law shall be determined after the benefits of another Plan covering such person as an employee or a retired employee, or a dependent of such person; and

(4) If either Plan does not have a provision regarding employees covered under continuation coverage, which results in an inability to establish a priority of benefits, then item (3) above shall not apply.

We have the right:

1. To require that the claimant provide *us* with information on such other Plans so that this provision may be implemented; and

B. To pay the amount due under the *policy* to another insurer or other organization if this is necessary, in *our* opinion, to satisfy the terms of this provision.

4. Coordination with Medicare

Notwithstanding all other provisions of the *policy*, *covered persons* who are eligible for *Medicare* benefits will be entitled to benefits under the *policy* in addition to *Medicare*. However, any benefits of the *policy* will be coordinated with *Medicare* in accordance with this Coordination of Benefits Provision of the *policy* and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 and other applicable legislation.

5. Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision of the *policy* or any provision of similar purpose of any other Plan, *we* have

the right to release or obtain benefit information without the consent of or notice to any person. Any person claiming benefits under the *policy* shall furnish *us* such information as may be necessary to implement this provision or determine its applicability.

SECTION IV - POLICY PROVISIONS

Incontestability

Written statements made by the *policyholder*, each *member* and each *covered person* will be considered representations, not warranties. No such representation will be used to void coverage or in defense of a claim under the *policy* unless a copy of the statement has been attached to the Certificate or furnished to the person or entity who made the statements.

The validity of the coverage under the *policy* shall not be contested, except for non-payment of premiums or fraud, after it has been in force for two (2) years from the *effective date*. No statement made by any *covered person* relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after the coverage under the *policy* has been in force for two (2) years, except with respect to statements made pertaining to a *covered person's* eligibility for coverage.

Effective and Termination Dates

Effective Date of Coverage Under the *Policy*

If the initial *premium* is paid, coverage for a *covered person* will become effective at 12:01 A.M. standard time in *the covered member's* state of residence either:

- on the *coverage effective date* as shown in the Schedule of Benefits page; or
- on the endorsement date when any *covered spouse* or *covered dependents* are added for coverage.

If the *covered person* is *totally disabled* on the date the *covered person's* coverage would otherwise take effect, the coverage for the *covered person* will take effect on the second consecutive day the *covered person* is not *totally disabled*. This requirement is not applicable to a *newborn* who would otherwise be covered from the moment of birth for *illness* or *injury*.

Newborn children are covered until the later of 31 days or the date the child is released from the *hospital* following birth. Adopted child(ren) are covered for 31 days from the date of placement. If *we* are notified and receive the required *premium* within 31 days of birth or placement for adoption, the *newborn* or adopted child(ren) will become *covered dependents* without requiring evidence of insurability.

For requests to add an *eligible* dependent after the initial 31 day period described above, *we* require an *application* for coverage and evidence of insurability. *We* reserve the right to decline or accept the *eligible dependent* based on the information in the *application* and evidence of insurability.

For requests to add an *eligible spouse* or stepchild, *we* require an *application* for coverage and evidence of insurability. *We* reserve the right to decline or accept the spouse or stepchild based on the information in the *application* and evidence of insurability.

Termination Date of the Covered Member's Coverage Under the *Policy*

The *covered member*'s coverage under the *policy* will end at 12:01 A.M. standard time in the *covered member*'s state of residence on the earliest of:

- the *premium* due date following the date the *covered member* requests termination in writing or the date *we* receive the request at *our* Home Office, whichever is later; or

- the date the *covered member*'s *premium* is due if not received by the end of the 31-day *grace period*; or

- the *premium* due date following the date the covered person is no longer an *eligible member*; or

- the *premium* due date following the date the *covered member* becomes eligible for *Medicare*; or

- the *premium* due date following the termination of the *policy*; or

- the *premium* due date following the date which we terminate all Certificates under this *policy* in the *covered member's* state of residence on the *covered member's effective date* of coverage. *We* will give the *covered member* 90 days notice prior to the date of termination and will offer the *covered member* coverage under any other policy which we are currently marketing in the *covered member's* state; or

- the *premium* due date following the date which we terminate all Certificates in the *covered member's* state of residence on the *covered member's effective date* of coverage. *We* will give the *covered member* 180 days notice prior to the date of termination; or

- the date of death of the *covered member*; or

- the date there is fraud or material misrepresentation made by, or with the knowledge of, the *covered member*, the *covered member*'s spouse, or the *covered member*'s dependents with regard to this *policy* or its benefits.

A courtesy *premium* notice will be mailed to the *covered member*'s address on file with *us*. The *premium* must be received by the due date, whether or not the *covered member* receives the *premium* notice.

Termination Date of the Covered Spouse's Coverage

Coverage will end for a *covered spouse* at 12:01 A.M. standard time in the *covered member*'s state of residence on the earliest of:

- the *premium* due date following the date the *covered member* requests termination in writing or the date *we* receive the request at *our* Home Office, whichever is later; or
- the date *premium* is due if not received by the end of the 31-day *grace period*; or

- the date the *covered member's* coverage terminates; or

- the *premium* due date following the date of the *covered member*'s and *covered spouse's* divorce; or

- the *premium* due date following the date he or she becomes eligible for *Medicare*; or

- the *premium* due date following the date which we terminate all Certificates under this *policy* in the *covered member's* state of residence on the *covered member's effective date* of coverage. *We* will give the *covered member* 90 days notice prior to the date of termination and will offer the *covered spouse* coverage under any other policy which we are currently marketing in the *covered member's* state; or

- the *premium* due date following the date which we terminate all Certificates in the *covered member's* state of residence on the *covered member's effective date* of coverage. *We* will give the *covered member* 180 days notice prior to the date of termination; or

- the date there is fraud or material misrepresentation made by, or with the knowledge of, the *covered member*, the *covered member*'s spouse, or the *covered member*'s dependents with regard to this *policy* or its benefits.

Termination Date of a Covered Dependent's Coverage

Coverage will end for a *covered dependent* at 12:01 A.M. standard time in the *covered member*'s state of residence on the earliest of:

- the *premium* due date following the date the *covered member* requests termination in writing or the date *we* receive the request at *our* Home Office, whichever is later; or

- the date *premium* is due if not received by the end of the 31-day *grace period;* or

- the date the *covered member's* coverage terminates; or

- the *premium* due date following the date he or she becomes eligible for *Medicare*; or

- the *premium* due date following the date which we terminate all Certificates under this *policy* in the *covered member's* state of residence on the *covered member's effective date* of coverage. *We* will give the *covered member* 90 days notice prior to the date of termination and will offer the *covered dependent* coverage under any other policy which we are currently marketing in the *covered member's* state; or

- the *premium* due date following the date which we terminate all Certificates in the *covered member's* state of residence on the *covered member's effective date* of

coverage. *We* will give the *covered member* 180 days notice prior to the date of termination; or

- the date there is fraud or material misrepresentation made by, or with the knowledge of, the *covered member*, the *covered member's* spouse, or the *covered member's* dependents with regard to the *policy* or its benefits; or

- on the *premium* due date following the earliest of:

  a. the date of *the covered dependent*'s marriage;

  b. the date *the covered dependent* reaches age 21 (or age 25 if the *covered dependent* is enrolled in a full-time course of study at an accredited 2 year or 4 year *college* or *university*).

A Covered Dependent May Continue to Be Insured Beyond Age 21 or 25

An unmarried *covered dependent* who cannot support himself/herself due to mental incapacity or physical handicap may continue to be insured. The *covered dependent* must be chiefly dependent on the *covered member* for support and maintenance. Proof of dependency must be given to *us* no later than 31 days after the *covered dependent* has reached the age at which coverage would otherwise terminate. Proof of dependency, and/or mental incapacity or physical handicap, may be requested anytime during the initial two year period following *the covered dependent's* attainment of the age coverage would normally terminate. After two years, *we* will request proof of continuing disability no more frequently than annually. *We* will charge an adult premium if coverage is continued beyond the specified age.

Extension of Benefits

If a *covered person* is confined in a *hospital* on the date coverage under the *policy* is terminated for any reason, except nonpayment of the premiums, coverage for that *covered person* only shall be extended. Extended coverage will terminate the earliest of:

- the date the *covered person* is discharged from the *hospital*;

- 10 days after the coverage under the policy is terminated; or

- payment of the maximum benefit.

Termination of the Policy

The *policy* becomes effective at 12:01 A.M. Standard Time at the *policyholder's* address on the effective date shown on the *group master application* and will remain in force until it is terminated by either the *policyholder* on 60 days prior written notice or by *us*. *We* can only terminate the *policy* upon 90 days prior written notice if *we* offer the *policyholder* coverage, on a guaranteed issue basis, under any other policy which we are currently marketing or upon 180 days prior written notice if *we* terminate all of our policies in the state of delivery.

Health Insurance Continuation. If a *covered member* dies, the covered surviving spouse 50 years of age or older may continue coverage under this *policy* as if they were a member. The *premium* will be the same as it would be if the spouse were a member. There will be no physical exam. The surviving spouse has 90 days from the date of the *covered member's* death in which to notify *us* of their intent to continue coverage. If *we* are aware of the *covered member's* death, *we* will notify the covered surviving spouse of the continuation privilege. If the surviving spouse chooses to continue coverage under this provision, coverage will continue without interruption unless:

1. *premium* is not paid by the expiration of any applicable grace period;

2. the surviving spouse becomes eligible for Medicare or another group accident and health plan;

3. the surviving spouse requests termination in writing;

4. *we* terminate all *Certificates* under this *policy* in the surviving spouse's state of residence;

5. there is fraud or material misrepresentation made by, or with the knowledge of, the surviving spouse with regard to this *policy* or its benefits; or

6. the surviving spouse remarries.

Covered dependents of a deceased member are entitled to convert, as outlined in the Health Insurance Conversion provision.

Covered members whose membership in the Association terminates or whose membership in the eligible class terminates are eligible to continue coverage for themselves, their covered spouses and their *covered dependents*. This benefit is offered to *covered members* who have been continuously covered under this *policy*, or for similar benefits under any other group policy that this *policy* replaced, for 3 consecutive months. *Covered members* are not eligible for continuation if they are eligible to participate in another group medical plan within 31 days of their termination in the Association, or if coverage terminated due to fraud or material misrepresentation. In order for the continuation benefit to apply, members must pay the applicable *premium* in advance for the full amount of coverage before their insurance would have otherwise terminated, however, this amount shall be no more than required for a one month period.

Continuation under this provision terminates on the earliest of the following:

1. one year from the date the *covered member's* insurance under this *policy* would have otherwise terminated due to termination of membership;

2. the *premium* due date following the date ending the period for which the member last makes his or her required contribution;

3. the date the member becomes eligible to be covered for similar benefits under any arrangement of coverage for individuals in a group; or

4. the date we terminate all *Certificates* under this *policy* in the *covered member's* state of residence;

5. The date there is fraud or material misrepresentation made by, or with the knowledge of, the *covered member* with regard to this *policy* or its benefits; or

6. the date the group *policy* is terminated, however, under this alternative, the *covered member* would have the right to convert, as outlined in the Health Insurance Conversion Provision.

Health Insurance Conversion. A *covered member* may convert his or her health insurance coverage under the *policy* to another form of insurance issued by *us*, if such insurance, or any portion of it, ends, provided the covered *person* is entitled to convert and, within 31 days after such coverage ends, the *covered person*:

1. applies in writing to *us* at our home office; and

2. pays the first premium.

No evidence of insurability will be required if the *covered member* converts under this provision.

Entitled to Convert. A *covered person* is entitled to convert under this option if the *covered person's* coverage under the *policy* terminates for any reason and the *covered person* has been covered continuously under the *policy*, and/or under any group policy providing similar benefits that the *policy* replaced, for at least 3 months prior to termination.

A *covered person* shall not be entitled to a converted policy if termination of coverage under the *policy* occurred due to nonpayment of *premium* or fraud or material misrepresentation, or because the *policy* was replaced by a similar policy within 31 days after discontinuance.

We will not issue a converted policy to any *covered person* who is:

1. covered or could be covered by Medicare; or

2. covered by another hospital, surgical, or major medical expense insurance policy; or

3. eligible for similar benefits as would be provided by the converted policy, whether or not the *covered person* is actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or an uninsured basis; or

4. or eligible for benefits under any state or federal law;

We may request that a *covered person* provide information relative to their eligibility for insurance coverage under this provision.

Type of Policy. The converted policy will be on a form chosen by us, however, it will not provide benefits less than those in the *policy*. The converted policy will cover all *covered persons* who were covered under the *policy* when coverage was terminated. *We* may, at *our*

option, issue a separate policy to cover a *covered spouse* or *covered dependent*.

The premium for the converted policy will be in accordance with premium rates applicable to the age and class of risk of each person to be covered under the converted policy and to the type and amount of insurance provided. However, the *premium* will not exceed the *premium* charged by the Louisiana Health Insurance Association, adjusted for difference in benefit levels provided for the two policies.

Notice of Conversion Right. Notice of the *covered person's* right to convert will be presented to the *covered member* or delivered to the *covered member's* last known address within 15 days from the date his or her coverage ends. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the initial 31-day period of time be extended beyond 60 days from the date insurance ends.

Notice of Claim

We must be notified of a claim in writing and receive *proof of loss* within 90 days after the start of a claim, or as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Notification of claim should include the following:

- the *covered member's* name and social security number;
- *policy* number;
- home address; and
- the *physician* or *hospital* bill.

If a claim is made for a *covered spouse* and/or *covered dependent*, his/her name and age should be included.

Send notification of a claim to:

The Provident
Claims Department
PO Box 31499
Tampa, FL 33631-3499

The time limitations required by this section will not be less than those permitted by the law of the state, district, or territory in which the *covered member* resides at the time the *certificate* is issued.

Our Right to Request Additional Information

If *the covered person* uses a *participating provider*, *the participating provider* may submit the necessary claim forms to *us*.

If *we* need any additional information, *we* will request that information within 15 days after the receipt of the claim. If, within those 15 days, *we* do not request any additional information, submitted *proof of loss* will be sufficient.

When requested, the *covered member* must cooperate with *us* and assist *us* by:

- authorizing the release of medical information including the names of all *providers* from whom the *covered person* has received treatment or services;
- providing information regarding the circumstances of the claim; and
- providing information about other insurance coverage.

How Claims are Paid

The highest level of benefits are available under this *policy* when a *participating provider* is used. *Participating providers* agree to provide health care services at negotiated prices and agree not to bill more than the *negotiated fee*. The *covered member* will be responsible for the *deductible, coinsurance,* and *co-payment* amounts. *The coinsurance* amount is based upon the *negotiated fee*. Please refer to the Schedule of Benefits page for the *benefit percentage*. *Participating providers* agree to file claims for the *covered person* and reimbursement is made directly to the *participating provider*.

The *policy* will pay a lower level of benefits when a *nonparticipating provider* is used. These *nonparticipating providers* have not signed contracts with *us* and do not provide services at agreed upon prices. When a *covered person* receives services from a *nonparticipating provider*, *covered expenses* are limited to the *usual, reasonable and customary charge*. The *covered member* will be responsible for the *deductible*, *coinsurance*, *co-payment*, any amount of the billed charges that exceed the *usual, reasonable and customary charge,* and all paperwork regarding the claim. Please refer to the Schedule of Benefits page for the *benefit percentage.* At the *covered member's* request, payment may be made directly to the *provider*.

We will pay all amounts due for *covered expenses* to the *covered member*, to the extent that the *covered member* is legally able to accept payment. If the *covered member* has died prior to the payment of a benefit, the payment may be made, at *our* discretion, to the *provider* of the services for which the charge is payable or to the *covered member's* estate. If the *covered member* is living, but not legally able to give a valid release for payment, *we* will make payment to the *immediate family* member who is legally authorized to provide a valid release.

Facility of Payment

If any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, *we* may pay the benefit, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the person who is deemed by *us* to be equitably entitled to the benefit. The amounts so paid will be deemed to be benefits paid under the *policy* and to the extent of such payments, *we* will be fully discharged from liability under the *policy*.

The benefits that are payable in accordance with this provision will be charged against any applicable maximum payment or benefit of the *policy* rather than the amount payable in the absence of this provision.

Other Insurance With This Insurer

If a *covered person* is covered under more than one medical policy with *us*, only one policy chosen by the *covered person* will be effective. *We* will refund all premiums paid for the coverage under all the other medical policies.

Allocation and Apportionment of Expenses

We reserve the right to allocate the *deductible* to any *covered expense* and to apportion the benefits to the *covered person* and any assignees. Such allocation and apportionment by *us* shall be conclusive.

Time of Payment of Claim

Benefits payable under this *policy* will be paid immediately upon receipt of due written *proof of loss*.

How to Request a Review of a Claim Decision

If the *covered person or* the *covered person's provider* would like additional information or have any complaints concerning the basis upon which payment was made, they may contact *our* Customer Service Department at 1-800-519-9175. *We* will address concerns and attempt to resolve them satisfactorily. If *we* are unable to resolve a concern over the phone, *we* will request submission of the concern in writing to pursue a formal grievance.
A formal grievance must be submitted, in writing to *us* at the following address:

The Provident
Claims Department
PO Box 31499
Tampa, FL 33631-3499

A formal grievance should include:

- The *covered member's* name and social security number;
- home address;
- *policy* number; and
- any other information, documentation, or evidence to support *your* request.

A formal grievance must be submitted within 90 days of the event that resulted in the complaint. *We* will acknowledge a formal grievance within 10 working days of its receipt. *Our*

decision will be sent to the *covered member* in writing within 30 days following receipt of the formal grievance.

If there are extraordinary circumstances requiring a more extensive review, *we* may take up to an additional 60 days to review the formal grievance before rendering a decision.

Our Right to Recover any Overpayment

In the event of any overpayment of benefits under *the policy*, *we* have the right to recover the overpayment. In the event that other insurance makes payment on charges for which *we* also made payment under this *policy*, *we* have the right to recover the overpayment, if any.

If payment is made to the *covered member* and that payment is found to be an overpayment, *we* will request a refund of the overpayment from the *covered member*. If the refund is not received from the *covered member*, the amount of the overpayment may be deducted from future benefits.

Similarly, if payment is made to a *provider* on behalf of the *covered person* and that payment is found to be an overpayment, *we* will request a refund of the overpayment.

Subrogation

In the event any benefits are paid under this *policy, we,* to the extent permitted by law, shall be subrogated and succeed to the *covered person's* right of recovery for incurred medical expenses from another source. The *covered person* shall have the right to be made whole for their medical expenses and be obligated to pay over to *us* all sums recovered by suit, settlement, or otherwise, on account of such incurred medical expenses, not to exceed the amount of benefits paid under the *policy*.

Medical expenses need not be specified in a recovery. *We* will assume recovery includes such medical costs if expenses were incurred.

A *covered person* must furnish information and assistance, and execute any assignment or other instrument that *we* may require to facilitate the enforcement of *our* rights and interests. A *covered person* must not take any action prejudicing *our* rights and interests.

Clerical Errors

Upon discovery of clerical errors by *us,* any needed adjustments will be made.

Correcting Misstatements

If any relevant fact about the *covered person* has been misstated, the true facts will be used to determine whether insurance is inforce. If the age of any *covered person* has been misstated, an adjustment in *premium* or benefits, or both, will be made based on the true facts. No misstatement of age will continue insurance otherwise terminated or terminate insurance otherwise inforce.

Policy will Conform with State Laws

Any provision of the *policy* which does not agree with the laws of the state in which the *covered member* resides on the *policy effective date*, is automatically changed to agree with the minimum requirements of those laws.

Entire Contract

The *policy* and any attached riders or endorsements constitutes the entire contract of insurance between the *policyholder* and *us*. The rights and duties under the *policy* of *us*, the *policyholder*, the *covered member* and each *covered person* are established by the terms and conditions of the *policy*. The *policyholder* may act on behalf of each *member*, and each *covered person* concerning coverage provided under the *policy*. Each act by, agreement with, or notice given to the *policyholder* will bind each *member* and each *covered person*.

How Changes to this Policy can be Made

A change in the terms and conditions of the coverage provided under the *policy* will be evidenced by an amendment agreed to by the *policyholder* and *us*. The consent of a *covered member, covered person* or *beneficiary* is not required prior to the amendment becoming effective. Only *our* executive officers may give consent on *our* behalf. No agent has authority to waive a complete answer to any question on a written *application*; pass on a person's insurability; or make, alter, or waive any provision of the *policy*.

Change in Benefit

An increase in a *covered person's* coverage resulting from an amendment to the *policy* or change in the *covered person's class* will take effect on the latest of:

1. The effective date of the change in the *covered person's class*;

2. The effective date of the *policy amendment*; or

3. If *totally disabled* on the otherwise *effective date*, the second consecutive day the *covered person* is no longer *totally disabled*.

A decrease in a *covered person's* coverage resulting from an amendment to the *policy* or change in the *covered person's class* will take effect on the effective date of the amendment or the change in *class*.

An increase in health benefits will not apply to a continuing *illness* or *injury* resulting from the same event which exists on the date the increase would otherwise take effect.

Our Right to a Physical Examination and Autopsy

We have the right, at *our* expense, to have a *covered person* examined while a claim is pending and/or to have an autopsy performed when not forbidden by law.

Computation of Premiums

Each *premium* provided to a *covered person* will be based on the *premium* rates applicable and in effect on the *premium* due date.

Premium **Changes**

Premium rates for each *certificate* issued under the *policy* are guaranteed not to increase during the first 12 months after the effective date of coverage, and then no more than once every 6 months thereafter, except if any of the following occur:

1. Addition or deletion of a *covered dependent(s)*;

2. Change in the age of a *covered member* or *covered dependent*(s);

3. Change in geographic location of a *covered member*; or

4. Increase or decrease in benefits.

Changes to the *premium* due to any of the above will take effect on the first of the month following the *effective date* of the change.

The *covered member* will be notified at least 45 days in advance of any *premium* increase of 20% or more.

Premium **Due Within 31-Day *Grace Period***

Premium must be paid on or before the *premium* due date or during the 31 day *grace period* immediately following the *premium* due date. Coverage under the *policy* remains inforce during the *grace period*. No benefits are payable for expenses incurred during the *grace period* if the *premium* has not been received by the end of the *grace period*. If the *premium* has not been received by the end of the 31 day *grace period*, coverage under the *policy* will lapse.

Reinstatement Provision

If any *premium* is not received by the end of the 31 day *grace period*, a later acceptance of *premium* by *us* shall reinstate coverage under the *policy*, except that if *we* require an *application* for reinstatement and issue a conditional receipt for the *premium* tendered, coverage under the *policy* will be reinstated upon approval of such *application* by *us* or, lacking such approval, upon the 45th day following the date of such conditional receipt unless *we* have previously notified the *covered member* in writing of the disapproval of such *application*.

The reinstated *coverage* shall cover only loss resulting from such accidental *injury* as may be sustained after the date of reinstatement and loss due to such sickness which begins more than ten days after such date. In all other respects the *covered member* and us shall have the same rights thereunder as they had under the *policy*, immediately before the due date of the defaulted *premium*, subject to any endorsement on, or riders attached to the *policy* in connection with reinstatement.

Legal Actions are Limited

A lawsuit to recover on a claim cannot be brought against *us* until at least 60 days, but no later than three years, after *proof of loss* is required to be filed.

The time limitations required by this section will not be less than those permitted by the law of the state, district, or territory in which the *covered member* resides at the time the *certificate* is issued.

Time Limit on Certain Defenses

The following Time Limits on Certain Defenses shall apply to all *covered persons*:

- *we* cannot void a benefit or deny a claim which begins two years after the *covered person's effective date* because of misstatements on the *application* for this *policy*, unless such misstatements were fraudulent; and

- *we* cannot reduce a benefit or deny a claim because a condition duly disclosed in *the application* was present before the *covered person's effective date*, unless a rider to the *policy* contains an exclusion for that condition.

We Will Add to the Lifetime Maximum Each Year

On each *renewal date*, the balance of the *lifetime maximum* for each *covered person* is increased by the lesser of:

- $10,000; or

- the amount needed to restore the full *lifetime maximum.*

Events that will Cause a Refund

If coverage under the *policy* is canceled or terminated, *we* will refund unearned *premium* to the *covered member* or the *covered member's* estate after deducting any claim for losses during the current term of the *policy*.

If a *covered person* dies, *we* will refund, on a pro rata basis, to the *covered member* or the *covered member's* estate within 30 days after notice to *us* of their death, that portion of the *premium*, fees or other sums paid beyond the *covered person's* date of death.