BCS Insurance Company
2 Mid America Plaza
Oakbrook Terrace, Illinois 60181

GROUP MAJOR MEDICAL EXPENSE INSURANCE

CERTIFICATE OF COVERAGE

Group Policy No. **PAI-Z-25350000** ("the Policy"), has been issued to **Alternative Staffing, Inc.**, which we refer to as "the Policyholder". We refer to BCS Insurance Company as "we", "us" or "our".

The Policy is administered on our behalf by "the Administrator" Planned Administrators, Inc.

The Policy was delivered in South Carolina and is governed by its laws and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

This certificate of insurance is evidence of the Insured's coverage under the Policy and of its benefits. Everything contained in this certificate is subject to the provisions, definitions and exceptions in the Policy. The Policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers may authorize a change to the Policy.

This certificate replaces all certificates and certificate riders, if any, previously issued to the Insured under the Policy.

IN WITNESS WHEREOF, we have signed the Policy at Oakbrook Terrace, Illinois.

SECRETARY

PRESIDENT

This is a Participating Provider Plan. There are differences in benefits provided under the Plan when a Covered Person receives Covered Services from a Participating Provider (In-Network) or Non-Participating Providers (Out-of-Network). We pay Covered Services at the In-Network or Out-of-Network benefit level shown in the Schedule of Benefits. Services or supplies from a Non-Participating Provider may be significantly higher than those same services or supplies received from a Participating Provider. However, if a Covered Person uses a Non-Participating Provider solely because he or she receives Medically Necessary Emergency Medical Care, then the benefits will be paid for Covered Services on the same basis as if the Covered Person had used the services of a Participating Provider, subject to the same In-Network Provider Cost-Sharing requirements.

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PART I - GENERAL DEFINITIONS

Throughout this certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. Wherever used in this certificate:

Accident means a sudden, unforeseeable event that causes Injury to one or more Covered Persons.

Alcoholism means a disorder characterized by a pathological pattern of alcohol use that causes a serious impairment in social or occupational functioning, also termed alcohol abuse or, if tolerance or withdrawal is present, alcohol dependence.

Ambulatory/Outpatient Surgical Facility means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Anesthesia Services means the administration of anesthesia and the performance of related procedures by a Physician or a certified registered nurse anesthetist that may be legally rendered by them respectively.

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

Autism Spectrum Disorder means one of the three (3) following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

a) Autistic Disorder;
b) Asperger's Syndrome;
c) Pervasive Developmental Disorder – not otherwise specified.

A **Calendar Year** is a 12-month period beginning each January 1 at 12:01 a.m. Standard Time.

Claim means notification in a form acceptable to us that a service has been rendered or furnished to a Covered Person. This notification must include full details of the service received, including name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which we may request in connection with services rendered to a Covered Person.

Claim Charge means the amount which appears on a Claim as the Provider's charge for service rendered to a Covered Person.

Claim Payment means the benefit payment calculated by us, after submission of a Claim, in accordance with the benefits described in this certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to a Covered Person.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), or as later amended.

Coinsurance is the percentage of Covered Expenses the Covered Person is responsible for paying (after the applicable Deductible is satisfied and/or Copayment paid). **Coinsurance does not include charges for services that are not Covered Services or charges in excess of the Eligible Charge. These charges are the Covered Person's responsibility and are not included in the Coinsurance calculation.**

Coinsurance Maximum is the amount of Coinsurance each Covered Person incurs for Covered Expenses in a Coverage Year. The Coinsurance **does not** include any amounts in excess of the Eligible Charge, the Deductible and/or any Copayments, any penalties, or any amounts in excess of other benefit limits of this Plan.

Coinsurance Percentage is the percentage of Covered Expenses we will pay after the applicable deductible amount(s) or copayment amount(s) for a service or supply that:

a) qualifies as a Covered Expense under one or more benefit provisions; and
b) is received while the Covered Person's insurance is in force under the Policy if the charge for the service or supply qualifies as a Covered Expense.

Confined/Confinement means being registered as an Inpatient in a Hospital or other Health Care Facility, on the order of a Physician, for Medically Necessary treatment.

Copayment is the fixed dollar amount of Covered Expenses the Covered Person is responsible for paying a Provider at the time of service in connection with specific Covered Services. **Copayment does not include charges for services that are not Covered Services or charges in excess of the Eligible Charge.**

Cosmetic and Reconstructive Surgery. **Cosmetic Surgery** is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Reconstructive Surgery** is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. **Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Course of Treatment is a planned, structured, and organized sequence of treatment procedures based on an individualized evaluation to restore or improve health function, or to promote chemical free status. A Course of Treatment is complete when the patient has finished a series of treatments without a lapse in treatment or has been medically discharged. If the Covered Person begins a series of treatments, it will count as one course of treatment, reducing the available benefits, even if the patient fails to comply with the treatment program for a period of thirty (30) days.

Coverage Year begins on the Policy Effective Date shown in the Schedule of Benefits and continues for the next 12 consecutive month period.

Covered Expenses are the expenses incurred for Covered Services. Covered Expenses for Covered Services received from Participating Providers will not exceed the Negotiated Rate. Covered Expenses for Covered Services received from Non-Participating Providers will not exceed the Eligible Charge. In addition, Covered Expenses may be limited by other specific maximums described in this Policy under Part III DESCRIPTION OF COVERED SERVICES or in the Schedule of Benefits. Covered Expenses are subject to applicable Deductibles, penalties and other benefit limits. **An expense is incurred on the date the Covered Person receives the service or supply.**

Covered Person means any person for whom coverage is in effect under the Policy.

Covered Services are Medically Necessary services or supplies that are listed in Part III THE DESCRIPTION OF COVERED SERVICES section of this Plan, and for which a Covered Person is entitled to receive benefits.

Creditable Coverage means coverage you had under any of the following:

a) A group health plan;
b) Health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;
c) Medicare (Part A or B of Title XVIII of the Social Security Act);
d) Medicaid (Title XIX of the Social Security Act);
e) CHAMPUS (Title 10 U. S. C. Chapter 55);
f) The Indian Health Service or a tribal organization;

g) A State health benefits risk pool, including the South Carolina Health Insurance Pool;
h) The Federal Employees Health Benefits Program;
i) A public health plan maintained by a State, county or other political subdivision of a State;
j) Section 5(e) of the Peace Corps Act;
k) Title XXI of the Social Security Act (State Children's Health Insurance Program).

Custodial Care Service means those services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to you if you are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to you as an Inpatient in the Health Care Facility involved.

Deductible means the amount of Covered Expenses specified in the Schedule of Benefits each Covered Person must pay for Covered Services before benefits are payable under this Plan. The **Family Deductible** means the amount of Deductibles specified in the Schedule of Benefits that must be met by all Covered Persons during the Coverage Year before no further Deductibles are required to be satisfied. Deductible does not include any copayment amount or charges in excess of the Eligible Charge.

Doctor (See Physician).

Diagnostic Services means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or Injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Durable Medical Equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an Injury or Sickness, are Medically Necessary and prescribed by a Doctor, can withstand repeated use, generally not useful to a person in the absence of Injury or Sickness and are appropriate for use in the patient's home.

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

The **Effective Date of the Policy** is the date that the Policy became active with us.

The **Effective Date of Coverage** is the date on which coverage under this Policy begins for the Insured and any other Covered Person. Refer to Effective Date under Part II INDIVIDUAL INSURING PROVISIONS.

Eligible Charge means the amount we will consider a Covered Expense with respect to charges made by a Provider for Covered Services. In the case of a Provider which has a written agreement with us and/or our authorized Administrator to provide care to a Covered Person at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services. In the case of a Provider who does not have a written agreement with us and/or our authorized Administrator to provide care to a Covered Person at the time Covered Services are rendered, the lesser of either of the following charges for Covered Services:

a) the charge which the particular Hospital or Health Care Facility usually charges its patients for Covered Services, or

b) the charge which is within the range of charges other similar Hospitals, Health Care Facilities or other Providers in similar geographic areas charge their patients for the same or similar services.

Eligible Dependent See Eligibility under Part II INDIVIDUAL INSURING PROVISIONS.

Eligible Employee means an individual who is:

a) employed by the Policyholder and working full-time according to state guidelines or at least 30 hours per week;
b) receiving monetary compensation from the Policyholder that is subject to FICA and federal income tax withholding by the Policyholder;
c) not a seasonal or temporary employee and is scheduled to work at least 9 months per Calendar Year; and
d) a partner or proprietor actively engaged in the business of the Policyholder on a full-time basis.

An individual who is laid off, retired, a consultant or on the board of directors will not be considered an Eligible Employee.

Emergency or Emergency Medical Care means services provided for the initial Outpatient treatment, including related Diagnostic Services, of an Illness or Injury displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

a) placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b) serious impairment to bodily functions;
c) serious dysfunction of any bodily organ or part; or
d) serious disfigurement of the Covered Person.

Experimental or Investigational Medical Treatment, Procedure or Drugs. A treatment, medication, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists: (1) It cannot be legally marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its proposed use; (2) It is not yet recognized as acceptable medical practice throughout the United States to treat that Sickness or Injury; or (3) It does not have the positive endorsement of national medical bodies or panels, such as the American Cancer Society. A treatment, drug, device, procedure, supply or service may be Experimental or Investigational based on the following evaluations: (1) Reports in peer review medical literature published in the English language as of the date of service; (2) Scientific evaluations published by organizations that conduct health care research such as the Agency for Health Care Policy and Research, the National Institutes of Health, the American Medical Association, and the American College of Physicians; (3) Opinions of independent medical consultants; (4) Listings in drug correspondence, including the American Medical Association's Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Drug Information; (5) Use of a written informed consent addressing the Experimental or Investigational nature of the service or supply. This applies whether consent is used by the Insured Person's Physician or by any other Physician studying the same or similar service or supply; (6) Any requirement that the use of the service or supply be subject to Institutional Review Board ("IRB") approval; (7) Written protocols used by the health care Provider.

Group Policy or Policy means the agreement between us and the Policyholder, any riders, this certificate, the Schedule of Benefits, the application and any employee application form of the persons covered under the Policy.

Habilitation Services means ongoing, Medically Necessary, therapies provided to persons with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and

skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a person's functional status over a lifetime and on a treatment continuum.

Health Care Facility means an institution providing health care services or a health care setting, including but not limited to Hospitals and other licensed inpatient facilities, Ambulatory/Surgical Facility, urgent care centers, Skilled Nursing Facility, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health care settings

Health Insurance Coverage means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer

Home Health Care Agency is a Provider of home health care that is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Covered Person's home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Home Infusion Therapy Provider is a Provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice Care Program means a coordinated, interdisciplinary program prescribed and supervised by a Physician to meet the special physical, psychological, and social needs of a terminally ill Covered Person and those of his or her Immediate Family.

Hospices are Providers that are licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as a hospice Provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospital means an institution that:

a) is operated pursuant to law for the care and treatment of injured or sick persons on an inpatient basis;
b) has organized facilities for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or has a contract with another hospital for these services;
c) has staff of one or more Physicians available at all times; and
d) has 24-hour a day nursing service by Registered Nurses (R.N.).

Hospital excludes any institution that is primarily a long term care, extended care facility rest home, nursing home, convalescent home, a home for the aged, an alcoholism or a drug addiction treatment facility or a facility for treatment of mental disorders.

Illness (See Sickness)

Immediate Family means the parents, spouse, children or siblings of any Covered Person or any person residing with the Covered Person.

Infertility means the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one (1) year.

Infusion Therapy is the administration of Drugs (prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include drugs administered by aerosol (into the lungs) and by feeding tube.

Injury means an accidental bodily injury of a Covered Person, which is the direct cause of a Loss independent of disease, bodily infirmity or any other cause.

In-Network/In-Network Provider(s) means a Hospital, Physician, Pharmacy or any other health services Provider which has signed an agreement affiliating with a Network Provider Organization to provide services and supplies at a predetermined rate. We or our subcontractor vendor selects In-Network Providers to make their services and supplies available to specific geographic areas at benefit levels as shown in the Schedule of Benefits. Your Network Provider Organization is identified on your insurance I.D. card. An In-Network Provider is a Preferred Provider.

Inpatient means that you are a registered bed patient and are treated as such in a Hospital or other Health Care Facility.

Insured/Insured Person means an employee for whom coverage is in effect under the Policy.

Investigative Procedures (See Experimental/Investigational)

Investigational or Investigational Services and Supplies means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the appropriate government agency at the time used or administered to you.

Late Enrollee means any Eligible Employee or Eligible Dependent who submits his/her written application after the expiration of the openl enrollment period.

Loss means an event for which benefits are payable under this Plan. A Loss must occur while the Covered Person is insured under this Policy.

Manipulative Therapy means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofacial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. Manipulative therapy is not limited to treatment by manual means.

Maternity Service means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy that, through vaginal delivery, results in an infant, who weighs *5* pounds or more.

Medical Care means the diagnosis, care, mitigation, treatment or prevention of disease.

Medically Necessary means the care, service or supply is:

a) prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and
b) appropriate, according to conventional medical practice for the Injury or Sickness in the locality in which the care or service is given.

Medicare means Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

Mental Health Disorders means a mental or emotional disease classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient.

Negotiated Rate is the rate of payment that we have negotiated with a Participating Provider for Covered Services.

Network means the group of Participating Providers providing services who have contracts that include an agreed upon price for health care expenses.

Network Provider Organization (Preferred Provider Organization) means a vendor under contract with us or our authorized Administrator to provide Covered Services within a Service Area. The vendor will enter into separate and distinct contracts with In-Network Providers to provide services covered by the Policy at a reduced predetermined rate.

Non-Participating Hospital (Out of Network) is a Hospital that has not entered into a Participating Hospital agreement with the Network Provider Organization at the time services are rendered.

Non-Participating Physician (Out of Network) is a Physician who does not have a Participating Provider agreement in effect with the Network Provider Organization at the time services are rendered.

Non-Participating Pharmacy (Out of Network) is a Pharmacy that has not entered into a Participating Pharmaceutical agreement with the Network Provider Organization at the time services are rendered.

Non-Participating Provider (Out of Network) is a Provider who does not have a Participating Provider agreement in effect with the Network Provider Organization at the time services are rendered.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Office Visit means a visit by the Covered Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

a) History (gathering of information on a Sickness or Injury);
b) Examination; or
c) Medical decision making (the Physician's diagnosis and Course of Treatment).

This does not include other services (e.g. X-rays or lab services) even if performed on the same day.

Out-of-Network/Out-of-Network Provider means a Hospital, Physician, Pharmacy or any other Provider who does not have an agreement with a Network Provider Organization to provide services and supplies at a predetermined rate at the time services are rendered.

Out-of-Pocket Maximum means those Covered Expenses that a Covered Person is required to pay that:

a) qualify as Covered Expenses; and
b) are not paid or payable if a claim were made under any Other Plan.

When the Out-of-Pocket Maximum has been met, additional Covered Expenses will be payable at 100%. The amount payable will be subject to any specific benefit limits stated in the Policy, a determination of eligible Covered Expenses and any reduction for a Covered Expense incurred at a Non-Participating Provider. The Out-of-Pocket Maximum includes the Deductible, Coinsurance and any Copayments the Covered Person is responsible for paying.

Outpatient means a person who incurs medical expenses at Doctors' offices, an Ambulatory/Outpatient Surgical Facility or other Health Care Facility while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in a Hospital emergency room regardless of whether you are subsequently registered as an Inpatient.

Partial Hospitalization Treatment Program means a planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Sickness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

Participating Hospital (In Network) is a Hospital that has a Participating Hospital agreement in effect with us or our authorized Network Provider Organization at the time services are rendered. Participating Hospitals agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Participating Physician (In Network) is a Physician who has a Participating Physician agreement in effect with us or our authorized Network Provider Organization at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Participating Provider (In Network) is a Participating Physician, Hospital, or other health care Provider that has a Participating Provider agreement in effect with us or our authorized Network Provider Organization at the time services are rendered. Participating Providers agree to accept the Negotiated Rate as payment in full for Covered Expenses.

Pediatric Preventative Care means those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a Physician and rendered to a child.

Physical Therapy means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician or Doctor means any duly licensed medical practitioner of a healing art who is recognized by the law of the state in which treatment is received as qualified to perform the service for which Claim is made.

Plan is the set of benefits described in the certificate of coverage. This Plan is subject to the terms and conditions of the Policy we issued to the Policyholder. If changes are made to the Policy or Plan, an amendment or revised certificate will be issued to the Policyholder for distribution to each Insured affected by the change.

Policy is the Group Policy we have issued to the Policyholder.

Prior Authorization means that you must contact our authorized Administrator to obtain authorization to receive a Covered Service. Although you can go to the Hospital or Provider of your choice, your benefits will be greater when you use the services of the Hospital or Provider approved by our authorized Administrator. If you do not obtain Prior Authorization, benefits will be paid at the portion of the Eligible Charge as shown in the Schedule of Benefits under Prior Authorization.

Private Duty Nursing Service means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse that is not providing this service as an employee or agent of a Hospital or other Health Care Facility. Private Duty Nursing Service does not include Custodial Care Service.

Provider means any Health Care Facility (for example, a Hospital) or person (for example, a Physician, dentist or other health care provider) or entity duly licensed to render Covered Services to a Covered Person.

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

Rehabilitation Medical Practitioner means a Physician, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A Rehabilitation Medical Practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitative Services means health care services that help a Covered Person keep, get back or improve skills and functioning for daily living that have been lost or impaired because the Covered Person

was sick, hurt or disabled. These services consist of Physical Therapy, Occupational Therapy and Speech Therapy in an Inpatient and/or Outpatient setting.

Serious Mental Illness means the following biologically-based mental disorders as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association:

1. schizophrenia;
2. bipolar disorder;
3. obsessive-compulsive disorder;
4. major depressive disorder;
5. paranoid and other psychotic disorder;
6. anxiety disorder;
7. post-traumatic stress disorder;
8. schizo-affective disorder; and
9. depression in childhood and adolescence.

Sickness means a sickness, disease, Complication of Pregnancy, Mental Health Disorder or Substance Abuse of a Covered Person treated by a Doctor that causes Loss while a Covered Person's coverage is in force under the Policy. Sickness does not include learning disabilities, attitudinal disorders or disciplinary problems.

Skilled Nursing/Rehabilitation Facility means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. This definition **excludes** any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or education care.

Skilled Nursing Service means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot be reasonably taught to a person who does not have specialized skill and professional training.

Speech Therapy means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, previous therapeutic processes, psycho-social speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation and which is designed and adapted to promote the restoration of a useful physical function.

Substance Abuse means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or psychologist.

Substance Abuse Rehabilitation Treatment means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist, or Clinical Professional Counselor, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Abuse Treatment Facility means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment.

Surgery means the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by our authorized Administrator.

Totally Disabled means with respect to the Insured Person, the complete inability by reason of Sickness or Injury to perform all the substantial and material duties of his or her occupation for which the Insured Person is or becomes qualified by reason of experience, education or training; or with respect to a Covered Person other than the Insured, the inability by reason of Sickness or Injury to engage in the normal activities of a person of the same age and sex who is in good health.

Waiting Period means the length of time that an Eligible Employee must continuously work before the Eligible Employee is covered under the terms of the Policy. The Waiting Period is determined by the Policyholder on the application for coverage under the Policy.

PART II - INDIVIDUAL INSURING PROVISIONS

Eligibility:

Insured - Each person, as described in the Schedule of Benefits, is eligible for coverage under the Policy as an Insured.

Eligible Dependents - Coverage under the Policy may also be extended to include the Insured's children who are less than age 26.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

Effective Date:

Insured: Contributory - Individual insurance becomes effective on the latest of:

a) the Policyholder's effective date if the person is eligible for coverage on that date and his or her enrollment and premium have been received on or before that date;

b) the date the person enrolls if: 1) he or she becomes eligible after the Policyholder's effective date, provided the person has satisfied any Waiting Period; and 2) the person's enrollment and premium are received within 31 days after the date the person becomes eligible; or

c) as provided in the Schedule of Benefits.

An eligible person may enroll only within 31 days after becoming eligible or acquiring a new dependent or during an open enrollment period. Open enrollment period means a pre-determined term during which any eligible person who previously did not enroll for coverage under the Policy, may enroll for coverage.

Dependents - Dependent insurance becomes effective on the latest of:

a) the Insured's effective date if the dependent is eligible for coverage as of that date and the Insured enrolls and pays premium for the dependent on or before that date;

b) the date the Insured enrolls a dependent if the dependent becomes eligible after the Insured's effective date and the enrollment and premium are received within 31 days after the date the dependent becomes eligible; or

c) as provided in the Schedule of Benefits.

If an Insured is required by a court or administrative order to provide health care coverage for a child, and if the Insured is eligible for family health care coverage, we shall do both of the following:

a) If the child is otherwise eligible for coverage, permit the Insured to enroll the child under the Policy without regard to any enrollment period restrictions;
b) If the Insured enrolled under the coverage but fails to make application to obtain coverage for the child, enroll the child under the Policy upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 to 669, the child support enforcement program.

We shall not terminate the child's coverage unless provided satisfactory written evidence of either of the following:

a) The court or administrative order is no longer in effect;

b) The child is or will be enrolled under comparable health care coverage provided by another health insurer, which coverage will take effect not later than the effective date of the termination of the current coverage; or
c) The employer has eliminated family health coverage for all of its employees.

We may not deny the enrollment of an Insured's dependent under the Policy if the child:

1) Was born out of wedlock;
2) Is not claimed on the Insured's federal income tax return; or
3) Does not reside with the Insured or does not reside in the local Service Area.

In no case will coverage for eligible dependents take effect before the Insured's. No dependent will be covered, unless application has been made and the correct premium has been paid.

Newborn Child Coverage: A child of an Insured born while his or her coverage under the Policy is in force is covered from the moment of birth for Injury and Sickness for the first 31 days following the birth. A notice of birth, together with the additional premium, must be submitted to us within thirty-one (31) days of the birth to continue coverage for Injury and Sickness beyond the initial thirty-one (31) day period. Necessary care and treatment of congenital defects, birth abnormality and premature birth, as well as routine newborn care, are covered the same as Sickness.

Adopted Children Coverage: A minor child who comes under the charge, care and control of the Insured while his or her coverage under the Policy is in force is covered for an initial thirty-one (31) days for Injury and Sickness following the date of the final decree of adoption or placement in the home for the purpose of adoption, whichever is earlier. For coverage to continue beyond this time, you must notify us and pay any required premium within the thirty-one (31) day period. Coverage is the same as provided for other members of the Insured's family. However, coverage starts at the moment of birth if the petition for adoption, application for coverage and payment of premium occur within thirty-one (31) days after the child's birth. Coverage for the minor child continues, unless the petition for adoption is dismissed or denied.

Alternate Enrollment Periods for Loss of Other Coverage - an eligible person may elect coverage under the Policy at any time (including coverage for Eligible Dependents) if:

a) the person or dependent was previously covered by another plan when coverage under the Policy was originally offered;

b) the person or dependent stated in writing that coverage was declined because of the Other Coverage, if the person or dependent was notified that such a statement was required;

c) the person exhausted COBRA benefits or lost eligibility or employer's subsidy for some other coverage; and

d) the person requests enrollment in writing within 31 days of loss of coverage.

Termination:

Insured - Coverage for an Insured ends on the earliest of:

a) the date the Insured is no longer eligible, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid;

b) any premium due date, if full payment for the Insured's coverage is not made within 31 days following the premium due date;

c) the date the Policy terminates; or

d) the date the Insured enters an armed service on full-time active duty. Premium will be returned on a pro-rata basis if the Policyholder notifies us in writing.

Dependents - Coverage for dependents ends on the earlier of:

a) the Insured's termination date; or

b) the date the dependent is no longer eligible, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid.

Coverage continues for any child who reaches the age limit and is both:

a) totally incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and

b) chiefly dependent on the Insured for support and maintenance.

The Insured must give us proof of the child's incapacity and dependency within thirty-one (31) days of the child's reaching the age limit. We may require proof again from time to time, but not more often than once a year after the two (2) years that follow the child's reaching the age limit.

In no case will coverage end later than the Insured's.

Termination will not affect a Claim for benefits for covered services received while the person was covered by the Policy.

Extension of Benefits:

If coverage under the Policy ends while the Covered Person is Totally Disabled due to Injury or Sickness, we will pay benefits for Covered Services received after the date coverage under the Policy ends if they meet the following requirements:

a) the Covered Service must be rendered due to the same Injury or Sickness causing the Covered Person to be Totally Disabled on the date coverage ends; and
b) the Covered Service must occur within 90 days after the date the Covered Person's coverage under the Policy ends.

This extension of benefits terminates on the first of the following to occur:

a) The date the Insured ceases to be Totally Disabled; or
b) at the end of the period stated in b) above.

PART III - DESCRIPTION OF COVERED SERVICES

Note: This is a Participating Provider Plan. There are differences in benefits provided under the plan when a Covered Person receives Covered Services from a Participating Provider (In-Network) or Non-Participating Provider (Out-of-Network). We pay Covered Services at the In-Network or Out-of-Network benefit level shown in your Schedule of Benefits. Charges you receive for services or supplies from a Non-Participating Provider may be significantly higher than those same services or supplies received from a Participating Provider. In addition to the Deductible amount, Copayment amount, and Coinsurance you are responsible for the difference between the Eligible Charge and the amount the Non-Participating Provider bills you for the services or supplies. Any amount you are obligated to pay to the Provider in excess of the Eligible Charge will not apply to your Deductible or Out-of-Pocket Maximum.

MEDICAL EXPENSE BENEFITS

Ambulance Service Benefit

Covered Expenses by a licensed ambulance service will include Medically Necessary ambulance services for local transportation:

a) To the nearest Hospital that can provide services appropriate to the Covered Person's Sickness or Injury; or
b) To the nearest neonatal special care unit for newborn infants for treatment of Sickness, Injury, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:

a) Services requested by police or medical authorities at the site of an Emergency; or
b) Those situations in which the Covered Person is in a location that cannot be reached by ground ambulance.

Non Covered Services - No benefits will be paid for:

a) Ambulance Services that are not for Emergency Medical Care;
b) Ambulance Services provided for a Covered Person’s comfort or convenience;
c) Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law; or
d) Air ambulance:
    1) Outside of the fifty (50) United States and the District of Columbia;
    2) From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia;
    3) From a location within the fifty (50) United States or the District of Columbia to a country or territory outside of the United States.

Cleft Lip and Cleft Palate

Covered Expenses are provided for the Medically Necessary care and treatment of cleft lip and palate and any condition or Illness related to or developed as a result of cleft lip and palate. Covered Services must be provided by or under the supervision of a Physician and include, but are not limited to:

a) oral and facial surgery, surgical management and follow-up care;
b) prosthetic treatment such as obdurators, speech appliances and feeding appliances;
c) orthodontic, prosthodontic, and otolaryngology treatment and management;
d) audiological assessment, treatment and management, performed by or under the supervision of a Physician, including surgically implanted amplification devices; and
e) physical therapy assessment and treatment.

Emergency Medical Care

Covered Expenses provided for Emergency Medical Care include:

a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency;
b) Such further medical examination and treatment that are required by federal law to Stabilize an Emergency and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

A Non-Participating Provider of Emergency Medical Care may send a Covered Person a bill for any charges remaining after the Plan has paid (this is called "balance billing"). Except where the Plan provides a better benefit, the Plan will apply the same cost sharing for Out-of-Network Emergency Medical Care as it generally requires for In-Network Emergency Medical Care.

The Plan will calculate the amount to be paid for Out-of-Network Emergency Medical Care in three different ways and pay the greater of:

a) the median charge the Plan pays to In-Network Providers for the Emergency Medical Care;(this calculation is not required if the Plan does not have negotiated per service amounts with In-Network Providers for the services furnished;
b) the amount that would be paid using the same method the Plan generally uses to determine the Eligible Charge for Out-of-Network services; or
c) the amount that would be paid under Medicare for the services provided.

All three of these amounts are calculated before application of any In-Network cost sharing.

Habilitation and Rehabilitation Care Facility Benefit

Covered Expenses include expenses incurred for Habilitation or Rehabilitation services or confinement in a Skilled Nursing/Rehabilitation Facility, subject to the following limitations:

a) Covered Expenses available to a Covered Person while Confined primarily to receive Habilitation or Rehabilitation are limited to those specified in this provision.
b) Rehabilitation services or confinement in a Skilled Nursing/Rehabilitation Facility must begin within fourteen (14) days of a Hospital stay of at least three (3) consecutive days and be for treatment of, or Rehabilitation related to, the same Sickness or Injury that resulted in the Hospital stay. Covered Expenses for Skilled Nursing/Rehabilitation Facility services are limited to charges made by a Hospital or Skilled Nursing/Rehabilitation Facility for:
    1) Daily room and board and nursing services;
    2) Diagnostic testing;
    3) Drugs and medicines that are prescribed by a Physician, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

    Covered Expenses for non-provider facility services are limited to charges incurred for the professional services of Rehabilitation Medical Practitioners.

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be Rehabilitation upon our determination of any of the following:

a) The Covered Person has reached maximum therapeutic benefit;
b) Further treatment cannot restore bodily function beyond the level the Covered Person already possesses;
c) There is no measurable progress toward documented goals; or
d) Care is primarily Custodial Care;

Non Covered Services
No benefits will be paid under these Habilitation and Rehabilitation Facility Expense Benefits for charges for services or Confinement related to treatment or therapy for Mental Health Disorders or Substance Abuse.

Home Health Care Benefit

Covered Expenses for home health care are limited to the following charges:

a) Home health aide services;
b) Services of a private duty registered nurse rendered on an Outpatient basis;
c) Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for home health care;
d) I.V. medication and pain medication;
e) Hemodialysis, and for the processing and administration of blood or blood components;
f) Necessary medical supplies;
g) Rental of the durable medical equipment set forth below:
    1) I.V. stand and I.V. tubing;
    2) Infusion pump or cassette;
    3) Portable commode;
    4) Patient lift;
    5) Bili-lights;
    6) Suction machine and suction catheters.

Charges under c) and f) are Covered Expenses to the extent they would have been Covered Expenses during an Inpatient Hospital stay.

At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a Provider we authorize before the purchase.
An agency that is approved to provide home health care to those receiving Medicare benefits will be deemed to be a Home Health Care Agency.

Limitations:
Each 4-hour period of home health aide services will be counted as one visit.

Covered Expenses for Outpatient Private Duty Nurse Services will be limited to $75 per visit and up to the maximum number of visits shown in the Schedule of Benefits.

Non Covered Services
No benefits will be payable for charges related to respite care, Custodial Care, or educational care.

Hospice Care Benefit

This provision only applies to a terminally ill Covered Person receiving Medically Necessary care under a Hospice Care Program.

Covered Expenses include:

a) Room and board in a Hospice while the Covered Person is an Inpatient;
b) Occupational therapy.
c) Speech-language therapy.
d) The rental of medical equipment while the terminally ill Covered Person is in a Hospice Care Program to the extent that these items would have been covered under the Policy if the Covered Person had been confined in a Hospital.
e) Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
f) Counseling the Covered Person regarding his or her terminal sickness. Terminal sickness counseling of members of the Covered Person's Immediate Family.
g) Up to $250 for bereavement counseling.

Benefits for Hospice Inpatient or Outpatient care are available to a terminally ill Covered Person for one continuous period up to 180 days in a Covered Person's lifetime. For each day the Covered Person is Confined in a Hospice, benefits for room and board will not exceed:

a) For a Hospice that is associated with a Hospital or nursing home, the most common semiprivate room rate of the Hospital or nursing home with which the Hospice is associated;
b) For any other Hospice, the lesser of the billed charge or $200 per day.

Mental Health Disorder and Serious Mental Illness Medical Expense Benefit

Covered Expenses for Inpatient and Outpatient treatment of Mental Health Disorders identified in the most recent edition of the Diagnostic and Statistical Manual and Serious Mental Illness are covered the same as any other Illness, including Autism Spectrum Disorder. Before a Covered Person may qualify to receive benefits, a Physician, psychologist, advanced practice Registered Nurse, or social worker must certify that the Covered Person has a Mental Health Disorder or Serious Mental Illness and prescribe appropriate treatment, which may include referral to other treatment Providers.

Miscellaneous Medical Expense Benefits

Covered Expenses for medical expense benefits are limited to charges:

a) Made by a Hospital for:

    1) Daily room and board and nursing services, not to exceed the Hospital's most common semi-private room rate;
    2) Daily room and board and nursing services while confined in an intensive care unit;
    3) Inpatient use of an operating, treatment, or recovery room;
    4) Outpatient use of an operating, treatment, or recovery room for Surgery;
    5) Services and supplies, including drugs and medicines that are routinely provided by the Hospital to persons for use only while they are an Inpatient.

b) For Surgery in a Physician's office or at an Ambulatory/Outpatient Surgical Facility, including services and supplies;

c) Made by a Physician for professional services, including Surgery;

d) Anesthesia services if administered at the same time as a covered Surgery in a Hospital or Ambulatory/Outpatient Surgical Facility;

e) Made by an assistant surgeon, limited to 20 percent of the Eligible Charge for the covered Surgery;

f) For dressings, crutches, orthopedic splints, braces, casts, or other necessary medical supplies;

g) For Diagnostic Testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included);

h) For chemotherapy and radiation therapy or treatment;

i) For hemodialysis, and the charges by a Hospital for processing and administration of blood or blood components;

j) For oxygen and its administration;

k) For dental expenses when a Covered Person suffers an Injury, after the Covered Person's Effective Date of Coverage, that results in:
    1) Damage to his or her natural teeth; and

2) Expenses are incurred within six months of the Accident or as part of a treatment plan that was prescribed by a Physician and began within six months of the Accident. Injury to the natural teeth will not include any injury as a result of chewing.

l) For a mastectomy as a result of breast cancer diagnosis. Coverage includes a minimum of 48 hours Inpatient care following a mastectomy and 24 hours Inpatient care following a lymph node dissection for the treatment of breast cancer;

m) Reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;

n) For charges made for services related to the diagnosis of infertility;

o) For Medically Necessary services and supplies used in the treatment of diabetes provided these services are rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management. Covered Expenses include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological Diagnostic Testing; self-management training, equipment and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;

p) For Medically Necessary Manipulative Therapy treatment on an Outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. Covered Expenses are subject to all other terms and conditions of the Policy, including deductible and coinsurance percentage provisions;

q) For Maternity and Newborn Infant Care: Outpatient and Inpatient pre and post-partum care including exams, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment and childbirth classes. An Inpatient stay for the mother and her newborn child or children is covered for at least forty-eight (48) hours after a vaginal delivery, not including the day of delivery, and for at least ninety-six (96) hours following a caesarean section, not including the day of surgery. If the mother and newborn child have a shorter hospital stay than that provided above, coverage under this benefit shall include one home visit by a qualified Provider within twenty-four (24) hours after Hospital discharge or as soon as reasonably possible. Covered Expenses for a newborn child, including nursery charges, are subject to a separate Deductible and Coinsurance than Covered Expenses for the mother;

r) For the following types of human organ transplants:

1) Allogeneic and autologous bone marrow transplant/stem cell rescue;
2) Cornea
3) Heart
4) Kidney;
5) Liver
6) Lung(s);
7) Pancreas;
8) Small intestine (small bowel)
9) Simultaneous heart/lung;
10) Simultaneous kidney/pancreas;
11) Any other transplants authorized by us.

All Covered Expenses for specified human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the benefit period that begins five (5) days before, and ends one (1) year after, the organ transplant.

Miscellaneous Outpatient Medical Services and Supplies Benefit

Covered Expenses for miscellaneous Outpatient medical services and supplies are limited to charges:

a) For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the Covered Person and the item cannot be modified). If more than one prosthetic device can meet a Covered Person's functional needs, only the charge for the most cost effective prosthetic device will be considered a Covered Expense;

b) For Medically Necessary genetic blood tests;

c) For Medically Necessary immunizations to prevent respiratory syncytial virus (RSV);

d) For two mastectomy bras per year if the Covered Person has undergone a covered mastectomy;

e) For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;

f) For the cost of one continuous passive motion (CPM) machine per Covered Person following a covered joint Surgery;

g) For the cost of one wig per Covered Person necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits;

h) For one pair of eyeglasses or contact lenses per Covered Person following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.

Outpatient Prescription Drug Benefit

Covered Expenses for Outpatient Prescription Drugs are limited to charges from a licensed pharmacy for a Prescription Drug if the Prescription Drug is:

a) approved by the United States Federal Drug Administration (FDA);
b) legally obtainable from only a licensed pharmacist and only upon written prescription from a Physician;
c) prescribed while the Covered Person is not Confined as an Inpatient; and
d) dispensed while such person is covered under this Policy.

Off-Label Drugs

Benefits are provided for off-label uses of pharmaceuticals that have been approved by the US FDA (but not approved for the prescribed use) and that the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed as evidenced by the results of good quality-controlled clinical studies published in at least two (2) or more peer reviewed full length articles in respected national professional medical journals.

This benefit shall not be construed to:

- Require coverage for any drug if the United States food and drug administration has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
- Require coverage for experimental drugs not approved for any indication by the United States food and drug administration;
- Alter any law with regard to provisions limiting the coverage of drugs that have not been approved

by the United States food and drug administration.

Definitions: For purposes of this benefit subsection the following definitions apply:

a) Drugs (Prescription Drugs) mean Prescription Drugs approved by state law or the Federal Food and Drug Administration for general use by the public. For purposes of this benefit, insulin is considered a Prescription Drug.
b) Generic Prescription Drug is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug. These Prescription Drugs are generally less costly than their Brand-Name Drug.
c) Preferred Brand Name Prescription Drug is a Prescription Drug that has been patented and is only produced by one manufacturer and has been determined to be superior or equal to brand Non-Preferred Prescription Drugs and generally more cost effective.
d) Non-Preferred Brand Name Prescription Drug is a Prescription Drug that has a more cost effective therapeutic alternative.
e) Specialty Drug is a Prescription Drug that is used to treat rare and chronic diseases. Some Specialty Drugs are oral medications, but the majority of Specialty Drugs may require injection, infusion or inhalation. They may be administered by a Physician as an Outpatient or self-administered in a home setting and are listed on the Specialty Drug List maintained by us or our authorized designee as revised from time-to-time. Specialty Drugs require Prior Authorization before a Covered Person receives them.

The appropriate Drug choice for a Covered Person is a determination that is best made by the Covered Person and his or her Physician. Covered Expenses are payable after satisfaction of the Deductible or Copayment, if applicable, and subject to the Coinsurance shown in the Schedule of Benefits. The Coinsurance varies by the type of drug being dispensed.

Covered Expenses include prescribed orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

Participating Pharmacy

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

a) When a covered Generic Prescription Drug is available and that Generic Drug is received, the Covered Person pays the Plan Deductible and Plan Coinsurance for that Generic Prescription Drug as shown in the Schedule of Benefits.

b) When a Generic Drug is not available and a Brand Name (either Preferred or Non-Preferred) Prescription Drug is received, the Covered Person pays the Plan Deductible and Plan Coinsurance for that Brand Name Prescription Drug as shown in the Schedule of Benefits.

c) If a Preferred or Non-Preferred Brand Name Prescription Drug is received when a Generic Prescription Drug is available, the Covered Person pays the Plan Deductible and Plan Coinsurance for that Preferred or Non-Preferred Brand Name Prescription Drug, plus the difference in the charge between the cost of the Brand Name Drug and the Generic Drug. This cost will not be reimbursed by us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Maximum.

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Expenses, the Covered Person must file a Claim with us. The Covered Person will be reimbursed at the Negotiated Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug.

Non-Participating Pharmacy

When the Covered Person has a Prescription Drug filled at a Non-Participating Pharmacy, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy. To receive reimbursement for Covered Expenses, the Covered Person must file a Claim with us. The Covered Person will be reimbursed subject to the Out of Network Plan Deductible and Plan Coinsurance shown in the Schedule of Benefits.

Designated Specialty Pharmacy Providers

A Covered Person must obtain Prior Authorization from us before a Specialty Drug is considered for possible coverage. Please refer to Part IV Prior Authorization section. If the Specialty Drug is authorized, we will advise the Covered Person how the Specialty Drug can be obtained from a Designated Specialty Pharmacy Provider and how to file a Claim with us.

Non Covered Services

The following are not Covered Expenses under this subsection:

a) Self-administered injectable drugs, except insulin;
b) Charges for more than a 34 day supply when dispensed in any one prescription or refill or any refill dispensed after twelve (12) months from the date of the Physician's original order;
c) Drugs and medications used to induce non-spontaneous abortions;
d) Drugs for the treatment of erectile dysfunction or to assist in or enhance sexual performance;
e) Dietary supplements; vitamins (except pre-natal vitamins), mineral, herb or botanical product which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition;
f) Drugs taken while a Covered Person is an Inpatient in a Health Care Facility;
g) Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs;
h) Syringes and/or needles, except those dispensed for use with insulin;
i) Immunizing agents, biological sera, blood, blood products or blood plasma;
j) Professional charges in connection with administering, injecting or dispensing of Drugs;
k) Drugs and medications dispensed or administered in an Outpatient setting, including but not limited to Outpatient Hospital facilities and Doctor's offices;
l) Drugs used for cosmetic purposes;
m) Drugs used for the primary purpose of treating infertility;
n) Anorexiants or Drugs associated with weight loss;
o) Drugs obtained outside the United States;
p) Drugs for treatment of a condition, Sickness or Injury for which benefits are excluded or limited by other contract limitation;
q) Growth Hormone Treatment;
r) Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent, except as specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES;
s) one resin based partial denture, replaced once within a three (3) year period;
t) one complete denture upper and lower, and one replacement denture per lifetime after at least five (5) years from the seat date;
u) rebasing and relining of complete or partial dentures once in a three (3) year period, if performed at least six (6) months from the seating date.

Preventive Care Services and Supplies Benefit

This benefit describes Covered Expenses provided to a Covered Person while they are well. Benefits for preventive care services and supplies listed in this provision are exempt from any Deductibles, Coinsurance and Copayment amounts under the Policy when the services are provided by an In-Network provider. Covered Expenses are subject to the applicable Deductible and Coinsurance requirements applicable to Out-of-Network Providers shown in the Schedule of Benefits.

As new recommendations and guidelines are issued, those services will be considered Covered Expenses when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Benefits include the charges incurred by a Covered Person for the following preventive health services if appropriate for that Covered Person in accordance with the following recommendations and guidelines:

A. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) including but not limited to:

    1. Annual routine cervical cancer screening (pap smear) for women ages eighteen (18) and older;

    2. Colorectal Cancer Screening and Examination in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening for Covered Persons age fifty (50) and older or for those Covered Persons under age fifty (50) who are at high risk for colorectal cancer include:
        a) Fecal occult blood test annually;
        b) Flexible Sigmoidoscopy every three (3) years;
        c) Colonoscopy every ten (10) years for low to moderate risk and every five (5) years for high risk persons.

    3. Mammography
        a) A baseline mammogram for an asymptomatic women at least thirty-five (35) years of age; and
        b) An annual mammogram for an asymptomatic women age forty (40) and over after a baseline mammogram.

        Benefits will be provided for any woman when a Physician's evaluation of a woman's physical condition, symptoms or risk factors indicates a probability of breast cancer higher than the general population.

    4. Prostate Cancer Screening - an annual screening for early detection of prostate cancer for men age forty (40) and older, consisting of a minimum of a prostate-specific antigen blood test and a digital rectal examination.

B. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, including but not limited to (a) diphtheria, (b) hepatitis B, (c) measles, (d) mumps, (e) pertussis, (f) polio, (g) rubella, (h) tetanus, (i) varicella, (j) haemophilus influenza type B, and (k) hepatitis A, or any other immunization subsequently required for children by the State Board of Health, in effect for at least one year prior to the Effective Date of this Policy. Recommended doses and ages may vary by population.

C. With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration include but are not limited to: for newborns: phenylketonuria (PKU) screening; screening for hearing loss; gonorrhea preventive medication

for the eyes; hypothyroidism screening; and sickle cell screening; lead screening; iron supplementation for those children at risk of anemia; oral fluoride supplementation for children whose water supply is without fluoride; Child Health Supervision services from the moment of birth through the age of eighteen years at the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years; Autism screening for children at 18 and 24 months; and for adolescents: alcohol and drug use assessments; depression screening; HIV screening; and sexually transmitted infection (STI) prevention and counseling.

D. With respect to Covered Persons who are adults, subject to specified age guidelines, additional preventive care services and screenings to the extent not included in A. above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration include: abdominal aortic aneurysm one-time screening for men who have ever smoked; alcohol misuse screening and counseling; aspirin use to prevent cardiovascular disease; blood pressure screening; cholesterol screening; depression screening; diabetes (type 2) screening; diet counseling; HIV screening; lung cancer screening; obesity screening and counseling; sexually transmitted infection (STI) prevention and counseling; syphilis screening and tobacco use screenings and up to two (2) cessation interventions per Coverage Year for tobacco users.

E. With respect to Covered Persons who are women, additional preventive care and screening to the extent not included in A or D. above, evidence-informed preventive care and screenings provided for in accordance with comprehensive guidelines supported by the Health Resources and Services Administration include but are not limited to:

1. One well women preventive care visit per Coverage Year; for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate;
2. One screening for gestational diabetes for pregnant women between 24-28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes;
3. High risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females thirty (30) years of age and over and will be covered no more frequently than once every three (3) years;
4. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer;
5. Breast Cancer Chemoprevention counseling for women at higher risk;
6. Chlamydia infection screening for women under age twenty-nine (29) or other women at high risk;
7. One counseling session per Coverage Year for counseling on sexually transmitted infections for all sexually active women;
8. Gonorrhea screening for all women at higher risk;
9. One counseling session per Coverage Year for human immune-deficiency virus infection for all sexually active women;
10. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This benefit does not include coverage for abortifacient drugs;
11. One screening and counseling for interpersonal and domestic violence per Coverage Year;
12. Folic Acid supplements for women who may become pregnant;
13. Anemia screening on a routine basis for pregnant women;
14. Syphilis screening for all pregnant women or other women at increased risk;
15. Hepatitis B screening for pregnant women at the first prenatal visit;

16. RH Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
17. Routine prenatal obstetrical office visits, up to one visit per month for women at 4-24 weeks' gestation, 2 visits per month for 28-36 weeks' gestation, one visit per week at 36 weeks' gestation to birth, and one postpartum office visit after birth. This benefit also covers laboratory services explicitly identified in the health reform Affordable Care Act, tobacco cessation counseling specific to pregnant women and immunizations recommended by the Advisory Committee on Immunizations Practices. This benefit does not cover radiology (i.e. obstetrical ultrasounds) delivery and high-risk pre-natal services (chorionic villus sampling and amniocentesis and other genetic testing);
18. Breastfeeding support, supplies and counseling in conjunction with each birth. Comprehensive lactation support and counseling in conjunction with each birth and/or in the postpartum period. Coverage includes the costs for renting or purchase of one breast pump per pregnancy for the duration of the breast feeding;
19. Osteoporosis screening for women over age forty-five (45) depending on risk factors, for a medically accepted bone mass measurement. A qualified woman is a Covered Person who; (i) has an estrogen deficiency with vertebral abnormalities, primary hyperparathyroidism or a history of fragility bone fracture; or (ii) is receiving long term glucocorticoid or (iii) is currently under treatment for osteoporosis.

Substance Abuse Benefit

Charges for Covered Expense for Inpatient and Outpatient treatment of Substance Abuse Disorders are covered the same as any other Illness. Prior Authorization is required before a Covered Person may qualify to receive benefits.

Transplant Covered Expenses

If we determine that a Covered Person is an appropriate candidate for a listed transplant, Covered Expenses will be provided for:

a) Pre-transplant evaluation;
b) Pre-transplant harvesting;
c) Pre-transplant stabilization, meaning an Inpatient stay to medically stabilize a Covered Person to prepare for a later transplant, whether or not the transplant occurs;
d) High dose chemotherapy;
e) Peripheral stem cell collection;
f) The transplant itself, not including the acquisition cost for the organ or bone marrow;
g) Post-transplant follow-up to 365 days after the transplant Surgery, or a lesser period not to exceed the termination date of this Policy.

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the Covered Person if:

a) They would otherwise be considered Covered Expenses under the Policy, but will be limited by any payment which might be made under any other hospitalization coverage plan*;*
b) The Covered Person received an organ or bone marrow of the live donor; and (ie donation made to a Covered Person)
c) The transplant was a listed transplant.

A Covered Person may obtain services in connection with a listed transplant from any Provider of such services. However, if services are received from a Participating Provider Covered Expenses for the listed transplant will include:

a) the acquisition cost of the organ or bone marrow;
b) We will pay a maximum of $10,000 per lifetime for the following services:

1) Transportation for the Covered Person, any live donor, and the Immediate Family to accompany the Covered Person;
2) Lodging at or near the Participating Hospital for any live donor and the Immediate Family accompanying the Covered Person while the Covered Person is Confined in the Participating Hospital.

We will pay the costs directly for transportation and lodging, however, you must make the arrangements.

Non Covered Services

Covered Expenses under these Transplant Expense Benefits do not include charges:

a) For search and testing in order to locate a suitable donor;
b) For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no listed transplant occurs;
c) related to animal to human transplants;
d) For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
e) For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
f) To keep a donor alive for the transplant operation;
g) For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
h) Related to transplants not included as a listed transplant;
i) For a listed transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.

Limitations on Transplant Expense Benefits

In addition to the exclusions and limitations specified elsewhere in this section:
a) Covered Expenses for listed transplants will be limited to two (2) transplants during any ten (10) year period for each Covered Person.
b) If a Participating Provider is not used, Covered Expenses for a listed transplant will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
c) If a Participating Provider is not used, the acquisition cost for the organ or bone marrow is not covered.

PART IV - PRIOR AUTHORIZATION

Prior Authorization Required: Some Covered Expenses require Prior Authorization. In general, Participating Providers must obtain authorization from us or our designee prior to providing a Covered Service or supply to a Covered Person. However, there are some Covered Expenses for which a Covered Person must obtain the Prior Authorization.

In general, for services or supplies that require Prior Authorization, as shown in the Schedule of Benefits, the Covered Person must obtain authorization from us if:

a) Receiving a service or supply from a Non-Participating Provider;
b) Admitted into a Network facility by a Non-Participating Provider; or
c) Receiving a service or supply from a Participating Provider to which the Covered Person was referred by a Non-Participating Provider.

How to Obtain Prior Authorization
To obtain Prior Authorization or to confirm that a Participating Provider has obtained Prior Authorization, contact us by telephone at the telephone number listed on the health insurance identification card before the service or supply is provided to the Covered Person.

Failure to Obtain Prior Authorization
Failure to comply with the Prior Authorization requirements will result in benefits being reduced. Please see the Schedule of Benefits for specific details.

Participating Providers cannot bill you for services for which they fail to obtain Prior Authorization as required.

Benefits will not be reduced for failure to comply with Prior Authorization requirements prior to an Emergency. However, you must contact us as soon as reasonably possible after the Emergency occurs.

Prior Authorization Does Not Guarantee Benefits
Prior Authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the Policy.

Requests for Predeterminations
You may request a predetermination of coverage. We will provide one if circumstances allow us to do so. However, we are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination we may make will be reviewed after the medical expense is incurred and a Claim is filed. A review that shows one or more of the following may cause us to reverse the predetermination:

a) The predetermination was based on incomplete or inaccurate information initially received by us.
b) The medical expense has already been paid by someone else.
c) Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a Loss in good faith. All benefit determinations are subject to our receipt of proper proof of loss.

PART V - EXCLUSIONS AND LIMITATIONS

Notwithstanding any provision of the Policy to the contrary, if the Policy generally provides benefits for any type of Injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health condition), even if the medical condition is not diagnosed before the Injury.

The Policy contains certain exclusions and limitations. Charges for any treatment, services, or supplies as described below will not be considered as Covered Expenses under the Policy and no benefits will be payable for such charges. The Policy does not provide any benefits for:

1. Any treatment, service or supply which is not due to a Sickness or Injury, except for Preventive Care as specified in Part III Description of Covered Services; or
2. Any treatment, service or supply unless administered or ordered by a Physician and is Medically Necessary to the diagnosis or treatment of an Injury or Sickness; or
3. Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of a Mental Health Disorder; or
4. Inpatient personal convenience items such as radio and television, massages, telephone charges, take home supplies and guest meals; or
5. Treatment, services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; or
6. Treatment, services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government whether or not that payment or benefits are received; or
7. Hospital and Physician Charges for weekend Hospital admissions for non-Emergency procedures, unless Medically Necessary or unless Surgery is scheduled for the next day; or
8. Treatment, services or supplies for any Illness or Injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; or
9. Physical or psychological examinations or Diagnostic Services required by any third party, such as by a court or for employment, premarital examinations, licensing, insurance, school, sports or recreational purposes and the completion of any forms for such examinations; or
10. Treatment, services or supplies for any Injury or Sickness resulting from war or any act of war, declared or undeclared, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an Employer; or
11. Treatment, services or supplies for any Injury or Sickness incurred during the commission or attempted commission of a crime or felony or while engaged in any illegal act; or
12. Treatment, services or supplies for any Injury or Sickness for Loss incurred as a result of a Covered Person being intoxicated, as defined by applicable state law in the state in which the Loss occurred, or being under the influence of any narcotic, barbiturate, hallucinatory or other drug, unless administered by a Physician and taken in accordance with the prescribed dosage or being under the influence of any illegal drug as defined by state or Federal law; or
13. Treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders; or
14. Treatment, services or supplies due to complications of a non-covered service; or
15. Cosmetic or plastic Surgery, or the complications of any such Surgery, except for Reconstructive Surgery that is incidental to or follows Surgery or an Injury that was covered under the Policy or is performed to correct a birth defect in a child who has been a Covered

Person from birth until the date of Surgery; or

16. Breast augmentation or reduction; the removal of breast implants unless Medically Necessary and related to Surgery performed as Reconstructive Surgery due to a Sickness; and breast reduction Surgery unless Medically Necessary due to a Sickness; or
17. Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy; or
18. Routine eye exams, except as specified in the Pediatric Vision Benefit under Part III DESCRIPTION OF COVERED SERVICES, eye glasses, visual therapy, or contact lenses; or
19. Routine hearing exams except as specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES; or
20. Assessment of the need for, or change to, hearing aids, and the purchase, fittings or adjustments of hearing aids; or
21. Dental treatment, surgery, dental prostheses and orthodontic treatment except as specified in the Pediatric Dental Expense Benefit under Part III DESCRIPTION OF COVERED SERVICES, except for dental care or services necessary due to congenital disease or anomaly; or
22. Penile implants; fertility and sterility studies; any treatment, services or supplies to restore or enhance fertility; or
23. Vasectomies and reversal of sterilization; or
24. Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including: in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, genetic counseling, and all Charges related to such in vitro fertilization; or
25. Injury or Sickness that is intentionally self-inflicted while sane, except that this exclusion does not apply to any self-inflicted Injury or Sickness that is the result of a medical condition; or
26. The voluntary taking of poison; or the voluntary inhaling of gas; or
27. Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy; or
28. Services rendered to a surrogate mother who is not a Covered Person; or
29. Sexual reassignments or sexual dysfunctions or inadequacies; or
30. Alternative treatments as defined by the Office of Alternative Medicine of the National Institutes of Health including but not limited to: acupressure, acupuncture, aroma therapy, hypnotism, and massage therapy; or
31. Routine foot care, except for Covered Persons diagnosed with diabetes, including the cutting or removal of corns, calluses or bunions, the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet; or
32. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot; or
33. Orthotics – specially fitted inserts to a shoe; or
34. Obesity, extreme obesity, morbid obesity or weight reduction, unless specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES, including wiring of the teeth and all forms of surgery including bariatric surgery, intestinal bypass surgery and complications resulting from such surgery; or
35. Any services performed by a member of a Covered Person's Immediate Family; or
36. Experimental or Investigational treatment, services and supplies (including Prescription Drugs or medications) and all related services and supplies; or
37. Any surgical removal of an organ or tissue unless Medically Necessary; or
38. Any over-the-counter medication or medication that may be obtained without a prescription unless specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES; or

39. Blood derivatives that are not classified as drugs in the official formularies; or

40. Custodial Care, regardless of who prescribes or renders such care; or

41. Treatment, services or supplies received or purchased outside the United States, except for an Emergency, while traveling for up to a maximum of ninety (90) consecutive days. If travel extends beyond ninety (90) consecutive days, no coverage is provided for Emergency Medical Care for the entire period of travel including the first ninety (90) days; or

42. Any education or training materials including, programs or materials for management of pain, asthma and heart disorders; or

43. Equipment, other than Durable Medical Equipment, including, modifications to motor vehicles or motor homes; wheelchair lifts or ramps; water therapy devices, such as Jacuzzis or hot tubs; and exercise equipment or comfort and convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, television and telephones; or

44. flying as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purposes or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar air transport service of any other country; or

45. An Injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any non-motorized vehicle or conveyance (if the Covered Person is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the Covered Person is paid to participate or to instruct); rock or mountain climbing (if the Covered Person is paid to participate or to instruct); or skiing (if the Covered Person is paid to participate or to instruct); or

46. Telephone and electronic consultations, appointment fees for failing to keep a scheduled visit, fees for completing claim forms, fees related to obtaining Prior Authorization, and fees related to the provision of medical records; or

47. Any treatment, services or supplies not identified or included as a Covered Expense under the Policy. You will be fully responsible for payment for any services that are not Covered Expenses; or

48. Treatment services or supplies that are provided prior to the Effective Date or after the termination date of this Policy, except as provided for under the Extension of Benefits provision. or

49. Treatment, services and supplies related to an abortion; except if the life of the mother would be in danger if the fetus were carried to term.

PART VI - COORDINATION OF BENEFITS (COB)

If the Covered Person is covered by more than one group medical plan, the Covered Person's benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each Covered Person, per Coverage Year, and are largely determined by law. Benefits from This Plan and any Other Plan are limited to the actual charges incurred. Any coverage the Covered Person has for medical benefits will be coordinated as shown below.

Definitions
The meanings of key terms used in this Part VI are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When the Insured sees these capitalized words, then he/she should refer to this Definitions provision.

Allowable Expense the portion of a Covered Expense used in determining the benefits This Plan pays when it is the Secondary Plan. The Allowable Expense is the lesser of:

a) The charge used by the Primary Plan in determining the benefits it pays;
b) The charge that would be used by This Plan in determining the benefits it would pay if it were the Primary Plan; and
c) The amount of the Covered Expense.

Insured Dependent is a member of the Insured's family who is eligible for and has coverage under This Plan.

Other Plan is any of the following:

a) Group, blanket or franchise insurance coverage, except blanket student accident coverage;
b) Group service plan contract, group practice, group individual practice and other group prepayment coverages;
c) Group coverage under labor management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans, or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement, which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Primary Plan is that plan which will have its benefits determined first.

Secondary Plan is the plan, which will have its benefits determined after the Primary Plan.

This Plan is that portion of this Plan, which provides benefits subject to this provision.

Order of Benefits Determination
The following rules determine the order in which benefits are payable:

a) A plan, which has no Coordination of Benefits provision, pays before a plan, which has a Coordination of Benefits provision.
b) A plan which covers the Covered Person as an Eligible Employee pays before a plan that covers the Covered Person as an Eligible Dependent.
c) For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to c) **above:** For a dependent child of parents who are divorced or separated, the following rules will be used in place of c):

1) If the parent with custody of that child for whom a Claim has been made has not remarried, then the plan of the parent with custody that covers that child as an insured dependent pays first.
2) If the parent with custody of the child for whom a Claim has been made has remarried, then the order in which benefits are paid will be as follows:

a. The plan which covers the child as an insured dependent of the parent with custody.
b. The plan which covers the child as an insured dependent of the stepparent (married to the parent with custody).
c. The plan which covered the child as an insured dependent of the parent without custody.
d. The plan which covers the child as an insured dependent of the stepparent (married to the parent without custody).

3) Regardless of 1) and 2) above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as an insured dependent of that parent pays first.

d) The plan covering the Insured as a laid-off or retired employee or as an Eligible Dependent of a laid-off or retired Insured pays after a plan covering the Insured as other than a laid-off or retired employee or the Eligible Dependent of such a person. But if either plan does not have a provision regarding laid-off or retired participant, Rule f) applies.

e) If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:
1) First the benefits of a plan covering the Insured as an Eligible Employee (or as that person's Eligible Dependent).
2) Second the benefits under the continuation coverage.

f) When the above rules do not establish the order of payment, the plan which the Covered Person has been enrolled the longest pays first.

Effect on the Benefits Payable: If This Plan is the Primary Plan, according to the Order of Benefits Determination provision above, the amount This Plan pays for a Covered Expense will be determined without regard to the benefits payable under any Other Plan.

If This Plan is Secondary, according to the Order of Benefits Determination provision above, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount payable by the Primary Plan during a claim determination period.

When we are the Secondary Plan, the benefits payable under This Plan will be reduced to the extent necessary so that when our benefit payments are added to the benefits payable under all Other Plans, all benefit payments do not exceed the total Allowable Expense for any services or supplies.

Right to Receive and Release Needed Information: Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or group health benefit plan administrator with whom we coordinate benefits.

Responsibility for Timely Notice: We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value: If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered the Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment: If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery: If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

PART VII - CONTINUATION OF COVERAGE

Coverage for Covered Services incurred as a result of Injury or Sickness may be continued under certain circumstances.

Evidence of insurability is not required for this provision. If a Covered Person exercises this provision, it will be in lieu of any continuation rights granted under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Eligibility:

Insured - Insureds may elect to continue coverage for themselves and their covered dependents. Coverage may be continued for 18 months if one of the following events occurs:

a) an Insured's employment is terminated for any reason other than gross misconduct; or

b) a change in eligible class or a reduction in an Insured's hours results in the loss of coverage.

Disabled Insured - Insureds who are determined to be disabled under the Social Security Act within sixty (60) days of the date they become eligible for continuation under this provision may continue coverage for themselves and their covered dependents for up to twenty-nine (29) months.

Dependents - A covered dependent may elect to continue coverage for a period of thirty-six (36) months if one of the following occurs:

a) The death of the Insured;

b) a dependent child is no longer a dependent child for the purposes of the plan; or

c) the Insured becomes entitled to Medicare benefits.

Coverage:

If a Covered Person exercises this provision, coverage will be identical in scope to the coverage provided in the Policy.

Premiums:

The Covered Person will pay premiums directly to the Policyholder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period.

Notice Requirements:

The Policyholder must notify us in writing within thirty-one (31) days after the date:

a) the Insured dies;

b) the Insured's employment is terminated, the Insured's hours are reduced or the Insured fails to remain in an eligible class; or

c) the Insured becomes entitled to Medicare benefits.

Each covered dependent who wishes to continue coverage must notify us in writing within sixty (60) days after the date dependent child is no longer a dependent child for the purposes of the plan.

Upon our receipt of any such notice, we must give written notice of the right to continue coverage to the Covered Person(s) within fourteen (14) days.

Covered Persons who wish to continue coverage must notify us in writing within sixty (60) days after the date they receive notice of their right to continue coverage.

Termination:

Covered Persons who exercise this provision will not have their coverage interrupted or canceled or otherwise terminated until the date on which:

a) they fail to make a premium payment in the time required to make that payment;

b) they become eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or any other plan or program (including Medicare);

c) the required period for continued coverage ends; or

d) the Policy is terminated.

Spousal Conversion Privilege

A covered spouse whose coverage under the Policy ends due to an entry of a valid decree of divorce may elect conversion coverage provided such spouse was not eligible for, or failed to elect, the Continuation of Coverage Privilege at termination of coverage under the Policy.

To convert from coverage under the Policy to conversion coverage, written application and the first premium payment must be made no more than sixty (60) days after coverage under the Policy has ended. Medical evidence of insurability is not required.

PART VIII - PREMIUMS

Premiums are shown in the Schedule of Benefits. The premium must be remitted to us not more than 31 days after the effective date of the eligible person's coverage. A person's coverage is not affected by the Policyholder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first anniversary of the Policy, with thirty-one (31) days advance notice in writing to the Policyholder.

If premiums for coverage under the Plan are deducted in whole or in part under a payroll deduction plan, we may not lapse the Policy or terminate coverage under the Policy until and unless we have sent a written or printed notice to each Insured of the failure of the Policyholder to remit the premium. This notice must:

a) state the amount due and to whom it must be paid; and

b) be duly addressed and mailed to the Insured at least fifteen (15) days before the Policy is terminated or lapsed.

Grace Period: The Policyholder has a thirty-one (31) day grace period after each premium due date after the first premium. Coverage will remain in force during this grace period and the Insurer will be liable for any Covered Expense incurred during the grace period. If a subsequent premium is not paid by the end of the grace period, coverage ends at the end of the grace period. If this happens, the Policyholder owes us all premiums then due, including any premium due for the grace period or for any part of the grace period. We will not be liable for any expenses incurred for any Loss that occurs following the end of the grace period.

PART IX - CLAIM PROVISIONS

Notice of Claim: Written notice of Claim must be given within thirty-one (31) days after a covered Loss starts or as soon as is reasonably possible. The notice must be given to the Administrator named in the Schedule of Benefits. Notice should include information that identifies the claimant and the Policy.

Claim Forms: When the Administrator receives notice of Claim, forms for filing proof of loss will be sent to the claimant. If these forms are not sent within fifteen (15) days, the claimant will meet the proof of loss requirements if the Administrator named in the Schedule of Benefits is given, within ninety (90) days, written proof of the nature and extent of the Loss.

Proof of Loss: Written proof of loss must be given to the Administrator named on the face page of this certificate within ninety (90) days after the Loss starts. We will not deny or reduce any Claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one year after it is due, unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for Loss covered by the Policy will be paid upon our receipt of a Clean Claim, including all related substantiating documentation, within the following time periods:

a) Claims will be paid within forty (40) business days of our receipt of a paper claim; and within twenty (20) business days of our receipt of an electronic claim.
b) If we deny or pend a claim we will provide notice within forty (40) business days of our receipt of a paper claim; and within twenty (20) business days of our receipt of an electronic claim to the Covered Person, or Provider filing the claim on behalf of the Covered Person, stating the reasons we may have for failing to pay the Claim, either in whole or in part, and which also gives the Covered Person or Provider a written itemization of any documents or other information needed to process the Claim or any portions thereof which are not being paid.

Any valid Claim not paid within the time periods noted above will accrue interest and will be included in the Claim payment or be provided by a separate check with a report detailing the Claim for which interest is being paid.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an assignment of benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. Any payment made by us in good faith pursuant to this provision fully releases us to the extent of the payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the Claim is pending.

Legal Action: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No action may be brought after six (6) years from the time written proof of loss is required to be furnished.

PART X - GRIEVANCE AND APPEAL PROCEDURES

State Law provides for an internal and independent external review of grievances. You have the right to file a grievance on any matter pertaining to Your contractual relationship with Us.

As used in this provision, the terms "You" and "Yours" means the Insured or Covered Person. The terms "We", "Us" and "Our" refer to BCS Insurance Company (BCS). The first letter of these words will be capitalized, wherever these terms are used in this provision.

No Covered Person who exercises the right to file a grievance or Appeal shall be subject to disenrollment or otherwise penalized due to the filing of a grievance or appeal.

All complaint procedures are voluntary and at any time, You, Your health care provider or Your authorized representative, may seek the assistance of the Deputy Director of Insurance, by writing to or calling at the following address:

Consumer Services Division
South Carolina Department of Insurance
Post Office Box 100105
Columbia, SC 29202-3105
Phone: 803-737-6180
Fax: 803-737-6103

Level 1: Internal Review (Grievance)

If a claim is denied either in whole or in part, You, Your treating physician or authorized representative, may file a Grievance either orally (by telephone or in person) or in writing within 180 days of receiving a denial in Your claim.

If Your claim was denied due to missing or incomplete information, You, Your treating physician or authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

You, Your treating physician or authorized representative, have the right to complain about any decision We make that denies payment on the claim for coverage of a health care service or treatment.

You, Your treating physician or authorized representative, may request more explanation when Your claim for coverage of a health care service or treatment is denied or was no fully covered.
Contact us when You:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Cannot find the applicable provision in Your Benefit Plan Document; or
- Disagree with the denial or the amount not covered and You want to appeal.

Your request should contain an explanation of all pertinent issues. To contact Us, You may:

- Send an email to: bcsassist@bcsins.com
- Call Us by dialing Our toll free number at: (800) 621-9215
- Write Us at the following address:

  BCS Insurance Company
  Attn: Appeal Request
  2 Mid America Plaza, Suite 200
  Oakbrook Terrace, IL 60181-4712

If Your claim was denied due to missing or incomplete information, You, treating physician or authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

Within 5 business days of receipt of Your request, You will receive a letter from Us confirming the receipt of Your grievance with the name, address and telephone number of the person who will be reviewing Your grievance. If all required information is complete, Your grievance will be resolved within 30 days of receipt. If additional information is required, We will send You a letter requesting the information. Your grievance will then be resolved within 20 days of receipt of all requested information.

Level 2: Internal Review (Appeal):

If You are not satisfied with Our decision on Your grievance, You, Your treating physician or authorized representative, have the right to appeal Our determination to confirm the denial of payment on Your claim for coverage of a health care service or treatment within 180 days of Your receipt of notice of Our Adverse Decision.

Adverse Decision means a determination by Us or a designee review agency, that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and based upon the information provided:

(a) does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness; or
(b) is experimental or investigational and involves a condition that is life-threatening or seriously disabling, and the requested health care service or treatment rendered and the payment for the service is therefore denied, reduced or terminated.

You may submit any comments, documents, records or other information without regard to whether those materials were considered in the initial grievance review.

You, Your treating physician or authorized representative, may contact Us by:

- Sending an email to: bcsassist@bcsins.com
- Calling Us at Our toll free number: (800) 621-9215
- Writing Us at the following address:

  BCS Insurance Company
  Attn: Grievance/Appeal Request
  2 Mid America Plaza, Suite 200
  Oakbrook Terrace, IL 60181-4712

All internal appeals must be sent to Us within 180 days of the date You received Our Adverse Decision. We will provide a fair and full review of Your claim by individuals associated with Us but who were not involved in making the initial denial of Your claim.

You, Your treating physician or authorized representative, may provide Us with additional information that relates to Your claim or may request copies of information that We have that pertains to Your claim. We will notify You, Your treating physician or authorized representative of Our decision in writing within 30 days of receiving Your request for appeal. If You do not receive Our decision within 30 days of receiving Your request for an appeal, You, Your treating physician or authorized representative, may be entitled to file a request for independent external review.

Expedited Internal Review:

If You have a medical condition that would seriously jeopardize Your ability to regain maximum function if treatment is delayed, You may be entitled to request an expedited internal review of Our denial either orally or in writing and at the same time, request an expedited external review. A decision will be made as expeditiously as possible but no more than 72 hours after Your request was received.

If given information is insufficient, You, Your treating physician or authorized representative, will be notified of information needed as soon as possible, and no later than 24 hours after receipt. You will be given no less than 48 hours to submit the specified information.

You, Your treating physician or authorized representative, will be notified of Our decision no later than 48 hours after (1) the receipt of the submitted information; or (2) the end of the 48 hour period given to provide the information, whichever is earlier.

However, an expedited internal review may not be provided for retrospective review decisions.

If You request an expedited internal appeal, You can request an expedited external review at the same time.

Independent External Review:
You may have the right to have Our decision reviewed by Independent Review Organization (IRO), who have no association with Us, if Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment rendered, by submitting to Us a request in writing for independent external review within 120 days after the receipt of the Final Adverse Decision.

You must exhaust the internal complaint review process to submit a request for independent external review. The process is exhausted when:

- We have denied Your request for Internal appeal;
- You have completed Our internal appeals process;
- You do not receive a timely decision from Us on Your appeal and You have not requested or agreed to the delay;
- Expedited internal appeal is requested, therefore You can request an expedited external review at the same time; or
- We have waived the exhaustion requirement.

Within 5 business days from the receipt of Your request for an external review, We shall:

(a) notify You in writing of the assignment to an IRO and You, Your treating physician or authorized representative may, provide additional information that relates to Your claim to the IRO within the first 5 business days of receipt of the letter. Information received within the 5 day timeframe will be considered by the IRO in their review and a copy of such information received will be provided to Us within 1 business day of receipt by the IRO;
(b) send the documents or any information considered in making the Adverse Decision to the IRO; or
(c) inform You or Your authorized representative in writing if the request does not meet the criteria for external review with an explanation of the reason for the non-acceptance. In this case, You have the right to contact the Director of Insurance or his designee for assistance at the address and phone number provided at the top of this document.

For standard external review, You, Your treating physician or authorized representative will be notified of the IRO's decision in writing within 45 days of receiving Your request.

If You have a medical condition that would seriously jeopardize Your ability to regain maximum function if treatment is delayed, You may be entitled to request an expedited external review of Our denial. However, an expedited external review may not be provided for retrospective review decisions.

For an expedited external review, You, Your treating physician or authorized representative will be notified of the IRO's decision within 72 hours of receiving Your request.

If Our denial to provide or pay for the health care services or course of treatment is based on a determination that the service or treatment is experimental or investigational, You also may be entitled to file a request for external review of Our denial. For more details, please review Your Benefit Plan Document, contact Us or Your state insurance department at the addresses provided above.

The ruling provided by the Commissioner of Insurance from an independent external review will be in writing and will be final and binding on You and BCSI to the same extent that each would have been bound by a judgment entered into an action of law or in equity, and except in the instance of fraud, may preclude You exercising any other right or remedy relating to the adverse determination.

Reconsideration of Our Decision:

If, at any time during the review process, You, Your treating physician or authorized representative, submits information to Us relevant to Our resolution of Your request for review and for which We had not originally considered, We may reconsider our determination.

If Your request has already been submitted for independent external review and We choose to reconsider Our decision, the independent review organization will suspend its review process until Our reconsideration process is completed. In such case, We will notify You of Our decision within 15 days of receiving the new information.

If we decide not to reconsider Our determination upon review of the new information, We will forward that new information to the independent review organization not more than 2 business days of receiving it.

PART XI - GENERAL PROVISIONS

Not in Lieu of Workers' Compensation: The Policy is not in lieu of, and does not affect requirements for, coverage under Workers' Compensation laws.

Misstatement of Age: If the age of a Covered Person has been misstated, we will adjust premiums based on the Covered Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, we will adjust the insurance coverages or amounts of benefits, or both, in accordance with the Covered Person's true age. The misstatement of age neither continues insurance otherwise validly terminated nor terminates insurance otherwise validly in force.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Plan due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, we will be entitled to a refund of all benefits we have paid from such recovery. Further, we have the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

We may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have a right to recovery of the full amount of benefits paid under the Plan for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. We will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to us or to the Administrator. The Covered Person must cooperate fully with us in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to us to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for us to institute legal action against the Covered Person for failure to repay us the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

If the Director or his designee, upon being petitioned by the Covered Person, determines that the exercise of subrogation by us is inequitable and commits an injustice to the Covered Person, subrogation is not allowed. Attorneys' fees and costs must be paid by us from the amounts recovered. This determination by the Director or his designee may be appealed to the Administrative Law Judge Division as provided by South Carolina Law.

Right of Recovery: Whenever we have made payments with respect to benefits payable under the Plan in excess of the amount necessary, we shall have the right to recover such payments. We shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, we have the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Replacement of Policy: If coverage under the Policy issued by BCS Insurance Company ("the policy") is effected to replace and continue without interruption similar coverage previously provided by another Insurer (the "Prior Plan"), such coverage will be provided as follows:

a) each person eligible for coverage under a plan of benefits set forth in the Policy shall be covered for that plan.

b) each person not covered in accordance with paragraph a) above, but who was validly covered under the Prior Plan, including benefit extensions, on the date of its discontinuance and who is in a class of persons eligible for coverage under the policy, shall be covered for not less than:

   1. the applicable level of benefits under this Plan, reduced by any benefits payable by the Prior Plan; and

   2. such coverage shall continue in force until the earliest of:

i. the date the person becomes eligible under the Policy in accordance with paragraph a) above; or

ii. the date benefits would terminate under the Policy in accordance with the provisions applicable to individual termination of coverage (subject to any extension of benefits provision in the Policy); or

In applying any deductibles or waiting periods under the Policy, credit shall be given for satisfaction or partial satisfaction of the same or similar provisions under the Prior Plan. With respect to deductibles based on accrued expenses, credit shall be given for expenses incurred during the ninety (90) days preceding the date coverage under the Policy became effective.

Prior Plan benefits, when applicable, will be determined in accordance with information furnished by the prior Insurer and will be applied as if the Prior Plan had not been replaced.

PART XII - SCHEDULE OF BENEFITS

1. POLICYHOLDER INFORMATION:

   Name: Alternative Staffing, Inc.

   Policy Number: PAI-Z-25350000

   Policy Effective Date: January 1, 2016

   Policy Anniversary Date: January 1st

   COVERAGE YEAR:

   Starts on January 1, 2016 through December 31, 2016.

2. ELIGIBILITY:* ALL REGULAR FULL-TIME EMPLOYEES AS DEFINED BY YOUR EMPLOYER

   Dependent Coverage:* ☑Yes ☐No

   * In no case will any person be covered, unless application has been made and the correct premium has been paid.

3. CERTIFICATE HOLDER INFORMATION: ON FILE

4. COVERAGE AND BENEFIT AMOUNTS:

   This is a Participating Provider Plan. The Network Provider Organization must be utilized to receive the maximum benefits available under this Policy. Services or supplies from a Non-Participating Provider may be significantly higher than those same services or supplies received from a Participating Provider. In addition to the Deductible amount, Copayment and Coinsurance you are responsible for the difference between the Eligible Charge and the amount the Non-Participating Provider bills you for the services or supplies. Any amount you are obligated to pay to the Provider in excess of the Eligible Charge will not apply to your Deductible or Out-of-Pocket Maximum. The Policy provides coverage for benefits in the amounts and up to the limits as shown below. Benefits will be paid for Covered Expenses incurred while coverage is in force. Benefits are subject to the provisions, definitions and exclusions and limitations in the Policy. Benefits listed in this Schedule are for each Covered Person unless otherwise indicated.

PLAN A

PLAN DEDUCTIBLES		
	In-Network	Out-of-Network
Individual Deductible each Coverage Year	$5,500	$11,000
Family Deductible each Coverage Year	$11,000	$22,000
In-Network Deductibles are distinct from Out-of-Network Deductibles. Charges that accrue to one Deductible do not accrue to another.		
Once 2 or more Covered Persons have collectively met the maximum Family Deductible, no additional Deductible will be taken during the Coverage Year		

ADDITIONAL DEDUCTIBLE:	
Failure to obtain Prior Authorization	$ 2,000
Failure to obtain Prior Authorization for Specialty Drugs	no coverage for the specified drug
Prior Authorization is required for the following Covered Services: Inpatient Confinement; Inpatient and Outpatient Surgery; Diagnostic Services: i) Cat Scan, ii) MRI; iii) Pet Scan, Mental Health Disorders or Substance Abuse programs; Pediatric Orthodontic Dental Services; Rehabilitative Services and transplant services.	
The additional deductible for failure to obtain Prior Authorization does not go towards satisfying the Plan Deductibles or Out-of-Pocket Maximum.	

PLAN COINSURANCE AND OUT-OF-POCKET MAXIMUM The Coinsurance is listed below unless specified elsewhere in the Schedule of Benefits.		
Once the Out-of-Pocket Maximum limit is met the Plan pays 100% of Covered Expenses unless otherwise specified.		
Charges for Specialty Pharmaceuticals obtained from a provider other than a Designated Specialty Pharmacy Provider are not covered		
	In-Network	Out-of-Network
Coinsurance (Percentage of Covered Expenses the Covered Person must pay.)	20% until the Out-of - Pocket Maximum is satisfied	40% until the Out-of - Pocket Maximum is satisfied
Individual Out-of-Pocket Maximum each Coverage Year(includes Deductible)	$6,350	$12,700
Family Out-of-Pocket Maximum each Coverage Year (includes Deductible)	$12,700	$25,400

Inpatient Hospitalization Services

	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services & Supplies	20% after Deductible	40% after Deductible
Inpatient Medical Care	20% after Deductible	40% after Deductible

Alternatives to Inpatient Hospital Care

Ambulatory Surgical Facility or other Health Care Facility	20% after Deductible	40% after deductible
Home Health Care – limited to 30 visits per Coverage Year	20% after Deductible	40% after Deductible
Hospice Care	20% after Deductible	40% after Deductible
Skilled Nursing/Rehabilitation Facility –up to 30 days per Coverage Year	20% after Deductible	40% after Deductible

Diagnostic Services

MRI, MRS, PET and CAT Scans & Nuclear Medicine	20% after Deductible	40% after Deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	20% after Deductible	40% after Deductible
Radiation Therapy	20% after Deductible	40% after Deductible

Emergency Medical Care

Hospital Emergency Room Emergency or Emergency Medical Care	20% after Deductible	20% after Deductible
Ambulance Services – any Medically Necessary transport	20% after Deductible	40% after Deductible

Human Organ Transplants

Transplant Donor Expenses will be covered up to a maximum of $10,000 per transplant. Transplant travel expenses will be covered up to a maximum of $10,000 per transplant lifetime provided a Covered Person obtains services in connection with a listed transplant from a Participating Provider as described in [1]Part III The Description of Covered Services Section.		
Specified Organ Transplants – when coordinated through a Participating Provider – no maximum benefit limit.	20% after Deductible	40% after Deductible, Covered Expenses are limited to a maximum of $100,000 for all expenses per transplant and 2 transplants per lifetime.

Maternity Services Provided by a Physician

	In Network	Out of Network
Pre-Natal and Post-Natal Care	20% after Deductible	40% after Deductible
Delivery and Nursery Care	20% after Deductible	40% after Deductible

Mental Health and Substance Abuse Services

Inpatient Mental Health	20% after Deductible	40% after Deductible
Outpatient Mental Health	20% after Deductible	40% after Deductible
Inpatient Substance Abuse	20% after Deductible	40% after Deductible
Outpatient Substance Abuse	20% after Deductible	40% after Deductible

Other Services

Habilitative Services	20% after Deductible	40% after Deductible
Manipulative Therapy applies to the office visit exam and/or spinal manipulation and all services performed during the visit (e.g., X-ray, physical therapy, etc.) –limited to 30 visits per Coverage Year	20% after Deductible	40% after Deductible
Outpatient Physical, Speech and Occupational Therapy limited to 30 visits for each therapy per Coverage Year	20% after Deductible	40% after Deductible
Durable Medical Equipment/Medical Supplies	20% after Deductible	40% after Deductible
Wigs/Scalp Prosthesis	20% after Deductible	40% after deductible
Prosthetic and Orthotic Appliances	20% after Deductible	40% after Deductible
Private Duty Nursing limited to 30 visits per Coverage Year	20% after Deductible	40% after Deductible

Outpatient Prescription Drugs

Generic	20% after Deductible	40% after Deductible
Preferred Brand	30% after Deductible	50% after Deductible
Non-Preferred Brand	40% after Deductible	50% after Deductible
Specialty	50% after Deductible	Not Covered

Outpatient Services

Surgery – includes related surgical services	20% after Deductible	40% after Deductible
Chemotherapy	20% after Deductible	40% after Deductible

Physician Office Visit

Office Visits include: • Primary care and specialist Physicians • Pre-surgical consultations	20% after Deductible	40% after Deductible

Preventive Care Screening and Immunizations

Listed in the recommendations of USPSTF A & B and HRSA Women's Preventive Services include:	In-Network	Out-of-Network
Annual Health Maintenance Exam – beginning age 19, includes related X-rays, EKG, lab procedures, and routine screening tests performed as part of the physical exam – one per Coverage Year	Deductible waived 0% Coinsurance	Deductible applies – 40% after Deductible
Annual Well Woman Exam – includes pelvic exam and breast exam– one per Coverage Year	Deductible waived 0% Coinsurance	Deductible applies – 40% after Deductible
Pap Smear Screening – laboratory services only – one per Coverage Year	Deductible waived 0% Coinsurance	Deductible applies – 40% after Deductible
Well-Baby and Child Care – through age 18	Deductible waived 0% Coinsurance	Deductible applies – 40% after Deductible
Immunizations – child and adult	Deductible waived 0% Coinsurance	Deductible applies – 40% after Deductible
Hearing Exams (newborn) performed by the examining Physician	Deductible waived 0% Coinsurance	Deductible applies – 40% after Deductible
Mammography Screening – one baseline at age 35 and one per Coverage Year for women age 40 and older.	Deductible waived 0% Coinsurance	Deductible applies 40% coinsurance
Prostate Specific Antigen (PSA) Screening – one per Coverage Year for men age 40 and older	Deductible waived 0% Coinsurance	Deductible applies 40% coinsurance

5. EFFECTIVE DATE:

If selected, the following will apply to Eligible Employees of the Policyholder and their eligible dependents in addition to the Effective Date provision: ☑Yes ☐No

Coverage will become effective the first of the month following completion of the waiting period and receipt of total premium by the carrier.

6. Waiting Period: 60 Days

7. PREMIUM PAYABLE: ☑Monthly ☐Annual

8. PREMIUMS:

☑Employee Only	$971.35
☑Employee and children	$1,748.66

Additional Taxes: TRF and PCORI fees - $2.45 per covered life per month will be added to the above premium.