Filing at a Glance

Company: Time Insurance Company

Product Name: Time Insurance-Base Chassis
SERFF Tr Num: ASWX-126318833
State: Arkansas

TOI: H16G Group Health - Major Medical
SERFF Status: Closed-Disapproved
State Tr Num: 43596

Sub-TOI: H16G.001C Any Size Group - Other
Co Tr Num: IH AR00825FIF02
State Status: Disapproved-Closed

Filing Type: Form
Reviewer(s): Rosalind Minor

Author: SPI AssurantHealthandEmployeeBenef
Disposition Date: 11/06/2009

Date Submitted: 09/24/2009
Disposition Status: Disapproved

Implementation Date Requested: 10/22/2009
Implementation Date:

State Filing Description:

General Information

Project Name: Time Insurance-Base Chassis
Status of Filing in Domicile:

Project Number: IH AR00825FIF02
Date Approved in Domicile:

Requested Filing Mode: Review & Approval
Domicile Status Comments:

Explanation for Combination/Other:
Market Type:

Submission Type: New Submission
Group Market Size:

Overall Rate Impact:
Group Market Type:

Filing Status Changed: 11/06/2009
Explanation for Other Group Market Type:

State Status Changed: 11/06/2009

Deemer Date:
Created By: SPI AssurantHealthandEmployeeBenef

Submitted By: SPI AssurantHealthandEmployeeBenef
Corresponding Filing Tracking Number:

PPACA: Pre-PPACA Submission

Filing Description:

Re: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Master Policy: TDT.MPO.XX
Certificate of Medical Insurance : TDT.CER.AR
Benefit Summary : TDT.BNC.AR
JOHN ALDEN LIFE INSURANCE COMPANY (NAIC #65080; FEIN 41-0999752)
Master Policy: JDT.MPO.XX
Certificate of Medical Insurance: JDT.CER.AR

Benefit Summary: JDT.BNC.AR

Dear Rosalind Minor,

Per our phone conversation of September 24, 2009, I withdraw Insurance Department # 43359, Serf Filing ID#ASWX-126284502 which was submitted using an incorrect category. As you instructed this resubmission will not require a new filing fee.

The enclosed medical insurance forms are hereby submitted for your review seeking approval. All forms are new and do not replace any forms currently on file with your Department. Master Policy form TDT.MPO.XX will be issued and delivered to a trust in the State of Illinois and the certificate forms will be issued to individuals under the trust policy. Coverage is issued on an individually underwritten basis and is not employer sponsored. A copy of the trust agreement is enclosed herewith.

Certificate of Medical Insurance form TDT.CER.AR and Benefit Summary form TDT.BNC.AR mirror Certificate of Medical Insurance form TIM.CER.AR (05/2008) and Benefit Summary form TIM.BNC.AR (05/2008) with the exception of SIG: 025.001.GE, SIG: 030.002.001.GE and EFF: 010.005.GE. Certificate of Medical Insurance form TIM.CER.AR (05/2008) and Benefit Summary form TIM.BNC.AR (05/2008) were approved by your Department on July 7, 2008 via SERFF Filing ID ASWX-125719472.

For your ease in review, the differences between the Certificate of Medical Insurance form and the form previously approved on July 7, 2008 are demarcated in the attached "marked/redlined".

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for both Time Insurance Company and John Alden Life Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. We are submitting identical forms for each company. The only differences are to the form numbers and company names. Because the forms are identical, we respectfully request that the same analyst review both filings.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional

information, please contact me at any of the numbers listed below.

Company and Contact

Filing Contact Information

Karen Griglak, Contract Compliance Analyst
501 W. Michigan St. 800-800-1212 [Phone]
Milwaukee, WI 53203 414-299-6168 [FAX]

Filing Company Information

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 W. Michigan St.	Group Code: 19	Company Type:
Milwaukee, WI 53203	Group Name:	State ID Number:
(800) 800-1212 ext. [Phone]	FEIN Number: 39-0658730	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	$0.00	09/24/2009	

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	11/06/2009	11/06/2009
Approved-Closed	Rosalind Minor	09/29/2009	09/29/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	11/05/2009	11/05/2009	SPI AssurantHealthandEmployeeBenef	11/05/2009	11/05/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Benefit Summary	SPI AssurantHealthandEmployeeBenef	11/04/2009	11/04/2009
Form	Certificate amendment rider	SPI AssurantHealthandEmployeeBenef	11/04/2009	11/04/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Response to November 5, 2009 objection	Note To Reviewer	SPI AssurantHealtha	11/05/2009	11/05/2009

		ndEmployeeBenef		
Amendment	Note To Reviewer	SPI AssurantHealthandEmployeeBenef	11/04/2009	11/04/2009
Re-open	Note To Filer	Rosalind Minor	10/30/2009	10/30/2009
Request to reopen this filing.	Note To Reviewer	SPI AssurantHealthandEmployeeBenef	10/30/2009	10/30/2009
Request to reopen filing	Note To Reviewer	SPI AssurantHealthandEmployeeBenef	10/07/2009	10/07/2009

Disposition

Disposition Date: 11/06/2009
Implementation Date:
Status: Disapproved
Comment:
Your request to market this product through The Health Advocates Group Insurance Trust is being disapproved.

We are of the opinion that the Trust was formed primarily for the purpose of marketing insurance. As your letter states...Coverage is issured on an individually underwritten basis and is note employer sponsored...". The group submission does not justify avoiding premium approval and the individual health laws and regulations.

If you wish to market the product to individuals by independent agents, the product must be submitted and approved as an individual product, along with the actuarial memorandum and rates.

The product will maintain its original approval date, but the request to market it through the trust is being dispproved effective on this date.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ASWX-126318833*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*43596*
Company Tracking Number:	*IH AR00825FIF02*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00825FIF02*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter, Trust Agreement, Variability Statement, Marked Benefit Summary, Marked Certificate	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes
Form	Master Policy	Approved-Closed	Yes
Form	Hospice offer	Approved-Closed	Yes
Form	Mammogram offer	Approved-Closed	Yes
Form	Mental Illness Offer	Approved-Closed	Yes
Form	Psychological Examiners	Approved-Closed	Yes
Form	Alcohol and Drug Offer	Approved-Closed	Yes
Form	TMJ/CMJ offer	Approved-Closed	Yes
Form	Hearing Aid offer	Approved-Closed	Yes
Form	Benefit Summary		Yes
Form	Certificate amendment rider		Yes

Disposition

Disposition Date: 09/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ASWX-126318833*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*43596*
Company Tracking Number:	*IH AR00825FIF02*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001C Any Size Group - Other*
Product Name:	*Time Insurance-Base Chassis*		
Project Name/Number:	*Time Insurance-Base Chassis/IH AR00825FIF02*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter, Trust Agreement, Variability Statement, Marked Benefit Summary, Marked Certificate	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes
Form	Master Policy	Approved-Closed	Yes
Form	Hospice offer	Approved-Closed	Yes
Form	Mammogram offer	Approved-Closed	Yes
Form	Mental Illness Offer	Approved-Closed	Yes
Form	Psychological Examiners	Approved-Closed	Yes
Form	Alcohol and Drug Offer	Approved-Closed	Yes
Form	TMJ/CMJ offer	Approved-Closed	Yes
Form	Hearing Aid offer	Approved-Closed	Yes
Form	Benefit Summary		Yes
Form	Certificate amendment rider		Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/05/2009
Submitted Date	11/05/2009
Respond By Date	

Dear Karen Griglak,

This will acknowledge receipt of the captioned filing.

Objection 1

- Benefit Summary, TDT.BNC.AR (Form)

Comment:

The Benefit Summary and Trust Agreement indicates that the Trust is set up for insurance purposes only. This is not allowed unless the Group meets a definition as outlined under ACA 23-86-106 (1) thru (5). Please advise as to the type of group.

How is the certificate marketed? Under "Participation in Trust" it appears that anyone can qualify as a covered person.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/05/2009
Submitted Date	11/05/2009

Dear Rosalind Minor,

Comments:
Response to November 5, 2009 Objection

Response 1

Comments: Please see attached cover letter

Related Objection 1

Applies To:

- Benefit Summary, TDT.BNC.AR (Form)

Comment:

The Benefit Summary and Trust Agreement indicates that the Trust is set up for insurance purposes only. This is not allowed unless the Group meets a definition as outlined under ACA 23-86-106 (1) thru (5). Please advise as to the type of group.

How is the certificate marketed? Under "Participation in Trust" it appears that anyone can qualify as a covered person.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank You

Sincerely,

SPI AssurantHealthandEmployeeBenef

Note To Reviewer

Created By:

SPI AssurantHealthandEmployeeBenef on 11/05/2009 02:48 PM

Last Edited By:

SPI AssurantHealthandEmployeeBenef

Submitted On:

11/05/2009 02:48 PM

Subject:

Response to November 5, 2009 objection

Comments:

Please see attached

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

November
November 5, 2009

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, AR 72201

Re: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Master Policy: TDT.MPO.XX
Certificate of Medical Insurance : TDT.CER.AR
Benefit Summary : TDT.BNC.AR
JOHN ALDEN LIFE INSURANCE COMPANY (NAIC #65080; FEIN 41-0999752)
Master Policy: JDT.MPO.XX
Certificate of Medical Insurance: JDT.CER.AR
Benefit Summary: JDT.BNC.AR

Dear Rosalind Minor,

We received an objection to this filing on November 5, 2009. Below please find a description of the objection and our response.

OBJECTION:
"The Benefit Summary and Trust Agreement indicates that the Trust is set up for insurance purposes only. This is not allowed unless the Group meets a definition as outlined under ACA 23-86-106 (1) thru (5). Please advise as to the type of group. How is the certificate marketed? Under "Participation in Trust" it appears that anyone can qualify as a covered person. '

RESPONSE:
Master Policy form TDT.MPO.XX will be issued and delivered to a trust in the State of Illinois and the certificate forms will be issued to individuals under the trust policy. Coverage is issued on an individually underwritten basis and is not employer sponsored. Upon approval, the forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Karen Griglak
Contract Compliance Analyst
Legal Department
karen.griglak@assurant.com
T 800.800.1212 Ext. 8687
F 414.299.7915

Note To Reviewer

Created By:

SPI AssurantHealthandEmployeeBenef on 11/04/2009 01:54 PM

Last Edited By:

SPI AssurantHealthandEmployeeBenef

Submitted On:

11/04/2009 01:54 PM

Subject:

Amendment

Comments:

See attached

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

November 4, 2009

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, AR 72201

Re: **TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730**)
Certificate Amendment Rider: TDT.6055.AR
Benefit Summary : TDT.BNC.AR Rev. 7-2009
JOHN ALDEN LIFE INSURANCE COMPANY (NAIC #65080; FEIN 41-0999752)
Certificate Amendment Rider: JDT.6055.AR
Benefit Summary: JDT.BNC.AR Rev. 7-2009

Dear Sir or Madam,

The above-referenced revisions to our Benefit Summary and Certificate Amendment Rider are hereby submitted for your review and approval.

Benefit Summary form TDT.BNC.AR, revised 07/2009, replaces TDT.BNC.AR, in its entirety which was approved by your Department on September 29, 2009 under Department No. IH AR00825FIF02. Certificate Amendment Rider TDT.6055.AR will be used to revise form TDT.CER.AR which was approved by your Department on September 29, 2009 under Department No. IH AR00825FIF02.

For your ease in review, the differences between the updated/revised forms and the forms previously approved are demarcated in the attached "marked/redlined" documents. Upon approval, these revisions will be incorporated into the Certificate of Medical Insurance. All Benefit Summary revisions have been incorporated into and are demarcated in the attached "marked/redlined" 07/2009 edition of the Benefit Summary.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

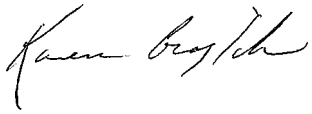
Upon approval, the forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for both Time Insurance Company and John Alden Life Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. We are submitting identical forms for each company. The only differences are to the form numbers and company names. Because the forms are identical, we respectfully request that the same analyst review both filings.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,



Karen Griglak
Product Compliance Analyst
Legal Department
Karen.griglak@assurant.com
T 414.299.8687 or 800.800.1212 ext. 8687
F 414.299.6168

Amendment Letter

Submitted Date: 11/04/2009

Comments:

The attached amendment rider and benefit summary outline changes to the approved forms.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
TDT.BNC.AR	Schedule Pages	Benefit Summary	Initial				0.000	TDT_BNC_AR.PDF
TDT.6055.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate amendment rider	Initial				0.000	TDT_6055_AR.PDF

Note To Filer

Created By:

Rosalind Minor on 10/30/2009 12:10 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/30/2009 12:10 PM

Subject:

Re-open

Comments:

The filing is being reopened. No filing fee is required.

Note To Reviewer

Created By:

SPI AssurantHealthandEmployeeBenef on 10/30/2009 09:30 AM

Last Edited By:

SPI AssurantHealthandEmployeeBenef

Submitted On:

10/30/2009 09:30 AM

Subject:

Request to reopen this filing.

Comments:

I would like to update the range provided within the certificate for the definition of benefit waiting period. It was filed as 150-180, I would like to change it to 0-180.

May I do this within this filing, without incurring a new filing fee?

Note To Reviewer

Created By:

SPI AssurantHealthandEmployeeBenef on 10/07/2009 02:40 PM

Last Edited By:

SPI AssurantHealthandEmployeeBenef

Submitted On:

10/07/2009 02:40 PM

Subject:

Request to reopen filing

Comments:

I would like to update the range provided within the certificate for the definition of benefit waiting period. It was filed as 150-180, I would like to change it to 0-180.

May I do this within this filing, without incurring a new filing fee?

Form Schedule

Lead Form Number: TDT.CER.AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/29/2009	TDT.CER.AR	Certificate	Certificate	Initial		0.000	TDT_CER_AR.PDF
Approved-Closed 09/29/2009	TDT.BNC.AR	Schedule Pages	Benefit Summary	Initial		0.000	TDT_BNC_AR.PDF
Approved-Closed 09/29/2009	Master Policy	Other	Master Policy	Initial		0.000	Master Policy.PDF
Approved-Closed 09/29/2009	TDT.4611	Other	Hospice offer	Initial		0.000	TDT_4611.PDF
Approved-Closed 09/29/2009	TDT.4612	Other	Mammogram offer	Initial		0.000	TDT_4612.PDF
Approved-Closed 09/29/2009	TDT.4613	Other	Mental Illness Offer	Initial		0.000	TDT_4613.PDF
Approved-Closed 09/29/2009	TDT.4614	Other	Psychological Examiners	Initial		0.000	TDT_4614.PDF
Approved-Closed 09/29/2009	TDT.4615	Other	Alcohol and Drug Offer	Initial		0.000	TDT_4615.PDF
Approved-Closed 09/29/2009	TDT.4616	Other	TMJ/CMJ offer	Initial		0.000	TDT_4616.PDF
Approved-Closed 09/29/2009	TD.4664	Other	Hearing Aid offer	Initial		0.000	TD_4664.PDF
	TDT.BNC.A	Schedule	Benefit Summary	Initial		0.000	TDT_BNC_A

R TDT.6055.AR	Pages Certificate Amendment, Insert Page, Endorsement or Rider	Certificate amendment rider	Initial	0.000	R.PDF TDT_6055_AR.PDF

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]
SIG: 005.002.GE

[[**CERTIFICATE OF MEDICAL INSURANCE**]
SIG: 015.003.GE

The insurance described in this certificate is effective on the date shown in the Benefit Summary only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan.
SIG: 020.003.GE

This certificate is evidence of Your coverage under the Policy of medical insurance issued to an trust.
SIG: 025.001.GE

This certificate describes the benefits and major provisions which affect Covered Persons. The final interpretation of any specific provision is based on the terms of the Policy. The Policy is issued in the State of [Illinois] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this certificate or the Policy. The certificate is subject to applicable laws of the state in which it is issued.
SIG: 030.002.001.GE

The Policy may be examined at Our Home Office or the main office of the Policyholder.
SIG: 040.001.GE

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

Please read Your certificate carefully and become familiar with its terms, limits and conditions.
SIG: 045.002.GE

[**RIGHT TO EXAMINE CERTIFICATE FOR 10 DAYS**
If You are not satisfied, return the certificate to Us or Our agent within 10 days after You have received it. All premiums will be refunded and Your coverage will be void.]

[**IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR ENROLLMENT FORM FOR INSURANCE**
Please read the copy of the enrollment form included with this certificate. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the enrollment form. If a material omission or misstatement is made in the enrollment form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount. Carefully check the enrollment form and, if any information shown in the enrollment form is not correct and complete, write to Us at the address above, within 10 days.]

Secretary

President

SIG: 050.001.GE

[**THIS CERTIFICATE CONTAINS AN UTILIZATION REVIEW PROVISIONS SECTION**]]
SIG: 060.002.GE

[[II.] [GUIDE TO YOUR CERTIFICATE]

The sections of the certificate appear in the following order:

I. [Signature Page]

II. [Guide To Your Certificate]

III. [Definitions] [for Medical and Outpatient Prescription Drug Coverage]

IV. [Effective Date and Termination Date]

V. [Utilization Review Provisions]

VI. [[Provider Charges] [and] [Maximum Allowable Amount] Provisions]

VII. [Medical Benefits]

VIII. [Outpatient Prescription Drug Benefits]

IX. [Life Insurance Benefits]

X. [Exclusions]

XI. [Pre-Existing Conditions Limitation]

XII. [Coordination of Benefits (COB)]

XIII. [Claim Provisions]

XIV. [Premium Provisions]

XV. [Recovery Provisions]

XVI. [Conversion]

XVII. [Other Provisions]]

TOC: 005.001.GE

[[**III.**] [**DEFINITIONS**] [**FOR MEDICAL AND OUTPATIENT PRESCRIPTION DRUG COVERAGE**]

When reading this certificate, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the certificate carefully.
DEF: 005.002.GE

[**Access Fee**
An Access Fee is the dollar amount that a Covered Person must pay each time certain [services are received] [or] [visits are made]. The Access Fee is subtracted from Covered Charges before applying any Deductible, Coinsurance or other Out-of-Pocket Limit. [An Access Fee will not be reimbursed by Us nor does it count toward satisfying any Deductible, Coinsurance or other Out-of-Pocket Limit.]

An Access Fee only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Access Fees are along with the Covered Charges to which they apply.

The following Access Fees may apply to Covered Charges:

[1.] [**Facility** [**Access**] **Fee:** The dollar amount that must be paid directly to the facility for each surgical procedure and each Inpatient stay. [A single Inpatient stay includes readmissions within [30 days] for the same condition.]]

[2.] [**Emergency Room** [**Access**] **Fee:** The dollar amount that must be paid directly to the facility for an Emergency Room visit. [We will waive an Emergency Room Access Fee if the Covered Person is admitted for an Inpatient stay immediately following the Emergency Room visit.]]
DEF: 010.001.GE

[**Accident or Accidental**
Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.

2. It results from an external agent or trauma.

3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.

4. It is definite as to time and place.

5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness.]
DEF: 015.001.GE

[**Administrator**
An organization or entity designated by Us to manage the benefits provided in this plan. [The designated Administrator will have the discretionary authority to act on Our behalf in the

administration of this plan.] [The Administrator may enter into agreements with various providers to provide services covered under this plan.]]
DEF: 020.001.GE

[**Assistant Surgeon**
A Health Care Practitioner who is qualified by licensure, training and credentialing to perform the procedure in an assistant role to the primary surgeon in the state and facility where the procedure is performed.]
DEF: 025.001.GE

[**Average Sales Price**
A published cost of a Prescription Drug as listed by Our national drug data bank or by a federal or other national source on the date the Prescription Drug is purchased.]
DEF: 030.001.GE

[**Average Wholesale Price**
A published cost of a Prescription Drug that is paid by a Pharmacy to a wholesaler as listed by Our national drug data bank on the date the Prescription Drug is purchased.]
DEF: 035.001.GE

[**Aversion Therapy**
A series of procedures, medications or treatments that are designed to reduce or eliminate unwanted or dangerous behavior through the use of negative experience, such as pairing the behavior with unpleasant sensations or punishment.]
DEF: 040.001.GE

[**Behavioral Health**
Any condition classified as a mental disorder in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. [Behavioral Health also includes family and marriage counseling.] [For the purpose of this plan, Behavioral Health does not include Substance Abuse.]]
DEF: 045.001.GE

[**Behavioral Health Facilities and Programs**
The following Behavioral Health Facilities and Programs are defined in this plan:
DEF: 050.001.GE

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

a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care or Subacute Medical Care for Behavioral Health or Substance Abuse.
b. Be staffed by an on duty licensed physician 24 hours per day.
c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
d. Maintain daily medical records that document all services provided for each patient.
e. Provide a restrictive environment for patients who present a danger to self or others.
f. Provide alcohol and chemical dependency detoxification services.

g. Handle medical complications that may result from a Behavioral Health or Substance Abuse diagnosis.
h. Not primarily provide Rehabilitation Services, residential, partial hospitalization or intensive Outpatient services although these services may be provided in a distinct section of the same physical facility.]

DEF: 050.002.GE

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

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

DEF: 050.003.GE

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

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

DEF: 050.004.GE

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

a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide care for Behavioral Health or Substance Abuse.

b. Provide at least 3 hours of individual or group psychotherapy by an appropriately licensed Health Care Practitioner 1 to 5 days per week. Recreational therapy, educational therapy, music and dance therapy and similar services may be provided but are not included in the 3 hour minimum requirement of psychotherapy.]]

DEF: 050.005.GE

[**Beneficiary**
A person to whom a life insurance benefit is payable in the event of a Covered Person's death. The Beneficiary is named by the Covered Person.]
DEF: 055.001.GE

[**Benefit Period**
The length of time [this plan is in force,] as shown in the Benefit Summary. [The Benefit Summary shows the maximum Benefit Period for which You [and any Covered Dependents] are covered under this plan.]
DEF: 060.001.GE

[**Benefit Waiting Period**
The period of consecutive days [or months] that must pass after the Effective Date of coverage before a Covered Person is eligible to be covered for [a Sickness,] [and] [specific benefits as shown in the Benefit Summary] [and] [or] [preventive medicine services] under the terms of this plan. Each Covered Person is responsible for payment of all services that are received during the Benefit Waiting Period. [The Benefit Waiting Period applies separately to each Covered Person.] [Benefits are available from the first day Covered Charges are Incurred for an Injury that is sustained on or after the Covered Person's Effective Date.]

[A Sickness that occurs within the first [150-180 days] after the Covered Person's Effective Date of coverage will not be covered for a period of [12 months] after the Effective Date.]

A Benefit Waiting Period only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Benefit Waiting Periods are along with the Covered Charges to which they apply.]
DEF: 065.001..001.GE

[**Calendar Year**
The period beginning on January 1 of any year and ending on December 31 of the same year.]
DEF: 070.001.GE

[**Calendar Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person in any one Calendar Year while this coverage is in force.]
DEF: 075.001.GE

[**Cardiac Rehabilitation Program**
An Outpatient program that is supervised by a Health Care Practitioner and directed at improving the physiological well-being of a Covered Person with heart disease.]
DEF: 080.001.GE

[**Certificate Holder**
The person listed on the Benefit Summary as the Certificate Holder.]
DEF: 085.001.GE

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

Coinsurance only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which it applies.]
DEF: 090.001.GE

[**Contracted Rate**
The amount a Health Care Practitioner, facility[, Participating Pharmacy,] [Specialty Pharmacy Provider] or supplier that has a contract with [Us or] Our Network Manager, as identified for this plan, has agreed to accept as total payment for the treatment, services [,or] supplies [or Prescription Drugs] provided.]
DEF: 095.001.GE

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

A Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.]
DEF: 100.001.GE

[**Cosmetic Services**
A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.]
DEF: 105.001.GE

[**Covered Charge**
An expense that We determine meets all of the following requirements:

[1.] [It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.]

[2.] [It is Incurred by a Covered Person while coverage is in force under this plan as the result of:

- [a.] [A Sickness [that first manifests itself on or after the Covered Person's Effective Date]; or]
- [b.] [An Injury [that is sustained on or after the Covered Person's Effective Date]; or]
- [c.] [For preventive medicine services [or family planning services] as outlined in the Medical Benefits section.]]

[3.] [It is Incurred for services or supplies listed in the Medical Benefits section [or Outpatient Prescription Drug Benefits section][, unless the charges are Incurred during a Benefit Waiting Period].]

[4.] [It is Incurred for treatment, services or supplies which are Medically Necessary.]

[5.] [It is not in excess of the Maximum Allowable Amount.]

Charges from the Covered Person's [Non-Network] [Non-Participating] Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by Us.]
DEF: 110.001.GE

[**Covered Charge**
An expense that We determine meets all of the following requirements:

[1.] [It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.]

[2.] [It is Incurred by a Covered Person while coverage is in force under this plan as the result of a Sickness or an Injury [or for preventive medicine services] [or family planning services] as outlined in the Medical Benefits section].]

[3.] [It is Incurred for services or supplies listed in the Medical Benefits section [or Outpatient Prescription Drug Benefits section][, unless the charges are Incurred during a Benefit Waiting Period].]

[4.] [It is Incurred for treatment, services or supplies which are Medically Necessary.]

[5.] [It is not in excess of the Maximum Allowable Amount.]

Charges from the Covered Person's [Non-Network] [Non-Participating] Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by Us.]
DEF: 110.002.GE

[**Covered Dependent**
A person who meets the definition of a Dependent and is eligible to receive benefits under this plan.]
DEF: 115.001.GE

[**Covered Person**
A person who is eligible to receive benefits under this plan.]
DEF: 120.001.GE

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

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or

2. Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or

3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.]

DEF: 135.001.GE

[**Deductible**
A Deductible is the dollar amount of Covered Charges that must be paid [during a Benefit Period] before benefits are paid by Us.

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

[One or more of the following Deductibles may apply to Covered Charges as shown in the Benefit Summary:]
DEF: 140.001.GE

[1.] [**Annual**] [**Carryover Deductible:** Covered Charges Incurred by a Covered Person [due to an Accident] [for Inpatient services] [for Inpatient services received on December 31st of a Calendar Year] [during the last [3] months of a [Plan Year] [Calendar Year] [Benefit Period]] that count toward satisfying a Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [[Non-Network] [Non-Participating] Provider Deductible,] [but do not satisfy the [Network] [Participating] Provider Deductible] [Individual Out-of-Pocket Limit]] [for that [Plan Year,] [Calendar Year,] [Benefit Period,]] will also count toward satisfying the Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [[Non-Network] [Non-Participating] Provider Deductible] for the next [Plan Year] [Calendar Year] [Benefit Period]. [This [Annual] Carryover Deductible [does not count toward satisfying the [maximum] Family Deductible] [and] [only applies in the first [Plan Year] [Calendar Year] [Benefit Period].]] [For the purpose of determining whether a[n Annual] Carryover Deductible applies, Covered Charges will be considered to apply toward the [Individual Deductible] [or] [[Non-Network] [Non-Participating] Provider Deductible] in the order the Covered Charges are processed.]]
DEF: 140.003.GE

[2.] [**Common Accident Deductible:** If more than one Covered Person is injured in the same Accident, only one Individual Deductible must be satisfied for all Covered Charges for that Accident. The Covered Charges must be Incurred within [the first 90 days] [a specified period of time] after the date the Accident occurs. [Covered Charges Incurred [more than [90 days]] after the [date the Accident occurs] [time period shown in the Benefit Summary] will be paid subject to all the terms, limits and conditions in this plan without regard to the Common Accident Deductible provision.]]
DEF: 140.004.GE

[3.] [**Condition Specific Deductible:** The dollar amount of Covered Charges that must be satisfied by a Covered Person because of a named condition, shown on [the Benefit Summary] [a Condition Specific Deductible endorsement that is included with this plan], and for any complications related to that named condition. When Covered Charges equal to the Condition Specific Deductible for the named condition have been Incurred and processed by Us, the Condition Specific Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the [Benefit Summary] [Condition Specific Deductible endorsement]]. After the Condition Specific Deductible is satisfied, additional Covered Charges for the named

condition will be paid subject to all the terms, limits and conditions in this plan, including satisfaction of any other applicable Coinsurance, Deductible or other fees.]

DEF: 140.005.GE

[4.] [**Family Deductible:** [The dollar amount that must be satisfied by all Covered Persons before benefits are payable by Us.] [The [Individual] Deductibles that all Covered Persons may have to pay are limited to the Family Deductible amount.] When the Family Deductible amount is reached, We will consider the Deductible requirements for all Covered Persons in Your family to be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary][, except for any Condition Specific Deductible that a Covered Person may have].]

DEF: 140.014.GE

[5.] [**Individual Deductible:** The dollar amount of Covered Charges each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Individual Deductible have been Incurred and processed by Us, the Individual Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.015.GE

[6.] [**Integrated Deductible:** Covered Charges Incurred by all Covered Persons[, including Covered Charges for Prescription Drugs,] count toward satisfying a single Deductible. When Covered Charges equal to the Integrated Deductible have been Incurred and processed by Us, the Integrated Deductible for all Covered Persons will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.016.GE

[7.] [**Network**] [**Participating**] **Provider Deductible:** The dollar amount of Covered Charges received from providers in the [Health Care Provider Network] [Participating Provider Network] that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Network] [Participating] Provider Deductible have been Incurred and processed by Us, the [Network] [Participating] Provider Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.017.GE

[8.] [**Non-Network**] [**Non-Participating**] **Provider Deductible:** The dollar amount of Covered Charges received from [Non-Network] [Non-Participating] Providers that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Non-Network] [Non-Participating] Provider Deductible have been Incurred and processed by Us, the [Non-Network] [Non-Participating] Provider Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.018.GE

[9.] [**Per Cause Deductible:** The dollar amount of Covered Charges that must be satisfied by a Covered Person for each Sickness or Injury and for any complications related to that Sickness or Injury before benefits are payable by Us. When Covered Charges equal to the

Per Cause Deductible have been Incurred and processed by Us, the Per Cause Deductible for that particular Sickness or Injury and for any complications related to that Sickness or Injury will be satisfied for the Covered Person for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.019.GE

[10.] [[**Select**] **Network Deductible:** The dollar amount of Covered Charges received from [Select] Participating Providers that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Select] Network Deductible have been Incurred and processed by Us, the [Select] Network Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.020.GE

[**Dental Injury**
Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.]
DEF: 145.001.GE

[**Dental Treatment Plan**
A dentist's report of recommended treatment on a form satisfactory to Us that:

1. Itemizes the dental procedures and charges required for care of the mouth; and

2. Lists the charges for each procedure; and

3. Is accompanied by supporting preoperative imaging tests and any other appropriate diagnostic materials required by Us.]

DEF: 150.001.GE

[**Dependent**
A Dependent is:

[1.] The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried; and]
[b.] [Who is age [18] or younger; and]
[c.] [Who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student; and]
[d.] [Whose legal address is the same as the Certificate Holder's legal address].]

[If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that:

[a.] [You are required by a qualified medical child support order to provide medical insurance; or]
[b.] [The child was claimed as an exemption on Your most recent federal income tax return].]

[If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

[a.] [The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
[b.] [The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Certificate Holder for financial support [and be claimed as an exemption on Your most recent federal income tax return]. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan or after the child reaches the normal age for termination. Additional proof may be requested periodically [but not more often than annually after the [2-year] period following the date the child reaches the normal age for termination].]

[A child will no longer be a Dependent on the earliest of the date that he or she:

[a.] [Is no longer a full-time student; or]
[b.] [Graduates; or]
[c.] [Ceases to be claimed as an exemption on the Certificate Holder's federal income tax return, except for a Dependent child who is a full-time student; or]
[d.] [Attains age [24]; or]
[e.] [Marries; or]
[f.] [Is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped[.][; or]]
[g.] [Or You request their coverage be terminated.]

[This plan terminates in accordance with the Termination Date of Coverage provision.]
[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]

DEF: 155.003.001.AR

[**Dependent**
A Dependent is:

[1.] [The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or]

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried][; and]
[b.] [Who is chiefly dependent on the Certificate Holder for financial support].]

[A child will no longer be a Dependent on the earliest of the date that:

[a.] [He or she marries][;]

[b.] [He or she is no longer chiefly dependent on the Certificate Holder for financial support][; or]
[c.] [He or she or the Certificate Holder request their coverage be terminated.]]
[This plan terminates in accordance with the Termination Date of Coverage provision.]
[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]
DEF: 155.007.001.GE

[**Designated Specialty Provider**
Any Health Care Practitioner, facility or supplier, identified for this plan by [Us or] the Network Manager, who has agreed to accept a Contracted Rate as payment for designated covered specialty treatment, services or supplies through Our Designated Specialty Provider Network.]
DEF: 160.001.GE

[**Designated Specialty Provider Network**
The group of Designated Specialty Providers, within the Health Care Provider Network as identified for this plan by [Us or] the Network Manager, who have agreed to accept a Contracted Rate as payment in full for designated covered specialty treatment, services or supplies. This list is subject to change at any time without notice.]
DEF: 165.001.GE

[**Designated Transplant Provider**
A Health Care Practitioner, facility or supplier, as determined by Us, that a Covered Person must use to obtain the maximum benefits available under the Transplant Services provision in the Medical Benefits section.]
DEF: 170.001.GE

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

1. A 12 month delay in one functional area; or

2. A 33% delay in one functional area or a 25% delay in each of two areas (when expressed as a quotient of developmental age over chronological age); or

3. A score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas if appropriate standardized instruments are individually administered in the evaluation.]

DEF: 175.001.GE

[**Diagnostic Imaging**

Procedures and tests including, but not limited to, x-rays, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition or determine the nature of a condition.]
DEF: 180.001.GE

[**Domestic Partner**
A person [of the same] [or] [opposite gender] who resides with the Certificate Holder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

1. Be at least [18] years of age.

2. Be competent to enter into a contract.

3. Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

A Domestic Partner must provide Us with an affidavit attesting that the domestic partnership has existed for a minimum period of [24 months] at the time of enrollment under this plan. Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.]
DEF: 185.002.GE

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

[1.] [It is designed for and able to withstand repeated use.]

[2.] [It is primarily and customarily used to serve a medical purpose.]

[3.] [It is used by successive patients.]

[4.] [It is suitable for use at home.]

[5.] [It is normally rented.]]
DEF: 190.001.GE

[**Effective Date**
The date coverage under this plan begins for a Covered Person. [The Covered Person's coverage begins at 12:01 a.m. local time at the Certificate Holder's state of residence.]]
DEF: 195.003.GE

[**Emergency Confinement**
An Inpatient stay for a Sickness or an Injury that develops suddenly and unexpectedly and if not treated immediately on an Inpatient basis would:

1. Endanger the Covered Person's life; or

2. Cause serious bodily impairment to the Covered Person.]
DEF: 205.001.GE

[**Emergency Room**

A place affiliated with and physically connected to an Acute Medical Facility and used primarily for short term Emergency Treatment.]
DEF: 210.001.GE

[**Emergency Treatment**
Treatment, services or supplies for a Sickness or an Injury that develops suddenly and unexpectedly and if not treated immediately would:

1. Endanger the Covered Person's life; or

2. Cause serious bodily impairment to the Covered Person.]

DEF: 215.001.GE

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

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or

2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or

3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or

4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

5. Medications used for non-FDA approved indications and/or dosage regimens.

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

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

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:

    a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
    b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.

2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:

    a. The American Medical Association Drug Evaluations; or
    b. The American Hospital Formulary Service Drug Information; or
    c. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.

3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:

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

DEF: 235.001.001.GE

[**Family Plan**
A plan of insurance covering the Certificate Holder and one or more of the Certificate Holder's Dependents.]
DEF: 240.002.GE

[**Health Care Practitioner**
A person licensed by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.]
DEF: 250.001.GE

[**Health Care Provider Network**
The group of Health Care Practitioners, facilities and suppliers, identified by [Us or] the Network Manager for this plan, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. This list is subject to change at any time without notice. [The Health Care Provider Network may be made up of various levels of provider networks.]]
DEF: 255.001.GE

[**Home Health Care**
Services provided by a state licensed Home Health Care Agency as part of a program for care and treatment in a Covered Person's home.]
DEF: 260.001.GE

[**Home Health Care Agency**
An organization:

1. Whose primary purpose is to provide Home Health Care; and

2. Which is certified by Medicare; and

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

DEF: 265.001.GE

[**Home Office**
Our office in [Milwaukee, Wisconsin] [or other administrative offices as indicated by Us].
DEF: 270.001.GE

[**Hospice**

An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of [6 months] or less as certified by a physician. A Hospice must meet all of the following requirements:

1. Comply with all state licensing requirements.

2. Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

3. Provide a treatment plan and services under the direction of a physician.]

An Inpatient Hospice facility must meet all of the following requirements in addition to the requirements above:

1. Be a dedicated unit within an Acute Medical Facility or a Subacute Rehabilitation Facility or a separate facility that provides Hospice services on an Inpatient basis.

2. Be licensed by the state in which the services are rendered to provide Inpatient Hospice services.

3. Be staffed by an on call physician 24 hours per day.

4. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

5. Maintain daily clinical records.

6. Admit patients who have a terminal illness.

7. Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided.]

DEF: 275.001.GE

[**Immediate Family Member**
An Immediate Family Member is:

1. You or Your spouse [or Domestic Partner]; or

2. The children, brothers, sisters and parents of either You or Your spouse [or Domestic Partner]; or

3. The spouses of the children, brothers and sisters of You and Your spouse [or Domestic Partner]; or

4. Anyone with whom a Covered Person has a relationship based on a legal guardianship.]

DEF: 280.001.GE

[**Incur or Incurred**
The date services are provided or supplies are received.]
DEF: 285.001.GE

[**Injury**
Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.]
DEF: 290.001.GE

[**Inpatient**
Admitted to [an Acute Behavioral Health Inpatient Facility,] an Acute Medical Facility or other licensed facility for a stay of at least [24 hours] for which a charge is Incurred for room and board or observation.]
DEF: 295.001.GE

[**Malocclusion**
Teeth that do not fit together properly which creates a bite problem.]
DEF: 305.001.GE

[**Mandibular Protrusion or Recession**
A large chin which causes an underbite or a small chin which causes an overbite.]
DEF: 310.001.GE

[**Maxillary or Mandibular Hyperplasia**
Excess growth of the upper or lower jaw.]
DEF: 315.001.GE

[**Maxillary or Mandibular Hypoplasia**
Undergrowth of the upper or lower jaw.]
DEF: 320.001.GE

[**Maximum Allowable Amount**
The maximum amount of a billed charge We will consider when determining Covered Charges, as determined by Us. Benefit payments of Covered Charges are not based on the amount billed but, rather, they are based on what We determine to be the Maximum Allowable Amount. Amounts billed in excess of the Maximum Allowable Amount by or on behalf of a Health Care Practitioner, facility or supplier are not payable by Us under this contract. [Please see the [Provider Charges] [and] [Maximum Allowable Amount] Provisions section for the method(s) We use to determine the Maximum Allowable Amount.]]
DEF: 325.001.GE

[**Maximum Lifetime Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person under this plan. [This maximum will apply even if coverage under this plan is interrupted.] When the Maximum Lifetime Benefit has been received, no other benefits are payable for that Covered Person.]
DEF: 330.001.GE

[**Medical Facilities**
The following Medical Facilities are defined in this plan:
DEF: 335.001.GE

[1.] [**Acute Medical Facility [(Hospital)]:** A facility that provides acute care or Subacute Medical Care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long term acute care facility and must meet all of the following requirements:

a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care or Subacute Medical Care.
b. Be staffed by an on duty physician 24 hours per day.

c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
d. Maintain daily medical records that document all services provided for each patient.
e. Provide immediate access to appropriate in-house laboratory and imaging services.
[f.] [Not primarily provide care for [Behavioral Health,] [Substance Abuse] [or] Rehabilitation Services although these services may be provided in a distinct section of the same physical facility.]
[g.] [Provide care in [an intensive care unit (ICU),] [a neonatal intensive care unit (NCU),] [a coronary intensive care unit (CCU)] [and] [step-down units].]]

DEF: 335.002.GE

[2.] [**Acute Medical Rehabilitation Facility:** A facility that provides acute care for Rehabilitation Services for a Sickness or an Injury on an Inpatient basis. A distinct section of an Acute Medical Facility solely devoted to providing acute care for Rehabilitation Services would also qualify as an Acute Medical Rehabilitation Facility. These types of facilities must meet all of the following requirements:

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

DEF: 335.003.GE

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

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

DEF: 335.004.GE

[4.] [**Skilled Nursing Facility:** A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility must meet all of the following requirements:

a. Be licensed by the state to provide skilled nursing services.
b. Be staffed by an on call physician 24 hours per day.
c. Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day.
d. Maintain daily clinical records.
e. Not primarily [be a place for rest, for the aged or for Custodial Care] [or] [provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility]. [The facility may also provide extended care or Custodial Care which would not be covered under this plan.]]

DEF: 335.005.GE

[5.] [**Subacute Rehabilitation Facility:** A facility that provides Subacute Medical Care for Rehabilitation Services for a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of the following requirements:

a. Be licensed by the state in which the services are rendered to provide Subacute Medical Care for Rehabilitation Services.
b. Be staffed by an on call physician 24 hours per day.
c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
d. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this plan.]

DEF: 335.006.GE

[6.] [**Retail Health Clinic:** A facility that meets all of the following requirements:

[a.] [[Be licensed by] [or] [operate pursuant to] the state in accordance with the laws for the specific services being provided in that facility;]
[b.] [Be staffed by a Health Care Practitioner in accordance with the laws of that state;]
[c.] [Is [attached to] [or] [part of] a store or retail facility;]
[d.] [Is separate from a[n] [Acute Medical Facility [(Hospital)]][, Emergency Room][, Acute Medical Rehabilitation Facility][, Free-Standing Facility][, Skilled Nursing Facility][, Subacute Rehabilitation Facility,] [or] [Urgent Care Facility] [and any Health Care Practitioner's office located therein,] [even when services are performed after normal business hours;]]
[e.] [Provides general medical treatment or services for a Sickness or Injury[, or provides preventive medicine services,] [on a non-seasonal basis;] [and]
[f.] [Does not provide room and board or overnight services.]]

DEF: 335.008.GE

[7.] [**Urgent Care Facility:** A facility that is attached to an Acute Medical Facility but separate from the Emergency Room or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:

a. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
b. Be staffed by an on duty physician during operating hours.
c. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.
d. Provide immediate access to appropriate in-house laboratory and imaging services.]]

DEF: 335.007. GE

[**Medical Review Manager**
Our Company or an organization or entity, designated by Us, which may:

[1.] [Review services as required by the Utilization Review Provisions section][; or]

[2.] [Perform discharge planning and case management services][; or]

[3.] [Evaluate the Medical Necessity of treatment, services or supplies][; or]

[4.] [Administer treatment for [Behavioral Health] [or] [Substance Abuse] through Health Care Practitioners, facilities or suppliers][; or]

[5.] [Review a Covered Person's [Behavioral Health] [or] [Substance Abuse] condition and evaluate the Medical Necessity of referral treatment].]

[The Medical Review Manager's name is shown on the insurance coverage identification (ID) card.]
DEF: 340.001.GE

[**Medical Supplies**
Disposable medical products or Personal Medical Equipment that are used alone or with Durable Medical Equipment.]
DEF: 345.001.GE

[**Medical Supply Provider**
Agencies, facilities or wholesale or retail outlets that make medical supplies available for use.]
DEF: 350.001.GE

[**Medically Necessary or Medical Necessity**
Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and

2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and

3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and

4. Is provided [in the most conservative manner or] in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.]
DEF: 355.001.GE

[**Medicare**
Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.]
DEF: 360.001.GE

[**Mid-Level Practitioner**
An individual with advanced education and experience in the direct care of patients with an emphasis on primary care. A Mid-Level Practitioner includes physician assistants, nurse midwives and nurse practitioners. A Mid-Level Practitioner must be licensed or certified by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury for which a claim is made. The Mid-Level Practitioner must be practicing within the limits of his or her license or certification and in the geographic area in which he or she is licensed or certified.]
DEF: 365.001.GE

[**Negotiated Rate**
The amount negotiated between Us, or on behalf of Us, and the Health Care Practitioner, facility or supplier as total payment for the services or supplies provided. [The Negotiated Rate may include any discount arrangement We may have with the Health Care Practitioner, facility or supplier.]]
DEF: 370.001.GE

[**Network Manager**
An organization or entity, designated by Us, which may administer the [Health Care Provider Network,] [and] [or] [Participating Provider Network,] [and] [or] [[Select] Participating Provider Network,] [and] [or] [Designated Specialty Provider Network,] [and] [or] [Participating Pharmacy Network] [and] [or] [Specialty Pharmacy Network].]

[The Network Manager's name is shown on the insurance coverage identification (ID) card.]
DEF: 375.001.GE

[**Network Provider**
Any Health Care Practitioner, facility or supplier belonging to the Health Care Provider Network including, but not limited to, the following:

[1.] [Participating Providers.]

[2.] [[Select] Participating Providers.]

[3.] [Designated Specialty Providers.]]
DEF: 380.001.GE

[**Non-Network Provider**
Any Health Care Practitioner, facility or supplier, not identified for this plan by [Us or] the Network Manager, as participating.]
DEF: 385.001.GE

[**Non-Participating Provider**
Any Health Care Practitioner, facility or supplier, not identified for this plan by [Us or] the Network Manager, as participating.]
DEF: 390.001.GE

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

1. Developing daily living skills.

2. Strengthening and enhancing function.

3. Coordination of fine motor skills.

4. Muscle and sensory stimulation.]

DEF: 395.001.GE

[**Office Visit**
A[n in-person] meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office[, an Acute Medical Facility's Outpatient department,] [a Free-Standing Facility][,] [a Retail Health Clinic] [or] [an Urgent Care Facility]. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury as defined in the most recent edition of Current Procedural Terminology [or provides preventive medicine services].]
DEF: 400.001.001.GE

[**Orthognathic Treatment**
Malocclusion, Mandibular Protrusion or Recession, Maxillary or Mandibular Hyperplasia or Maxillary or Mandibular Hypoplasia. Refer to the Definitions of these conditions in this section of the plan.]
DEF: 405.001.GE

Orthotic Device
An external device that is; 1) Intended to restore physiological function or cosmesis to a patient; and 2) Custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient. Orthotic device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: 1) Is carried in stock and sold with out therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and 2) Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.
DEF: 408.001.AR

[**Out-of-Pocket Limit**
The Out-of-Pocket Limit is the sum of the Covered Charges for which We do not pay benefits [during a Benefit Period] [because of the [Coinsurance,] [or] [Deductible].] [When Covered Charges equal to the Out-of-Pocket Limit have been Incurred and processed by Us, the Out-of-Pocket Limit will be satisfied] [for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].] [The Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this plan.]

The following do not count toward satisfying any Out-of-Pocket Limit:

[1.] [All [Access Fees] [and] [Copayments] [and] [Deductibles].]

[2.] [All penalties applied under the Utilization Review Provisions section.]

[3.] [Amounts not paid by Us due to the difference between the [Non-Network] [Non-Participating] Provider benefit and the benefit that would have been paid had a [Network] [Participating] Provider been used.]

[4.] [Amounts in excess of the Maximum Allowable Amount.]

[5.] [Charges Incurred after the maximum amount has been paid for a benefit under this plan.]

[6.] [All [Ancillary Charges,] [Ancillary Pharmacy Network Charges,] [Prescription Drug Coinsurance amounts,] [Prescription Drug Copayments,] [and] [Prescription Drug Deductibles].]

DEF: 410.001.GE

An Out-of-Pocket Limit only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Out-of-Pocket Limits are along with the Covered Charges [[and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply].

[1.] [**Family Out-of-Pocket Limit:** [The total dollar amount of Covered Charges that must be paid by You and Your Covered Dependents before We will consider the Out-of-Pocket Limit for all Covered Persons under the same Family Plan to be satisfied.]

[2.] [**Individual Out-of-Pocket Limit:** The dollar amount of Covered Charges that must be paid by each Covered Person before the Out-of-Pocket Limit is satisfied for that Covered Person.]

[3.] [**Network**] [**Participating**] **Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from providers in the [Health Care Provider Network] [Participating Provider Network] that must be paid by each Covered Person before the [Network] [Participating] Provider Out-of-Pocket Limit is satisfied for that Covered Person.]

[4.] [[**Non-Network**] [**Non-Participating**] **Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from [Non-Network] [Non-Participating] Providers that must be paid by each Covered Person before the [Non-Network] [Non-Participating] Provider Out-of-Pocket Limit is satisfied for that Covered Person.]]

DEF: 415.001.GE

[**Outpatient**
Treatment, services or supplies received at a licensed medical facility, Health Care Practitioner's office or dispensary on other than an Inpatient basis for a stay of less than 24 hours.]
DEF: 420.001.GE

[**Outpatient Calendar Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for Outpatient treatment, services or

supplies. When the Outpatient Calendar Year Maximum Benefit has been received, no other benefits are payable for Outpatient treatment, services or supplies that the Covered Person receives for the remainder of that Calendar Year.]
DEF: 425.001.GE

[**Participating Provider**
Any Health Care Practitioner, facility or supplier, identified for this plan by [Us or] the Network Manager, as participating.]
DEF: 435.001.GE

[**Participating Provider Network**
The group of Participating Providers within the Health Care Provider Network, identified for this plan by [Us or] the Network Manager, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. This list is subject to change at any time without notice.]
DEF: 440.001.GE

[**Per Cause Limit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person for each Sickness or Injury and for any complications related to that Sickness or Injury. When the Per Cause Limit has been paid, no other benefits are payable under this plan for that particular Sickness or Injury and for any complications related to that Sickness or Injury for the Covered Person [over the lifetime of that Covered Person] [for the [time period] [Plan Year] [Calendar Year] [Benefit Period] shown in the Benefit Summary].]
DEF: 445.001.GE

[**Period of Confinement**
The initial and subsequent Inpatient stays resulting from the same or a related Sickness or Injury and/or any complications unless the current Inpatient stay begins more than [30 days] after the date of discharge from the most recent Inpatient stay.]
DEF: 450.001.GE

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

1. Is designed for and able to withstand repeated use; and

2. Is primarily and customarily provided to serve a medical purpose; and

3. Is not intended for use by successive patients.]

DEF: 455.001.GE

[**Physical Medicine**
Treatment of physical conditions relating to bone, muscle or neuromuscular pathology. This treatment focuses on restoring function using mechanical or other physical methods.]
DEF: 460.001.GE

[**Physical Therapy**
The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and alleviating pain.]
DEF: 465.001.GE

[**Plan Year**
The period beginning on the month and day of the Effective Date in any year and ending on the same month and day as the Effective Date in the following year.]
DEF: 475.001.GE

[**Plan Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person in any one Plan Year while this coverage is in force.]
DEF: 480.001.GE

[**Policy**
The group master contract issued by Us to the Policyholder providing benefits for Covered Persons.]
DEF: 485.001.GE

[**Policyholder**
The [person,] [organization] [or] [entity] to [which] [whom] the Policy is issued as shown in the Benefit Summary.]
DEF: 490.001.GE

[**Policy Owner**
The parent or legal guardian who signs the enrollment form for coverage under this plan when only minor children are Covered Persons.]
DEF: 495.001.GE

[**Pre-Existing Condition**
A Sickness or an Injury and related complications[, not fully disclosed on the [enrollment form]]:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] during the [24-month] period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or

2. That produced signs or symptoms during the [24-month] period immediately prior to the Covered Person's Effective Date.

   The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

   a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
   b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

   [A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.]]

DEF: 500.002.001.GE

[**Prescription Drug**
Any medication that:

[1.] [Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States][; and]

[2.] [Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws][; and]

[3.] [Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or "Rx Only" on the manufacturer's label, or similar wording as designated by the FDA].]

DEF: 505.001.GE

Prosthetic Device

An external device that is; 1) Intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and 2) Custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient. Prosthetic device does not include an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

DEF: 510.001.AR

[**Rehabilitation Services**

Specialized treatment for a Sickness or an Injury which meets all of the following requirements:

1. Is a program of services provided by one or more members of a multi-disciplinary team.

2. Is designed to improve the patient's function and independence.

3. Is under the direction of a qualified Health Care Practitioner.

4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.

5. May be provided in either an Inpatient or Outpatient setting.]

DEF: 515.001.GE

[[**Select**] **Participating Provider**

Any Health Care Practitioner, facility or supplier as identified for this plan by [Us or] the Network Manager who has agreed to accept a Contracted Rate as payment for specific treatment, services or supplies through Our [Select] Participating Provider Network.]

DEF: 520.001.GE

[[**Select**] **Participating Provider Network**

The group of [Select] Participating Providers, within the Health Care Provider Network as identified for this plan by [Us or] the Network Manager, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. The list is subject to change at any time without notice.]

DEF: 525.001.GE

[**Service Area**

The geographic area, as defined by Us, served by [Participating Providers,] [and] [or] [[Select] Participating Providers,] [and] [or] [Specialty Care Providers] [and] [or] [Designated Specialty Providers]. Contact [the Network Manager] [or] [Us] to determine the precise geographic area serviced by [Participating Providers,] [and] [or] [[Select] Participating Providers,] [and] [or] [Specialty Care Providers] [and] [or] [Designated Specialty Providers]. The Service Area is subject to change at any time without notice.]
DEF: 530.001.GE

[**Sickness**
A disease or illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.]
DEF: 535.001.GE

[**Single Plan**
A plan of insurance covering only the Certificate Holder.]
DEF: 540.003.GE

[**Special Exception Rider**
A form that is included with this plan which identifies a body part, system, disease, Sickness, Injury or other condition for a Covered Person in which all charges related to that body part, system, disease, Sickness, Injury or other condition are excluded from coverage [for a specified period of time as shown in the Special Exception Rider].]
DEF: 555.001.GE

[**Specialty Care Provider**
A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties [or who is designated by the Network Manager as a Specialty Care Provider]. [A Specialty Care Provider cannot be a Primary Care Provider.]
DEF: 560.001.GE

[**Speech Therapy**
The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.]
DEF: 565.001.GE

[**Subacute Medical Care**
A short-term comprehensive Inpatient program of care for a Covered Person who has a Sickness or an Injury that:

1. Does not require the Covered Person to have a prior admission as an Inpatient in a licensed medical facility; and

2. Does not require intensive diagnostic and/or invasive procedures; and

3. Requires Health Care Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.]

DEF: 570.001.GE

[**Substance Abuse**

Abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. [For the purpose of this plan, Substance Abuse does not include Behavioral Health.]]
DEF: 570.002.GE

[**Surgical Assistant**
A Health Care Practitioner who is licensed to assist at surgery in the state and credentialed at the facility where the procedure is performed but who is not qualified by licensure, training and credentialing to perform the procedure as a primary surgeon at that facility.]
DEF: 575.001.GE

[**Telehealth Services**
The use of modern telecommunication and information technologies by a Health Care Practitioner in the treatment of his or her established patient.]
DEF: 580.001.GE

[**Telemedicine Services**
A medical inquiry initiated by a Health Care Practitioner for the purpose of assistance with a patient's assessment, diagnosis, consultation, treatment or the transfer of medical data that requires the use of modern telecommunications technology.]
DEF: 585.001.GE

[**Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction**
TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing:

1. Clicking and/or difficulties in opening and closing the mouth.

2. Pain or swelling.

3. Complications including arthritis, dislocation and bite problems of the jaw.]

DEF: 590.001.GE

[**Total Disability/Totally Disabled**
You or Your spouse [or Domestic Partner] are unable to perform the essential duties of any occupation for which reasonably fitted by education, training or experience, whether performed for financial gain or not. Retired individuals and homemakers shall not be considered unable to perform an occupation solely because they are unemployed. [A Covered Dependent child is Totally Disabled only if confined as a patient in an Acute Medical Facility [or Behavioral Health Facility].]]
DEF: 595.001.GE

[**Urgent Care**
Treatment or services provided for a Sickness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and

2. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.]

DEF: 600.001.GE

[**We, Us, Our, Our Company**
Time Insurance Company [or its Administrator].]
DEF: 605.002.GE

[**You, Your, Yours**
The person listed on the Benefit Summary as the Certificate Holder.]
DEF: 610.002.GE

[**In addition to the definitions listed above, the following definitions apply to the Outpatient Prescription Drug Benefits section**:]
DEF: 615.001.GE

[**Allowance**
The initial amount to be paid by Us toward the cost of a covered Prescription Drug, dispensed by a [Participating Pharmacy,] [Specialty Pharmacy Provider] [or a] [Non-Participating Pharmacy]. [The Allowance is shown on [a Drug List] [the Benefit Summary].] [The difference in cost between the Allowance and the actual charge for the Prescription Drug must be paid by the Covered Person.]

[The Allowance does not count toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or any other section in this plan].]]
DEF: 620.001.GE

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

[The Ancillary Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or any other section in this plan].]]
DEF: 625.001.GE

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

The Ancillary Pharmacy Network Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]
DEF: 630.001.GE

[**Average Sales Price**

A published cost of a Prescription Drug as listed by Our national drug data bank or by a federal or other national source on the date the Prescription Drug is purchased.]
DEF: 635.001.GE

[**Average Wholesale Price**
A published cost of a Prescription Drug that is paid by a Pharmacy to a wholesaler as listed by Our national drug data bank on the date the Prescription Drug is purchased.]
DEF: 640.001.GE

[**Brand Name Drug**
A Prescription Drug for which a pharmaceutical company has received a patent or trade name.]
DEF: 645.001.GE

[**Compounded Medication**
A drug product made up of two or more active parts or ingredients which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered to be Non-Preferred Brand Name Drugs.]
DEF: 650.001.GE

[**Drug List**
A list of Prescription Drugs that We designate as eligible [for reimbursement]. A Drug List is subject to change at any time without notice.]
DEF: 655.001.GE

[**Generic Drug**
A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug [within the same or a similar Therapeutic Class]; and

2. Does not carry any drug manufacturer's brand name on the label; and

3. Is not protected by a patent.

It must be listed as a Generic Drug by Our national drug data bank on the date it is purchased [and it must be approved by Us]. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by Our national drug data bank on the date it is purchased [and it must be approved by Us].]
DEF: 660.001.GE

[**Mail Service Prescription Drug Vendor**
A Participating Pharmacy that is under contract with Us or Our Network Manager through Our Participating Pharmacy Network. The Mail Service Prescription Drug Vendor dispenses selected Prescription Maintenance Drugs to Covered Persons through the mail.]
DEF: 665.001.GE

[**Maximum Allowable Cost (MAC) List**
A list of Prescription Drugs that are considered for reimbursement at a Generic Drug product level [or a Prescription Drug Class level] [based on the Prescription Drug Class Reference Price] that is established by Us. This list is subject to change at any time without notice.]

DEF: 670.001.GE

[**New-to-Market Prescription Drugs:** Prescription Drugs fully approved by the United States Food and Drug Administration (FDA) [as new drugs] [or] [as drugs used to treat a different indication than that for which they were originally approved] [within the past [12 months]], which will be subject to an evaluation process [not to exceed [12 months]]. The evaluation process will review additional information on the safety, cost-effectiveness and efficacy of those drug products. This evaluation process will take place to determine appropriate clinical standards of practice.]
DEF: 675.001.GE

[**Non-Participating Pharmacy**
A Pharmacy that is not under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network [or Specialty Pharmacy Network].]
DEF: 680.001.GE

[**Non-Preferred Brand Name Drug**
A Brand Name Drug that is not listed as preferred in a Drug List.]
DEF: 685.001.GE

[**Non-Preferred Generic Drug**
A Generic Drug that is not listed as preferred in a Drug List.]
DEF: 690.001.GE

[**Participating Pharmacy**
A Pharmacy that is under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network [or Specialty Pharmacy Network].]
DEF: 695.001.GE

[**Participating Pharmacy Network**
A Prescription Drug delivery system established by Us or the Network Manager in which Participating Pharmacies are under contract with Us or Our Network Manager. The list of Participating Pharmacies is subject to change at any time without notice.]
DEF: 700.001.GE

[**Pharmacy**
A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.]
DEF: 705.001.GE

[**Preferred Brand Name Drug**
A Brand Name Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.]
DEF: 710.001.GE

[**Preferred Generic Drug**
A Generic Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.]
DEF: 715.001.GE

[**Prescription Card Service Administrator (PCSA)**

An organization or entity that administers the processing of claims under the Outpatient Prescription Drug Benefits section. This organization or entity may be changed at any time without notice.]
DEF: 720.001.GE

[**Prescription Drug Calendar Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for Prescription Drugs. When the Prescription Drug Calendar Year Maximum Benefit has been received, no other benefits are payable for Prescription Drugs that the Covered Person receives for the remainder of that Calendar Year.]
DEF: 725.001.GE

[**Prescription Drug Class**
Prescription Drugs that are grouped by Us according to a specific category, such as [Therapeutic Class,] Brand Name Drug or Generic Drug designation, diagnosis or cost effectiveness. The actual Prescription Drugs that are included in each category are shown on a Drug List that is broken down by tiers or levels based on the way Covered Charges for the drugs are reimbursed by Us. We may periodically change the placement of a Prescription Drug from one tier or level to another at any time without notice. As a result of these changes, a Covered Person may be required to pay more or less for a Prescription Drug.

The Benefit Summary will identify what any applicable Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible and other Prescription Drug Out-of-Pocket Limits and any maximum limits are for each tier or level of coverage in each category [along with the [time period] [Plan Year] [Calendar Year] [Benefit Period] that applies to each coverage tier or level].]
DEF: 730.001.GE

[**Prescription Drug Coinsurance**
The Prescription Drug Coinsurance is the [dollar amount or] percentage of Covered Charges for Prescription Drugs that must be paid by a Covered Person after any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug Copayment] [and] [or] [Prescription Drug Deductible] are satisfied. The Covered Person must pay any applicable Prescription Drug Coinsurance directly to the Participating Pharmacy [or Specialty Pharmacy Provider].

The Prescription Drug Coinsurance only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Prescription Drug Coinsurance percentage [or amount] is [along with the [Prescription Drug Class] [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which it applies]. [The Prescription Drug Coinsurance does not count toward satisfying any Out-of-Pocket Limit under the Medical Benefits section.]]
DEF: 735.001.GE

[**Prescription Drug Condition Specific Deductible**
The dollar amount of Covered Charges for Prescription Drugs that must be satisfied by a Covered Person because of a named condition, shown in [the Benefit Summary] [a Condition Specific Deductible endorsement that is included with this plan], and for any complications related to that named condition. When Covered Charges for Prescription Drugs equal to the Prescription Drug Condition Specific Deductible for the named condition have been Incurred and processed by Us, the Prescription Drug Condition Specific Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary] [shown in the Condition Specific Deductible endorsement]. [After the Prescription Drug Condition Specific Deductible is satisfied, additional Covered Charges for

Prescription Drugs for the named condition will be paid subject to all the terms, limits and conditions in this plan[, including satisfaction of any other applicable [Prescription Drug Coinsurance,] [Prescription Drug Deductible,] [Deductible under any other section of this plan,] [or] [other fees].]]
DEF: 740.001.GE

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

A Prescription Drug Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Copayments are [along with the Prescription Drug Class to which they apply]. [A Prescription Drug Copayment does not count toward satisfying any Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]]
DEF: 745.001.GE

[**Prescription Drug Deductible**
A Prescription Drug Deductible is the dollar amount of Covered Charges for Prescription Drugs that each Covered Person pays [during a Benefit Period] before benefits are paid by Us. The Covered Person must pay any applicable Prescription Drug Deductible directly to the Participating Pharmacy [or Specialty Pharmacy Provider]. When Covered Charges equal to the Prescription Drug Deductible have been Incurred and processed by Us, the Prescription Drug Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary]. [Charges applied to the Prescription Drug Deductible do not count toward satisfying any Prescription Drug Condition Specific Deductible that would apply.]

A Prescription Drug Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Prescription Drug Deductibles are [along with the [Prescription Drug Class] [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply]. [Charges applied to the Prescription Drug Deductible do not count toward satisfying any Out-of-Pocket Limit under the Medical Benefits section.]]
DEF: 750.001.GE

[**Prescription Drug Family Deductible**
[The dollar amount that must be satisfied by all Covered Persons before benefits are payable by Us.] [The Prescription Drug Deductibles that all Covered Persons may have to pay are limited to the Prescription Drug Family Deductible amount.] When the Prescription Drug Family Deductible amount is reached, We will consider the Prescription Drug Deductible requirements for all Covered Persons in the family to be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary][, except for any Prescription Drug Condition Specific Deductible that a Covered Person may have].

The Prescription Drug Family Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Family Deductible amount is [and the [time period] [Plan Year] [Calendar Year] [Benefit Period] to which it applies]. [Charges applied to the Prescription Drug Family Deductible do not count toward satisfying any Out-of-Pocket Limit under the Medical Benefits section.]]
DEF: 755.001.GE

[**Prescription Drug Family Out-of-Pocket Limit**
[We will consider the Prescription Drug Out-of-Pocket Limit for all Covered Persons to be satisfied, for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary], when the total amount of Covered Charges applied to the Prescription Drug Out-of-Pocket Limit under the same Family Plan equals the Prescription Drug Family Out-of-Pocket Limit.]

A Prescription Drug Family Out-of-Pocket Limit only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Family Out-of-Pocket Limit is along with the Covered Charges [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which it applies.]
DEF: 760.001.GE

[**Prescription Drug Out-of Pocket Limit**
The Prescription Drug Out-of-Pocket Limit is the sum of Covered Charges for Prescription Drugs for which We do not pay benefits [during a Benefit Period] [because of the [Prescription Drug Deductible] [and] [Prescription Drug Coinsurance]]. When Covered Charges equal to the Prescription Drug Out-of-Pocket Limit have been Incurred and processed by Us, the Prescription Drug Out-of-Pocket Limit for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary]. The Prescription Drug Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this plan.]

[The following do not count toward satisfying any Prescription Drug Out-of-Pocket Limit:

[1.] [All [Ancillary Charges,] [Ancillary Pharmacy Network Charges,] [or] [Prescription Drug Copayments].]

[2.] [Amounts in excess of the Allowance.]

[3.] [All penalties applied under the Utilization Review Provisions section.]

[4.] [Amounts in excess of the Maximum Allowable Amount.]

[5.] [Charges Incurred after the maximum amount has been paid for a benefit under this plan.]

[6.] [All [Access Fees,] [Coinsurance,] [Copayments,] [Deductibles] [or] any other fees that apply under the Medical Benefits section.]

[A Prescription Drug Out-of-Pocket Limit only applies if it is shown in the Benefit Summary.] The Benefit Summary will identify what the applicable Prescription Drug Out-of-Pocket Limits are [along with the Covered Charges [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply].]
DEF: 765.001.GE

[**Prescription Maintenance Drugs**
Prescription Drugs that are:

1. [Oral contraceptives or] [D][d]rugs that are taken regularly to treat a chronic health condition; and

2. Covered under this Outpatient Prescription Drug Benefits section; and

3. Approved by Us for coverage under the Mail Service Prescription Drug Vendor provision in this section.

[Prescription Maintenance Drugs must be dispensed through a Mail Service Prescription Drug Vendor for benefits to be considered under this plan.]]
DEF: 770.001.GE

[**Prescription Order**
The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill; or

2. Insulin [or insulin derivatives] only by prescription; or

3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:

   a. Disposable insulin syringes and needles; or
   b. Disposable blood/urine/glucose/acetone testing agents or lancets.]

DEF: 775.001.GE

[**Reference Price**
The maximum amount that We will pay for covered Prescription Drugs within a Prescription Drug Class or within similar Prescription Drug Classes as established by Us.]
DEF: 780.001.GE

[**Specialty Pharmaceuticals**
These types of Prescription Drugs include:

[1.] [Drugs used to treat rare or certain chronic diseases.]

[2.] [Drugs that have a highly targeted, cellular mechanism of action.]

[3.] [Drugs that may require [self-]injection or other parenteral or unique method of administration.]

[4.] [Drugs that may require special administration and monitoring.]

[5.] [Drugs that are regularly supplied by Specialty Pharmacy Providers.]

[6.] [Drugs that are otherwise defined by Us in the Benefit Summary or in a Drug List.]

[If a Specialty Pharmaceutical Prescription Drug is covered under this Outpatient Prescription Drug Benefits section, is dispensed or administered at a Health Care Practitioner's office setting, and is not obtained through a Specialty Pharmacy Provider, the Covered Person may be billed for any applicable Ancillary Charge, Prescription Drug Coinsurance, Prescription Drug Copayment and Prescription Drug Deductible in addition to a Copayment under the Medical Benefits section for an Office Visit.]]
DEF: 785.001.GE

[**Specialty Pharmacy Provider**
A Pharmacy that may be under contract with Us or Our Network Manager to distribute Specialty Pharmaceuticals to the Covered Person through Our Specialty Pharmacy Network. [A Specialty Pharmacy Provider may also act as Our preferred distributor of Specialty Pharmaceuticals even though they are not part of Our Specialty Pharmacy Network.]
DEF: 790.001.GE

[**Specialty Pharmacy Network**
A Prescription Drug delivery system for Specialty Pharmaceuticals that is established by Us or the Network Manager in which Specialty Pharmacy Providers are under contract with Us or Our Network Manager. The list of Specialty Pharmacy Providers is subject to change at any time without notice.]
DEF: 795.001.GE

[**Therapeutic Class**
A classification into which Prescription Drugs are grouped based on the drugs' mechanisms of action and/or the symptoms or diseases they are used to treat. [The actual Prescription Drugs that are included in a Therapeutic Class are shown on a Drug List.]]
DEF: 800.001.GE

[[IV.] [EFFECTIVE DATE AND TERMINATION DATE]
EFF: 005.002.GE

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

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

The rates may change if the Certificate Holder moves to another zip code, there is a change in benefits [or Dependents are added or deleted].]
EFF: 010.005.GE

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

[1.] [**Adding a Newborn Child:** [A newborn child can be added on the date the child was born.] You must [call Our office or] send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date the child is born. If this is a Single Plan and these requirements are not met, the child will not be covered from birth. However, if this is a Family Plan and if these requirements are not met, Your newborn child will be covered [for Sickness or Injury] only for the first 90 days from birth.]

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

[3.] [**Adding Any Other Dependent:** [To add any other Dependent, an enrollment form must be completed and sent to Us along with any required premium.] [Evidence of insurability must also be provided.] [The Effective Date of coverage will be 12:01 a.m. local time at the

Certificate Holder's state of residence on the date We approve coverage under Our coverage criteria.] [Coverage will take effect at 12:01 a.m. local time at the Certificate Holder's state of residence in accordance with the definition of Effective Date in this plan.]
EFF: 015.001.AR

[**Termination Date of Coverage**
The Certificate Holder may cancel this coverage at any time by sending Us written notice or calling Our office. [Upon cancellation, [We will return the unearned portion of any premium paid] [any premium paid for a time not covered will be returned [on a [short rate] [pro-rata] basis] [in accordance with the laws in the Certificate Holder's state of residence] [minus any claims that were Incurred after the termination date and paid by Us].]]

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

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

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

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

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

[5.] [The date all certificates with the same form number are non-renewed in the state in which this certificate was issued or the state in which the Certificate Holder presently resides.]

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

[7.] [The date the Certificate Holder moves to a state where We do not provide individual medical insurance coverage.]

[8.] [The date a Covered Person moves outside of the Service Area if he or she has a PPO plan.]

[9.] [The date a Covered Person becomes eligible for Medicare, if allowed by federal law.]

[10.] [The date a Covered Dependent no longer meets the Dependent definition in this plan.]

[We will pay benefits to the end of the time for which We have accepted premiums.]]]
EFF: 020.004.GE

[[V.] [UTILIZATION REVIEW PROVISIONS]

[Utilization Review Process
THE COVERED PERSON MUST CALL THE TOLL FREE NUMBER GIVEN ON THE IDENTIFICATION (ID) CARD TO OBTAIN OUR AUTHORIZATION FOR THE SERVICES LISTED UNDER THE WHEN TO CALL PROVISION IN THIS SECTION. [BENEFITS WILL BE REDUCED AS DESCRIBED IN THE REDUCTION OF PAYMENT PROVISION IN THIS SECTION, IF A COVERED PERSON DOES NOT COMPLY WITH THIS UTILIZATION REVIEW PROCESS AND DOES NOT OBTAIN AUTHORIZATION.]

A REVIEW BY THE MEDICAL REVIEW MANAGER DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. PAYMENT OF BENEFITS WILL BE SUBJECT TO ALL THE TERMS, LIMITS AND CONDITIONS IN THIS CERTIFICATE.

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

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

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

1. The certificate number for this plan.

2. The Health Care Practitioner's name and telephone number.

3. The service, procedure and diagnosis.

4. The proposed date of admission or date the service or procedure will be performed.

5. The facility's name and phone number.

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

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

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

[a.] [Non-Emergency Confinements: Call at least [7 business days] prior to an Inpatient admission for a non-emergency confinement that will exceed 24 hours in length.]
[b.] [Emergency Confinements: Call within [24 hours], or as soon as reasonably possible, after admission for an Emergency Confinement that will exceed 24 hours in length. The

Covered Person must provide or make available to the Medical Review Manager the full details of the Emergency Confinement.]

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

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

[a.] [Any surgical procedures.]

[b.] [Invasive cardiology services for diagnostic or therapeutic cardiac procedures, except cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).]

[c.] [Invasive radiology services for diagnostic or interventional purposes.]

[d.] [Dialysis.]

[e.] [Radiation therapy.]

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

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

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

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

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

[6.] [**Physical Medicine:** Call at least [7 business days] prior to beginning a course of treatment if the anticipated course of treatment will exceed [12 visits] or will last longer than [30 days].]

[7.] [**Infertility:** Call at least [7 business days] prior to beginning treatment.]

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

[9.] [**Home Health Care:** Call at least [7 business days] prior to beginning Home Health Care.]

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

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

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

[1.] No benefits will be paid under this plan for any transplant services that are not authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment or donor search [when services are provided by a [non-Designated Transplant Provider] [Non-Network][Non-Participating] Provider]]..

[2.] [If authorization is not obtained for the Covered Person's course of treatment for the other services listed in the When to Call provision above, benefits will be reduced for otherwise Covered Charges by [XX%] but by no more than [$XXXXX] per course of treatment [when services are provided by a [[Network][Participating provider] [or] [[Non-Network][Non-Participating] Provider]], if any of the following occur:

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

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Access Fee, Coinsurance, Copayment, Deductible or Out-of-Pocket Limit.]]
URP: 005.002.001.GE

[[VI.] [[PROVIDER CHARGES] [AND] [MAXIMUM ALLOWABLE AMOUNT] PROVISIONS]

[YOU [AND YOUR COVERED DEPENDENTS] ARE FREE TO USE ANY PROVIDER YOU [AND YOUR COVERED DEPENDENTS] CHOOSE. IT IS THE COVERED PERSON'S RESPONSIBILITY TO DETERMINE IF A PROVIDER IS A [NETWORK PROVIDER,] [PARTICIPATING PROVIDER,] [[SELECT] PARTICIPATING PROVIDER,] [OR] [DESIGNATED SPECIALTY PROVIDER] OR A [NON-NETWORK] [NON-PARTICIPATING] PROVIDER BEFORE ANY SERVICES ARE RENDERED. PLEASE SEE THE BENEFIT SUMMARY FOR SPECIFIC BENEFIT LEVELS [THAT APPLY TO EACH TYPE OF PROVIDER].]

[[NON-NETWORK] [NON-PARTICIPATING] PROVIDERS MAY BILL MORE THAN WE DETERMINE TO BE A MAXIMUM ALLOWABLE AMOUNT AND THE COVERED PERSON IS RESPONSIBLE FOR PAYMENT OF ANY AMOUNT BILLED ABOVE THE MAXIMUM ALLOWABLE AMOUNT. [THE COVERED PERSON IS NOT RESPONSIBLE FOR PAYMENT OF AMOUNTS BILLED BY A [NETWORK PROVIDER] [PARTICIPATING PROVIDER] [PROVIDER] IN EXCESS OF THE MAXIMUM ALLOWABLE AMOUNT FOR COVERED CHARGES RECEIVED WITHIN THE COVERED PERSON'S NETWORK.]]

[Payment of [Network] [Participating] Provider Benefits
[A Covered Person may receive a higher benefit level for Covered Charges received from a Participating Provider. The [Network] [Participating] Provider benefit levels are shown in the Benefit Summary.] [A higher benefit level may also be obtained by using a [[Select] Participating Provider] [or Designated Specialty Provider]. [Network services and supplies for which We have a Contracted Rate are not subject to Maximum Allowable Amount reductions.]

Using a [Network] [Participating] Provider is not a guarantee of coverage. All other requirements of this plan must be met for Covered Charges to be considered for payment. [Deductibles may vary based on whether the provider is a [Participating Provider,] [[Select] Participating Provider,] [or] [Designated Specialty Provider].] [Covered Charges can accrue only to one Deductible at a time, based on the provider's benefit level.]

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

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

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

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

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

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

[**Maximum Allowable Amounts for** [**Network**] [**Participating**] **Providers**
For goods and services provided by a [Network] [Participating] Provider, facility or supplier, the Maximum Allowable Amount is the lesser of billed charges or the Contracted Rate. A Covered Person is not responsible for payment of amounts billed by a [Network] [Participating] Provider in excess of the Maximum Allowable Amount for Covered Charges received within the Covered Person's network.]

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

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

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

[1.] Billed charges; or

[2.] The Negotiated Rate; or

[3.] If a Negotiated Rate is not available, in accordance with [the] [lesser of] [greater of] [average of] [weighted average of] [median of] [one or more of] the following methodologies:

[a.] [The amount a Health Care Practitioner, facility or supplier of a similar type [and] [or] [and/or] in the same geographic area bills for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted charge data and relative values.]

PAR: 005.014.GE

[b.] [The amount derived by applying comparable markups from facilities of a similar type [and] [or] [and/or] in the same geographic area, to the estimated costs of the facility providing the goods and services reported on the claim, established utilizing the facility's most recently available cost reports submitted to The Centers for Medicare and Medicaid Services (CMS).]

PAR: 005.015.GE

[c.] [The expected or estimated charges of facilities of a similar type [and] [or] [and/or] in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through CPT or HCPCS codes, or grouping of services as determined through standard DRG, refined DRG, APC or other standard industry methodologies, depending upon the services and setting reported on the claim.]

PAR: 005.016.GE

[d.] [The [lowest] [average] [mode] [median] Contracted Rate [and] [or] [and/or] [non-Medicare or non-Medicaid] Negotiated Rate amount a Health Care Practitioner, facility or supplier of a similar type [and] [or] in the same geographic area has accepted for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted claims data.]

PAR: 005.017.GE

[e.] [[XX] times the amount, as would be allowed to the facility by Medicare, for the goods and services reported on the claim, established utilizing the most currently available Medicare, facility-specific, reimbursement schedules [and methodologies].]

PAR: 005.018.GE

[f.] [[XX] times the amount, as would be allowed to the provider of a similar type [and] [or] [and/or] in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes by Medicare.]

PAR: 005.019.GE

[g.] [The amount as defined in another schedule or method of deriving Maximum Allowable Amounts, as identified [and] [or] [and/or] shown in the Benefit Summary, for the goods and services reported on the claim.]

PAR: 005.020.GE

[h.] [The [lowest] [average] [mode] [median] amount a Health Care Practitioner, facility or supplier of a similar type [and] [or] [and/or] in the same geographic area, for the goods

and services reported on the claim, has accepted for the same or similar goods and services, derived from Our or another payers' Maximum Allowable Fees or actual amounts paid.]

PAR: 005.021.GE

[i.] [The expected or estimated charges of facilities of a similar type [and] [or] [and/or] in the same geographic area, for the goods and services reported on the claim, using the facility's overall charge structures as a benchmark, determined by utilizing overall charges per discharge or encounter, adjusted by a valid, facility-specific, case or service mix index available.]

PAR: 005.022.GE

[j.] [The amount as defined in a fee schedule that We develop, for the goods and services reported on the claim.]

PAR: 005.023.GE

[k.] [For [infusion] [injectable] therapy and services [not processed through the pharmacy benefit manager] [not filled by prescription through a Participating Pharmacy] [submitted on a standard medical claim form], the amount most commonly paid [by Us or another payer] [to a nationally contracted Specialty Pharmacy Provider] [to a contracted provider], not to exceed the [Contracted Rate discounts off of Average Wholesale Price (AWP),] [or] [Maximum Allowable Cost (MAC),] [or] [Average Sales Price (ASP),] other nationally recognized drug cost basis used by nationally contracted vendors, or any other methodology described under this plan.]]

PAR: 005.024.GE

[**Methodology Is Subject to Change**

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

[**Using the** [**Health Care Provider Network**] [**Participating Provider Network**]

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

[**Using Designated Specialty Providers**

If the Covered Person elects to receive designated covered specialty services from a Designated Specialty Provider, benefits may be paid at a higher benefit level than when a [Participating Provider] [or] [[Select] Participating Provider] is used. The benefit level payable when designated specialty treatment, services or supplies are received from a Designated Specialty Provider is shown in the Benefit Summary. For the Designated Specialty Provider benefit level to be payable, both the service and the provider must be designated by Us at the specialty services benefit level. IT IS YOUR RESPONSIBILITY to verify that a provider is a Designated Specialty Provider at the

time of service and that the services to be received are designated as specialty services from that provider.]

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

[**Receiving Care for Emergency Conditions**
Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement will be paid at the Participating Provider benefit level until the Covered Person's condition has stabilized. After the condition has stabilized, benefits will be paid at the [Non-Network] [Non-Participating] Provider benefit level. We will, if possible, assist in the Covered Person's transfer to a [Network] [Participating] Provider if requested by the Covered Person. [Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement may be subject to Maximum Allowable Amount reductions.]]

[**Receiving Ancillary Services**
Please note that certain ancillary services, such as lab tests or services performed by anesthesiologists, radiologists, pathologists or Emergency Room physicians, that are ordered by a [Network] [Participating] Provider are sometimes out-sourced to a [Non-Network] [Non-Participating] Provider. [Covered Charges for such services will be processed as [Non-Network] [Non-Participating] Provider benefits.] [To obtain [Network] [Participating] Provider benefits, it is important that such services be referred to another [Network] [Participating] Provider when possible.] [[Covered Charges for such services rendered in association with direct treatment from a [Network] [Participating] Provider will be paid at the corresponding benefit level].] [and may be subject to the Maximum Allowable Amounts for [Network] [Participating] Providers and Maximum Allowable Amounts for [[Non-Network] [Non-Participating]] Providers provisions.]] [A higher benefit level may be available if the Covered Person uses a Designated Specialty Provider for ancillary services that are designated by Us to be specialty services from that provider.]]]
PAR: 010.001.001.GE

[[VII.] [MEDICAL BENEFITS]

[WE WILL PAY COVERED CHARGES ONLY FOR THE SERVICES AND SUPPLIES LISTED AS MEDICAL BENEFITS IN THIS SECTION OF THE PLAN. HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED SERVICES AND SUPPLIES LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY.

REFER TO THE EXCLUSIONS SECTION OF THE PLAN FOR SERVICES AND SUPPLIES THAT ARE NOT COVERED UNDER THIS CERTIFICATE.

THE COVERED PERSON MUST FOLLOW THE UTILIZATION REVIEW PROVISIONS SECTION [AND THE PROVIDER CHARGES] [AND] [MAXIMUM ALLOWABLE AMOUNT] PROVISIONS SECTION] TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER THIS CERTIFICATE.]

[After the Covered Person has paid any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for medical benefits listed in this section of the certificate for each Covered Person [during a Benefit Period]. Any applicable [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] or other fees and the Covered Charges [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply are shown in the Benefit Summary. Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[We will not pay benefits for charges that are Incurred for [a Sickness,] [specific benefits as shown in the Benefit Summary] [and] [or] [preventive medicine services] during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Benefit Summary. Benefits are available from the first day Covered Charges are Incurred for an Injury that is sustained on or after the Covered Person's Effective Date.]

[Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section unless they are specifically listed as Covered Charges in the Medical Benefits section.] [Expenses Incurred under this section do not apply toward any Out-of-Pocket Limits under any other section of this plan.]]

We pay only for the following Covered Charges:
MED: 005.002.GE

[**Inpatient Medical Facility Services**
Services that are provided in an Acute Medical Facility:

[1.] [Daily room and board [in the most appropriate setting in the Acute Medical Facility].]

[2.] [Daily room and board in an intensive care setting, such as an intensive care unit (ICU), a neonatal intensive care unit (NCU), a coronary intensive care unit (CCU) and a step-down unit.]

[3.] [Routine nursing services and pediatric charges, including charges for testing for hypothyroidism, phenylketonuria, galactosemia and sickle-cell anemia, or a well newborn child for up to [5] full days in an Acute Medical Facility nursery or until the mother is discharged from the Acute Medical Facility following the birth of the child, whichever is later.]

[4.] [Other Medically Necessary services.]

[For Rehabilitation Services benefits, see the Inpatient Rehabilitation Services provision even when these services are received in an Acute Medical Facility. For interpretation of Diagnostic Imaging

and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section. For benefits for all other professional services, see the Health Care Practitioner Services provision in this section.]]
MED: 010.001.AR

[**Outpatient Medical Facility Services**
Services performed in an Acute Medical Facility's Outpatient department, a Free-Standing Facility or an Urgent Care Facility. [However, Physical Medicine is covered under the Outpatient Physical Medicine Services provision in this section.]

[We will pay benefits for Covered Charges Incurred for Emergency Treatment at a [Non-Network] [Non-Participating] Provider at the benefit level of a [Network] [Participating] Provider. [However, services received by a [Non-Network] [Non-Participating] Provider may be subject to Maximum Allowable Amount reductions.] Follow-up visits after the initial Emergency Treatment will be subject to all the terms, limits and conditions in this plan [including, but not limited to, the [Non-Network] [Non-Participating] Provider Deductible, Coinsurance and other [Non-Network] [Non-Participating] Provider Out-of-Pocket Limits and may be subject to Maximum Allowable Amount reductions when services are received from a [Non-Network] [Non-Participating] Provider].]

[Covered Charges for services received in an Emergency Room that are not for Emergency Treatment will be paid subject to all the terms, limits and conditions in this plan as if the same services had been received in the least intensive setting.]
MED: 015.001.GE

[**Doctor**] [**Physician**] **Office Visit**
Office Visit charges Incurred during an Office Visit for a [Covered Person] [Covered Dependent child] are payable as shown in the Benefit Summary. [For the purpose of this provision, Office Visits include evaluation and management services as defined in the most recent edition of Current Procedural Terminology [and preventive medicine services].] [An Office Visit will also include [allergy testing,] [allergy shots,] [immunotherapy injections of inhaled allergens,] [and] [laboratory and radiology services [which are covered preventive medicine services]].

[Covered Charges will not include [laboratory and radiology services [which are not a covered preventive medicine service,]] [magnetic resonance imaging (MRI),] [computerized axial tomography (CAT scan),] [preventive medicine services,] [surgical procedures,] [chemotherapy,] [allergy testing,] [diagnosis or treatment of [Behavioral Health] [and] [Substance Abuse]] [or] [any other service not specifically listed as a Covered Charge in the Benefit Summary for this [Doctor] [Physician] Office Visit provision].]
MED: 020.001.GE

[**Preventive Medicine Services**
[1.] [Preventive medicine services for well child care and adult care, including immunizations as recommended by the United States Preventative Services Task Force on the date the service is Incurred.] [This does not include routine well newborn care at birth [unless the Maternity Care Services coverage is included in this plan as shown in the Benefit Summary].]

[2.] [The following diagnostic services:]

[a.] [Pap smears with chlamydia screening.]

[b.] [Mammography screening.]
[c.] [Stool for occult blood testing.]
[d.] [Prostate specific antigen screening.]
[e.] [Fasting glucose testing.]
[f.] [Lipid profile testing.]
[g.] [Complete blood count (or component parts) testing.]
[h.] [Urinalysis testing.]
[i.] [Tuberculin skin testing with purified protein derivative.]
[j.] [Other diagnostic services as recommended by the United States Preventative Services Task Force on the date the service is Incurred.]]

Preventive medicine services also include an annual prostate cancer specific antigen screening for covered males who are 40 years of age or older.

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.] [The Benefit Waiting Period will be waived if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan.] [The maximum benefit for preventive medicine services is shown in the Benefit Summary.]
MED: 025.001.GE

Colorectal Cancer Examination Coverage
Coverage includes colorectal cancer examination and laboratory tests for a Covered Person:

1. age fifty (50) years of age or older;

2. less than fifty (50) year of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and

3. experiencing the following symptoms of colorectal cancer as determined by a Health Care Practitioner licensed under the Arkansas Medical Practices Act:

   a. bleeding from the rectum or blood in the stool; or
   b. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

Colorectal screening shall involve an examination of the entire colon, including the following examinations and/or laboratory tests:

1. annual fecal occult blood test utilizing take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

2. double-contrast barium enema every five (5) years; or

3. colonoscopy every ten (10) years; and

4. any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

Screenings for the management or subsequent need for follow-up colonoscopies shall be limited to:

1. if the initial colonoscopy is normal, follow-up is recommended in ten (10) years;

2. for individuals with one (1) or more neoplastic polyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;

3. if single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and

4. for patients with large sessile adenomas greater than three centimeters (> 3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

MED: 026.002.AR

Loss or Impairment of Speech or Hearing
Coverage shall be provided for Medically Necessary audiology and speech pathology services for the treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech – Language Pathology and Audiology. Coverage does not include hearing instruments or devices.
MED: 027.002.AR

[**Accident Medical Expense Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] accident medical expense benefit is included in this plan.]

Covered Charges Incurred by a [Covered Person] [Covered Dependent child] for the treatment of an Accidental Injury are covered at [100%] up to the amount shown in the Benefit Summary if:

1. The Injury occurs and Covered Charges are received while this Accident Medical Expense Benefit provision is in force; and

2. Covered Charges for treatment of the Injury are Incurred within [the first [90 days]] [a specified period of time] after the date the Accident occurs [as shown in the Benefit Summary].

[Covered Charges in excess of the accident medical expense benefit shown in the Benefit Summary or Incurred [more than [90 days]] after the [date the Accident occurs] [time period shown in the Benefit Summary] will be paid subject to all the terms, limits and conditions in this plan without regard to this Accident Medical Expense Benefit provision.]]
MED: 030.001.GE

[**Accident Medical Expense Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] accident medical expense benefit is included in this plan.]

Covered Charges that are received as a result of an Accidental Injury that occurs while this accident medical expense benefit coverage is in force will be subject to the following requirements [provided that the charges are Incurred within the [first [90 days] after the date the Accident occurs] [time period shown in the Benefit Summary]]:

1. The [Covered Person] [Covered Dependent child] who is injured in an Accident must satisfy a [$XXX] Deductible [and Coinsurance [of [XX%]] up to [$XXXX] [the amount shown in the Benefit Summary]] for Covered Charges Incurred as a result of the Injury; and

2. Once the Deductible [and Coinsurance] [is] [are] satisfied, Covered Charges related to the Injury are paid at [100%] [up to [$XXXX] [the amount shown in the Benefit Summary]] [then] [Covered Charges are subject to the [plan] [Individual] [Inpatient] [Outpatient] [or] [Integrated] Deductible [and] [or] [plan] [Inpatient] [Outpatient] Coinsurance]; and

3. The Deductible [and Coinsurance] that [is] [are] met under this accident medical expense benefit [does] [do] not count toward satisfying any other Deductible[, Coinsurance] or Out-of-Pocket Limit under any section of this plan.

Additional Covered Charges resulting from the Accident [that exceed [$XXXX] [the amount shown in the Benefit Summary]] [or] [that are Incurred [more than [90 days]] after the [date the Accident occurs] [time period shown in the Benefit Summary]], will be paid subject to all the terms, limits and conditions in this plan without regard to this Accident Medical Expense Benefit provision.]
MED: 040.001.GE

[**Accident Medical Expense Reduced Plan Deductible**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] accident medical expense reduced plan deductible is included in this plan.]

For a [Covered Person] [Covered Dependent child] who is injured in an Accident, We will reduce the [Individual,] [Outpatient,] [Inpatient,] [or] [Integrated] [Deductible] [and] [or] [Coinsurance] amount that must be satisfied for Covered Charges resulting from the Accident. The reduced amount that will be applied is shown in the Benefit Summary. [Coinsurance will apply.] When Covered Charges related to the Accident exceed the reduced [Individual,] [Outpatient,] [Inpatient,] [or] [Integrated] [Deductible] [and] [or] [Coinsurance] amount specified in the Benefit Summary, benefits will be paid by Us provided that:

1. The Injury occurs and Covered Charges are received while this Accident Medical Expense Reduced Plan Deductible provision is in force; and

2. Covered Charges for treatment of the Injury are Incurred within [the first [90 days]] after the date the Accident occurs; and

3. We receive proof that the services were received as a result of an Accident.

When additional Covered Charges resulting from the Accident are Incurred more than [90 days] after the date the Accident occurs, the [Covered Person] [Covered Dependent child] will have to satisfy the regular [Individual] [Outpatient] [Inpatient] [Deductible] [and] [or] [Coinsurance] under this plan minus any amount that was previously satisfied. Benefits for those additional services

that are related to the Accident and for Covered Charges that are unrelated to the Accident will be paid subject to all the terms, limits and conditions in this plan without regard to this Accident Medical Expense Reduced Plan Deductible provision.]

No credit will be provided under this provision if the [Covered Person's] [Covered Dependent child's] [Individual] [Outpatient] [Inpatient] [Deductible] [and] [or] [Coinsurance] [was] [were] satisfied prior to receiving Covered Charges resulting from the Accident.]
MED: 045.001.GE

[**Diagnostic Imaging Services** [**and Laboratory Services**]
1. Diagnostic Imaging services [and laboratory services].

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

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary[, unless Emergency Treatment is required].]]
MED: 050.001.GE

[**Laboratory Services**
1. Laboratory services.

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

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary[, unless Emergency Treatment is required].]]
MED: 055.001.GE

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

[1.] [Physical Therapy, Occupational Therapy and Speech Therapy.]

[2.] [Pulmonary rehabilitation programs.]

[3.] [Adjustments[, and] manipulations [and] [massage therapy].]

[4.] [Cardiac Rehabilitation Programs.]

[5.] [Services for treatment of Developmental Delay.]

Coverage for Outpatient Physical Medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]
MED: 065.001.001.GE

[**Outpatient Alternative Medicine Services**
[The following services, as each is defined by the Office of Alternative Medicine of the National Institutes of Health, when provided by a Health Care Practitioner on an Outpatient basis:]

[1.] [Acupuncture.]

[2.] [Massage therapy.]

[3.] [Nutritional counseling.]

[4.] [Meditation or relaxation therapy.]

[5.] [Naturopathic medicine.]

Coverage for Outpatient alternative medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.]

For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]
MED: 070.001.GE

[**Durable Medical Equipment and Personal Medical Equipment**
[1.] [Rental or purchase, whichever is most cost effective as determined by Us, of the following items when prescribed by a Health Care Practitioner:]

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

[2.] [Casts, splints, trusses and orthopedic braces, excluding foot orthotics.]

[3.] The [temporary interim and] initial permanent basic artificial eye.

[4.] Prosthetic Devices and Orthotic Devices, including repairs or replacements one time every three years, that are prescribed and provided by a licensed doctor and are determined by US to be Medically Necessary.

[5.] [External breast prostheses needed because of surgical removal of all or part of the breast.]

6.] [Oxygen and the equipment needed for the administration of oxygen.]

[7.] [Other Durable Medical Equipment and supplies that are approved in advance by Us.]

[Charges for replacement of or maintenance, repair, modification or [enhancement to the whole or parts of wheelchairs will be covered when authorized by Us before any equipment is purchased] [Charges for replacement of or maintenance, repair, modification or [enhancement to the whole or parts of] any of the items listed above are not covered, regardless of when the item was originally purchased.] [Replacements due to outgrowing [wheelchairs] Durable [or Personal] Medical Equipment] as a result of the normal skeletal growth of a child will be covered when authorized by Us before any equipment is purchased.] [Charges for duplicate Durable Medical Equipment, Personal Medical Equipment and supplies are not covered.]]
MED: 075.001.001.AR

[**Maternity Care Services**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] maternity care services coverage is included in this plan.]

1. Prenatal care.

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

3. Postpartum care.

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary [provided that a Health Care Practitioner determines the pregnancy began after the Benefit Waiting Period and the pregnancy terminates while this coverage is in force].]

[Benefits will only be considered for Covered Charges Incurred while the maternity care services coverage is in effect.]
MED: 080.001.GE

[**Complications of Pregnancy**
Any Sickness associated with a pregnancy [that begins after the Effective Date of coverage], except for hyperemesis gravidarum or a non-emergency caesarean section delivery.]
MED: 085.001.GE

[**Infertility Services**
[This coverage is optional.] The Benefit Summary will indicate if the [optional] infertility services coverage is included in this plan.]

[1.] [Infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications, related tests, services or procedures for treatment to promote conception.]

[2.] [Artificial insemination.]

[3.] [In vitro fertilization.]

[4.] [Reversal of reproductive sterilization.]

[5.] [Cryopreservation of sperm or eggs.]

[6.] [Surrogate pregnancy.]

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.]]
MED: 090.001.GE

[**Health Care Practitioner Services**

1. Services of a primary surgeon, an Assistant Surgeon or a Surgical Assistant during the surgery. Benefits will be reduced for additional surgical procedures performed in the same operative session.

2. Other Health Care Practitioner services.

[For interpretation of Diagnostic Imaging and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]]
MED: 095.001.GE

[**Professional Ground [or Air] Ambulance Services**
Professional ground [or air] transportation in an ambulance for a Covered Person who needs Emergency Treatment for a Sickness or an Injury to the nearest Acute Medical Facility that can treat the Sickness or Injury. [The ambulance service must meet all applicable state licensing requirements.]]
MED: 100.001.GE

[**Home Health Care Services**
[1.] [Home Health Care visits by a licensed nurse.]

[2.] [Respiratory therapy.]

[3.] [Intravenous injectable parenteral drug therapy [when authorized by Us to be paid under the Medical Benefits section].]

[4.] [Non-intravenous injectable drug therapy [when authorized by Us to be paid under the Medical Benefits section.]]

Home Health Care must be provided by a Home Health Care Agency. [One visit consists of up to [2 hours] of care within [a 24-hour period] by anyone providing services or evaluating the need for Home Health Care]. Services must be included in a plan of treatment established by a Health Care Practitioner.

[For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.]
[[For intravenous injectable parenteral drug therapy] [and] [non-intravenous injectable drug therapy] benefits, see the Outpatient Prescription Drug Benefits section.]]
MED: 105.001.GE

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

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

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

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

[The covered counseling services listed above are not subject to the limitations for treatment of [Behavioral Health] [or] [Substance Abuse].]]
MED: 110.001.GE

[**Inpatient Rehabilitation Services**
Services provided as an Inpatient in an Acute Medical Rehabilitation Facility that include, but are not limited to:

1. Rehabilitation Services provided for the same or a related Sickness or Injury that required an Inpatient Acute Medical Facility stay.

2. Treatment of complications of the condition that required an Inpatient Acute Medical Facility stay.

3. Physical Therapy, Occupational Therapy and Speech Therapy.

4. Pulmonary rehabilitation programs.

5. The evaluation of the need for the services listed above.

[Coverage for Inpatient Rehabilitation Services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.]
MED: 115.001.GE

[**Subacute Rehabilitation Facility and Skilled Nursing Facility Care**
Services in a Subacute Rehabilitation Facility or Skilled Nursing Facility that are:

[1.] [Provided in lieu of care in an Acute Medical Facility][; or]

[2.] [For the same condition that required confinement in an Acute Medical Facility and the Covered Person must enter the Subacute Rehabilitation Facility or Skilled Nursing Facility within [14 days] after discharge from the Acute Medical Facility after a confinement of at least [3 days].]

[Coverage for Subacute Rehabilitation Facility or Skilled Nursing Facility care will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.]]
MED: 120.001.GE

[**Family Planning Services**
The following services [when provided by a Participating Provider]:

[1.] [Health Care Practitioner Office Visits for contraception management.]

[2.] [Services ordered by a Health Care Practitioner in relation to administration and dispensing of FDA-approved contraceptive Prescription Drugs or injections or the fitting or dispensing of an IUD or diaphragm.]

[3.] [The insertion or removal of Norplant or other similar device by a Health Care Practitioner.]

[For oral contraceptive benefits, see the Outpatient Prescription Drug Benefits section.]]
MED: 125.001.GE

[**Sterilization**

Services for permanent sterilization for each Covered Person. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.]]
MED: 130.001.GE

[**Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction**
Surgical treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction are only those services that are included in a treatment plan authorized by Us prior to the surgery.

The following services for non-surgical treatment of TMJ and CMJ:

[1.] [Diagnostic examination.]

[2.] [Diagnostic Imaging services.]

[3.] [Injection of muscle relaxants.]

[4.] [Therapeutic drug injections.]

[5.] [Physical Therapy.]

[6.] [Diathermy therapy.]

[7.] [Ultrasound therapy.]

[For Physical Therapy benefits, see the Outpatient Physical Medicine Services provision in this section.]]
MED: 135.001.GE

[**Diabetic Services**
The following services are for a Covered Person with diabetes:

1. Routine eye exams.

2. Nutritional counseling.

3. Diabetic training.

4. Routine foot care.

5. Home glucose monitoring [and diabetic supplies].

[6.] [Insulin, syringes, needles, lancets and testing agents.]]

[For insulin, syringes, needles, lancets and testing agents benefits, see the Outpatient Prescription Drug Benefits section.] [For other diabetic equipment and supplies benefits, see the Durable Medical Equipment and Personal Medical Equipment provision in this section.]
MED: 140.001.GE

[**Growth Hormone Therapy Services**
Treatment, diagnosis or supplies, including drugs and hormones, only when such treatment is clinically proven to be effective for any of the following conditions:

1. Growth hormone deficiency as confirmed by documented laboratory evidence.

2. Growth retardation secondary to chronic renal failure before or during dialysis.

3. AIDS wasting syndrome.

Growth hormone treatment must be likely to result in a significant improvement in the Covered Person's condition.]
MED: 145.001.GE

[**Tonsils and Adenoids**
[Services for removal of tonsils and adenoids. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary, unless Emergency Treatment is required.] [The Benefit Waiting Period will be waived if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan.]]
MED: 150.001.GE

[[**Bunions,**] [**Hemorrhoids**] [**and**] [**Varicose Veins**]
[Services for surgical treatment of [bunions,] [hemorrhoids] [and] [varicose veins]. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.] [The Benefit Waiting Period will be waived if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan.]]
MED: 155.001.GE

[**Inguinal Hernia**
[Services for surgical treatment of an inguinal hernia. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary]. [The Benefit Waiting Period will be waived [if surgical treatment is required for incarcerated or strangulated inguinal hernia] [or] [if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan].]]
MED: 160.001.GE

[**Blood Product Transfusions**
Whole blood, blood plasma and blood products if not replaced.]
MED: 165.001.GE

[**Transplants**
All transplants must be authorized in advance by Us. [No benefits will be paid for any organ, tissue or cellular transplants that are not reviewed by Us prior to transplant evaluation, testing, preparative treatment or donor search.]

[Benefits for the following transplants will be considered on the same basis as benefits for any other Sickness:] [Benefits for the following transplants will be paid as shown in the Benefit Summary:]

1. Kidney.

2. Cornea.

3. Skin.

[Transplants with Designated Transplant Provider:] [We have contracted with Designated Transplant Providers to provide transplantation services for specified types of transplants to Covered Persons at a Negotiated Rate. [When the Covered Person uses a Designated Transplant Provider at the time the first service is Incurred for transplant evaluation, testing, preparative treatment and/or donor search, the maximum transplant benefit [is] [may be] increased.] [When a Designated Transplant Provider is used, travel expenses for the Covered Person and one travel companion are paid, subject to Our guidelines.] [If the Covered Person later decides to use a

Health Care Practitioner for transplant related services instead of a Designated Transplant Provider, benefits will be paid as outlined below.]

[When the Covered Person does not use a Designated Transplant Provider at the time the first service is Incurred for transplant evaluation, testing, preparative treatment and/or donor search, the maximum transplant benefit applies. The maximum transplant benefit will not be increased for any reason even if the Covered Person chooses to use a Designated Transplant Provider at a later date [unless approved by Us]. The maximum transplant benefit that is available when a Covered Person does not use a Designated Transplant Provider applies to all transplant related services that are provided by a non-Designated Transplant Provider, regardless of whether the Health Care Practitioner is a Participating Provider or [Non-Network] [Non-Participating] Provider.]

[Benefits for the following transplants will be paid as shown in the Benefit Summary.] [The following transplants are eligible for the increased maximum transplant benefit:]

1. Lung(s).

2. Heart.

3. Simultaneous heart/lung.

4. Liver.

5. Simultaneous kidney/pancreas.

6. Allogeneic and autologous bone marrow transplant/stem cell rescue. All marrow ablative chemotherapy, harvesting of the bone marrow, harvesting of the stem cell, the reinfusion of the marrow or blood precursor cells and any other treatment protocols connected with a bone marrow transplant/stem cell rescue apply toward meeting the maximum transplant benefit limit as shown in the Benefit Summary.

7. Any other transplants that are shown in the Benefit Summary.

The maximum transplant benefit applies to all Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ. All Covered Charges associated with transplants are applied toward the maximum transplant benefit including, but not limited to:

1. All Inpatient and Outpatient care, facility fees, professional fees and follow-up care.

2. Prescription Drug benefits even though they may be paid under the Outpatient Prescription Drug Benefits section.

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

Covered Charges for transplants authorized by Us include all related medical services Incurred [14 days] before the transplant surgery until [365 days] after the transplant surgery[, or a lesser period not to exceed the termination date of this plan]. All payments for these services are applied toward the maximum transplant benefit.

[All Covered Charges for transplant related benefits will also be applied [and are subject] to the [Calendar Year] [Plan Year] maximum [and] [Maximum Lifetime Benefit] as shown in the Benefit Summary.]]
MED: 170.001.GE

[**Transplants**

All transplants must be authorized in advance by Us. [No benefits will be paid for any organ, tissue or cellular transplants that are not reviewed by Us prior to transplant evaluation, testing, preparative treatment or donor search.]

We pay Covered Charges for the following transplants:

1. Kidney.

2. Cornea.

3. Skin.

4. Lung(s).

5. Heart.

6. Simultaneous heart/lung.

7. Liver.

8. Simultaneous kidney/pancreas.

9. Allogeneic and autologous bone marrow transplant/stem cell rescue. All marrow ablative chemotherapy, harvesting of the bone marrow, harvesting of the stem cell, the reinfusion of the marrow or blood precursor cells and any other treatment protocols connected with a bone marrow transplant/stem cell rescue apply toward satisfying the maximum transplant benefit limit as shown in the Benefit Summary.

10. Any other transplants that are shown in the Benefit Summary.

[Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ are applied toward the [Calendar Year] [Plan Year] [and] [Outpatient Calendar Year Maximum Benefit] [and] [Maximum Lifetime Benefit] including, but not limited to:

1. All Inpatient and Outpatient care, facility fees, professional fees and follow-up care.

2. Prescription Drug benefits even though they may be paid under the Outpatient Prescription Drug Benefits section.

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

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

All Covered Charges for transplant related benefits will be applied[, and are subject] to the [Calendar Year] [Calendar Year Maximum Benefit] [Plan Year] [and] [transplant limit] [and] [Outpatient Calendar Year Maximum Benefit] [and] [Maximum Lifetime Benefit] as shown in the Benefit Summary.]
MED: 175.001.GE

[**Behavioral Health** [**and Substance Abuse**]
The following services for treatment of Behavioral Health [and Substance Abuse]:

1. Inpatient services when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

2. Outpatient services when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Behavioral Health [or Substance Abuse] in an office setting.

[Drugs prescribed for the treatment of Behavioral Health [and Substance Abuse] are covered under this provision in the plan.] [For benefits for drugs prescribed for the treatment of Behavioral Health [and Substance Abuse], see the Outpatient Prescription Drug Benefits section.]]
MED: 180.002.GE

[**Substance Abuse**
The following services for treatment of Substance Abuse:

1. Inpatient services when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

2. Outpatient services when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Substance Abuse in an office setting.

[Drugs prescribed for the treatment of Substance Abuse are covered under this provision in the plan.] [For benefits for drugs prescribed for the treatment of Substance Abuse, see the Outpatient Prescription Drug Benefits section.]]
MED: 185.002.GE

[**Reconstructive Surgery**
Reconstructive surgery:

[1.] [To restore function for conditions resulting from an Injury [provided the Injury occurred while the Covered Person is covered under this plan].

[2.] [That is incidental to or follows a covered surgery resulting from a Sickness or an Injury of the involved part [if the trauma, infection or other diseases occurred or had their onset while the Covered Person is covered under this plan].

[3.] [Following a Medically Necessary mastectomy. Reconstructive surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and physical complications in all stages of mastectomy, including lymphedemas.]

[4.] [Because of a congenital Sickness or anomaly of a Covered Dependent child[, who was covered under this plan since birth,] that resulted in a functional defect].]

[Cosmetic Services and services for complications from Cosmetic Services are not covered regardless of whether the initial surgery occurred while the Covered Person was covered under this plan or under any previous coverage.]]
MED: 190.001.GE

[**Dental Services**

[1.] [Services related to the dental extraction of teeth as a prerequisite of scheduled radiation therapy.]

[2.] [The treatment of a Dental Injury from an Accidental blow to the face causing trauma to teeth, the gums or supporting structures of the teeth. The treatment must begin within [90 days] and be completed within [365 days] of the Dental Injury.]

[3.] Anesthesia and Acute Medical Facility or Free-Standing Facility performed in connection with Medically Necessary dental procedures if the Health Care Practitioner treating the patient certifies that:

a. a child under seven (7) years of age has been determined by two (2) dentists licensed under the Arkansas Dental Practice Act, to require, without delay, Medically Necessary dental treatment for a significantly complex dental condition;
b. a person has been diagnosed with a serious mental or physical condition; or
c. a person has a significant behavioral problem as determined by the Covered Person's Heath Care Practitioner licensed under the Arkansas Medical Practices Act.

[The Covered Person may submit a Dental Treatment Plan to Us before treatment starts for an estimate of any benefits that would be payable.] [We reserve the right to limit benefits to the least expensive procedure that will produce a professionally adequate result.]]
MED: 195.001.AR

[**Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]
Services for total parenteral nutrition and other fluids, blood and blood products, and medications requiring a written prescription that would be administered intravenously.]
MED: 200.001.GE

[**Non-Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]
Services for Prescription Drugs that can be administered by means of intramuscular or subcutaneous injection. [If the injectable drug is covered under the Medical Benefits section, any administration fees are covered under the Health Care Practitioner Services provision in this section when the injectable drug is received on an Outpatient basis through a method other than self-administration.] [For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.]]
MED: 205.001.GE

[**Telehealth Services**
Telehealth Services that may include the use of:

[1.] [Telephone.]

[2.] [Facsimile.]

[3.] [E-mail.]

[4.] [Internet.]

[5.] [Compressed digital interactive video, audio or data transmission.]

[6.] [Clinical data transmission using computer imaging by way of still-image capture and store forward.]

[7.] [Other technology that facilitates access to the Health Care Practitioner.]]
MED: 215.001.GE

[**Telemedicine Services**
Telemedicine Services that may include the use of:

[1.] [Telephone.]

[2.] [Facsimile.]

[3.] [E-mail.]

[4.] [Internet.]

[5.] [Compressed digital interactive video, audio or data transmission.]

[6.] [Clinical data transmission using computer imaging by way of still-image capture and store forward.]

[7.] [Other technology that facilitates access to the Health Care Practitioner.]]
MED: 220.001.GE

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

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

[Benefits are not payable for any services Incurred in a country where travel warnings, issued by the U.S. State Department, exist for visitors from the United States at the time the services are received.]]
MED: 225.001.GE

[**Out-of-Network Travel Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] out-of-network travel benefit is included in this plan.]

If an unforeseen Sickness or Injury occurs while a Covered Person is traveling in the United States but outside of his or her network Service Area, benefits will be payable on the same basis as if they were provided by a [Network] [Participating] Provider provided that the services could not have been reasonably delayed until the Covered Person was able to return to his or her network Service

Area. The maximum benefit available is shown in the Benefit Summary. Covered Charges are for the following services [at the Network Provider] [Participating Provider] level and may be subject to the Maximum Allowable Amount] that are required as a result of a Sickness or an Injury:

1. Health Care Practitioner Office Visits.

2. Diagnostic Imaging services and laboratory services, as outlined in the Diagnostic Imaging Services and Laboratory Services provision in the Medical Benefits section.

3. Other Urgent Care services.

Benefits are subject to all the other terms, limits and conditions in this plan. Benefits are available under this provision only for Covered Charges Incurred while this out-of-network travel benefit is in effect. Treatment, services or supplies that are received for conditions, other than those which created the immediate need for medical care, while traveling outside of the Service Area will be paid at the [Non-Network] [Non-Participating] Provider level.]
MED: 230.001.GE

[**Choice of Network Service Area Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] choice of network service area benefit is included in this plan.]

Each Covered Person may choose a different [Health Care Provider Network] [Participating Provider Network] if a Covered Person is located outside the Service Area of the primary [Health Care Provider Network] [Participating Provider Network]. The Covered Person may use any [Network] [Participating] Provider in the Service Area that he or she selects. However, benefits will be reduced if Covered Charges are received from a [Non-Network] [Non-Participating] Provider or in a Service Area that is different from the one selected, except for Emergency Treatment.

A Covered Person may request a transfer from one network Service Area to another by providing Us with a written request. This request must include the reason for the transfer. No change is effective until the transfer request is received by Us and approved by Us.

Covered Charges Incurred by a Covered Person in his or her network Service Area will be applied toward satisfying any [Family Deductible] [or] [Integrated Deductible] and [integrated] Family Out-of-Pocket Limit. Benefits are subject to all the terms, limits and conditions in this plan. Benefits are available under this provision only for Covered Charges Incurred while this choice of network service area benefit is in effect.]
MED: 235.001.GE

[**Nationwide Network Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] nationwide network benefit is included in this plan.]

We have a nationwide network of providers[, through Private Healthcare Systems (PHCS),] who provide services at discounted rates. If You have this coverage, a Covered Person may receive services from one of these providers anywhere in the United States. The Out-of-Pocket Limit will

be lower than if a [Non-Network] [Non-Participating] Provider is selected. Although services are billed by the provider at a discounted rate, benefits may be subject to Maximum Allowable Amount reductions. The [Copayment,] [Deductible] [and] [Coinsurance] amounts that must be satisfied are shown in the Benefit Summary.

You [and Your Covered Dependents] are responsible for verifying that the provider is a member of the nationwide network prior to receiving treatment. Our customer service department may be contacted at the telephone number listed on the ID card to determine if a provider belongs to the nationwide network. The list of network providers is subject to change at any time. We cannot guarantee that the provider is still participating in the nationwide program at the time treatment is received. Covered Charges Incurred after a provider's participation in the nationwide network has terminated will be paid at the [Non-Network] [Non-Participating] Provider level.

Benefits are subject to all the other terms, limits and conditions in this plan. Benefits are available under this provision only for Covered Charges Incurred while this nationwide network benefit is in effect.]
MED: 240.001.GE

[**International Coverage**
[The Benefit Summary will indicate if the international coverage is included in this plan.]

Covered Charges for international coverage are:

[1.] [Health Care Practitioner visits for a Sickness or an Injury.]

[2.] [Preventive medicine services that are administered and delivered by a Health Care Practitioner as:

- [a.] [Outlined in the Preventive Medicine Services provision in the Medical Benefits section.]
- [b.] [Recommended by the United States Centers for Disease Control and Prevention.]
- [c.] [Recommended for residents by the public health care authorities in the country in which the Covered Person works or resides.]]

[3.] [Diagnostic Imaging services and laboratory services, as outlined in the Diagnostic Imaging Services and Laboratory Services provision in the Medical Benefits section.]

[4.] [Drugs, prescribed during a Health Care Practitioner visit, that have a biological equivalent to Prescription Drugs as outlined in the Outpatient Prescription Drug Benefits section.]

[5.] [Emergency Treatment.]

If You have this coverage and a Covered Person Incurs Covered Charges while residing or working outside of the United States [or the possessions of the United States], benefits may be payable [at the Network Provider] [Participating Provider] level and may be subject to the Maximum Allowable Amount] for such foreign medical expenses provided that:

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

[2.] The foreign medical expenses are determined by Us to be Covered Charges under this plan.

Expenses will be based on the exchange rate in effect on the date the services are Incurred. Covered Charges will be based on the location of the Participating Employer.

Benefits are not payable for any services Incurred in a country where travel warnings, issued by the U.S. State Department, exist for visitors from the United States at the time the services are received. Benefits will only be considered for Covered Charges Incurred while the international coverage is in effect.]
MED: 245.001.GE

[**Travel Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] travel benefit coverage is included in this plan.]

If You have this coverage and a Covered Person Incurs Covered Charges while traveling outside of the United States, possessions of the United States or outside of Canada, benefits may be payable [at the Network Provider] [Participating Provider] level and may be subject to the Maximum Allowable Amount] for such foreign medical expenses provided that:

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

2. The foreign medical expenses are determined by Us to be Covered Charges under this plan.

Benefits are not payable for any services Incurred in a country where travel warnings, issued by the U.S. State Department, exist for visitors from the United States at the time of the Covered Person's visit. Benefits will only be paid while the travel benefit coverage is in effect.]
MED: 250.001.GE

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

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

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

2. Be approved in writing by Us.

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

Providing benefits for alternate medical care in a particular case does not commit Us to do so in another case, nor does it waive or modify the terms and conditions of this plan, render them unenforceable or prevent Us from strictly applying the benefits, limitations and exclusions of this plan at any other time or for any other insured person, whether or not the circumstances are similar or the same.]]
MED: 265.001.GE

[**Repatriation Services**
Covered Charges are for the preparation and transportation of a Covered Person's remains to his or her home country or [country] [state] of regular domicile should the Covered Person die while covered under this plan[, provided treatment of the Illness or Injury that caused the Covered Person's death would have been covered under this plan had the person not died]. If applicable, such action will be in accordance with any international transportation requirements.

[Repatriation must be authorized by Us in advanced before the remains are prepared for transportation.] [No benefits will be paid for transportation expenses of anyone accompanying the body.]]
MED: 275.001.GE
[**Medical Evacuation Services**:
Covered Charges are for the Covered Person's Medically Necessary evacuation to his or her home country or to a facility operated pursuant to the laws of his or her home country for the treatment of a Sickness or Injury, should the Covered Person be admitted on an Inpatient basis to [an Acute Behavioral Health Inpatient Facility,] an Acute Medical Facility or other licensed facility as a result of a Sickness or Injury.

[Medical Evacuation must be [authorized by Us in advance before the Covered Person is evacuated] [and] [approved by the attending Health Care Practitioner]. [Except as specifically provided herein, no benefits will be provided for charges Incurred outside of the United States or its possessions [or Canada].]]
MED: 280.001.GE

Medical Foods
Benefits are payable for Covered Charges incurred for Medically Necessary Health Care Practitioner prescribed amino acid modified preparations, low protein modified food products and any other special dietary products and formulas for the treatment of phenylketonuria, when the expense exceeds [$2,400] per Covered Person per calendar year.
MED: 291.002.AR

[[VIII.] [OUTPATIENT PRESCRIPTION DRUG BENEFITS]

[ONLY THE PRESCRIPTION DRUGS LISTED AS OUTPATIENT PRESCRIPTION DRUG BENEFITS IN THIS SECTION OF THE PLAN WILL BE CONSIDERED COVERED CHARGES. HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED PRESCRIPTION DRUGS LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY. REFER TO THE EXCLUSIONS SECTION OF THE PLAN FOR DRUGS, MEDICATIONS AND SUPPLIES THAT ARE NOT COVERED UNDER THIS PLAN.

[THE COVERED PERSON MUST FOLLOW THE UTILIZATION REVIEW PROVISIONS SECTION [AND USE THE PARTICIPATING PHARMACY NETWORK] [OR SPECIALTY PHARMACY NETWORK] TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER THIS PLAN.]

[PRIOR AUTHORIZATION MAY BE REQUIRED FOR CERTAIN PRESCRIPTION DRUGS BEFORE THEY ARE CONSIDERED FOR COVERAGE UNDER THE OUTPATIENT PRESCRIPTION DRUG BENEFITS SECTION. PLEASE ACCESS THE WEBSITE LISTED ON THE BACK OF THE IDENTIFICATION (ID) CARD TO RECEIVE INFORMATION ON WHICH PRESCRIPTION DRUGS REQUIRE PRIOR AUTHORIZATION, TO CHECK PRESCRIPTION DRUG COVERAGE AND PRICING OR TO LOCATE A PARTICIPATING PHARMACY.]]

[After the Covered Person has paid any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Coinsurance,] [Copayment,] [Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan. Any applicable [Coinsurance,] [Copayment,] [Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary. Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[Any [Ancillary Charge] [or] [any Ancillary Pharmacy Network Charge] under this section will not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

[After the Covered Person has paid any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan.] [Any applicable [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary.] [Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]]

[Any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible,] under this section will not count toward satisfying any [Access Fee,] [and] [or] [Coinsurance,] [and] [or] [Copayment,] [and] [or] [Deductible] [and] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

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

under the Outpatient Prescription Drug Benefits section.] [Any amount in excess of the maximum amount provided under this section is not covered under any other section of this plan.] [Expenses Incurred under this section do [not] apply toward any Out-of-Pocket Limits under any other section of this plan.]

[A Prescription Drug must be dispensed through a [Participating Pharmacy] [or Specialty Pharmacy Provider] to receive benefits.] Certain Prescription Drugs may be covered under this plan only if they are dispensed through a Specialty Pharmacy Provider.] [These limitations will be shown in the Benefit Summary.]

[This plan provides benefits only for the following Covered Charges for [Prescription] [Generic] Drugs that are received on an Outpatient basis [and dispensed through a] [Participating Pharmacy] [or Specialty Pharmacy Provider] [as shown in the Benefit Summary]:

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

[2.] [[Prescription] [Generic] Drugs that are listed in Our Drug List.]

[3.] [[Up to a] [15 consecutive day] supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this plan. [We will pay [up to a] [90 consecutive day] supply for each Prescription Order for Prescription Maintenance Drugs, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

[4.] [[Up to] [3 vials] [or] [up to a] [15 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]]

[5.] [[Up to] [100] disposable insulin syringes and needles[, up to] [100] disposable blood/urine/glucose/acetone testing agents[, or] [up to] [100] lancets[, or] [up to a] [15 consecutive day] supply for each Prescription Order[, whichever is less]. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]]

[6.] [Prescription Maintenance Drugs that are dispensed through a Mail Service Prescription Drug Vendor. We will pay for the following:

[a.] [Up to] [9 vials] [or] [up to a] [90 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]

[b.] [Up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]

[c.] [Up to a] [90 consecutive day] supply for each Prescription Order for Prescription Maintenance Drugs, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

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

[8.] [[Prescription] [Generic] Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a [Prescription] [Generic] Drug [or within a Therapeutic Class based on the Prescription Drug Class].]

[9.] [[Prescription] [Generic] Drugs and [Prescription] [Generic] Drug products if all active ingredients are covered under this plan.]

[10.] [[Prescription] [Generic] Drugs used for Outpatient treatment of [Behavioral Health] [or] [Substance Abuse].]

[11.] [Prescription] [Generic] Drugs used for contraception that are oral contraceptives, contraceptive patches, contraceptive vaginal rings, injectable contraceptives, contraceptive implants or diaphragms.

[12.] [Specialty Pharmaceuticals that are authorized by Us to be paid under the Outpatient Prescription Drug Benefits section [and are obtained through a [Participating Pharmacy] [or] [Specialty Pharmacy Provider].]

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

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

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

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

[Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, limits and conditions of coverage or will not be covered by this plan if the original drug would not be covered.]]

PAYMENT OF BENEFITS

[**Participating Pharmacy**
Present the identification (ID) card to the Participating Pharmacy to obtain benefits. The Covered Person must pay any applicable [Coinsurance] [and] [Deductibles] [under the Medical Benefits section,] [and][Ancillary Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment] [and] [or] [Prescription Drug] [Deductible] to the Participating Pharmacy. The following additional cost sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

[1.] [When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the [Prescription Drug] [Copayment][,][and] [or] [Prescription Drug] [Deductible][,][and] [or] [Prescription Drug] [Coinsurance][,] [and] [or] [Contracted Rate] for that Generic Drug as shown in the [Benefit Summary] [Drug List].]

[2.] [When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the [Prescription Drug] [Copayment][,] [and] [or] [Prescription Drug] [Deductible][,] [and] [or] [Prescription Drug[[Coinsurance][,] [and] [or] [Contracted Rate] for that Brand Name Drug as shown in the [Benefit Summary] [Drug List].]

[3.] [If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the [Prescription Drug] [Copayment][,] [and] [or] [Prescription Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurance][,] [and] [or] [Contracted Rate] for that Brand Name Drug, as shown in the [Benefit Summary] [Drug List], plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]

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

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug] [Coinsurance] amount,] [Prescription Drug] [Copayment,][and/or] [Prescription Drug] [Deductible].]] [The Covered Person will be reimbursed up to the Allowance for the cost of the covered Prescription Drug.] [Any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug] [Coinsurance] amount,] [Prescription Drug] [Copayment,] [Prescription Drug] [Deductible] [and/or] any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,]

[Deductible] [or] [Out-of-Pocket Limit] under the medical portion [or the Outpatient Prescription Drug Benefits section] of this plan.]]

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

[**Non-Participating Pharmacy**
When the Covered Person has prescriptions 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 Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy [or Specialty Pharmacy Provider] for the cost of the covered Prescription Drug minus any applicable [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment] [and/or] [Prescription Drug] [Deductible.]] [The Covered Person will be reimbursed up to the Allowance amount for the cost of the covered Prescription Drug.] [Any [Ancillary Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment,] [Prescription Drug] [Deductible] [and/or] any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical portion of this plan.]]
RXP: 005.002.002.AR

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

[The following [Prescription Drug] [Copayment] cost sharing provisions apply to covered Outpatient Prescription Maintenance Drugs that are obtained through a Mail Service Prescription Drug Vendor for home delivery:

[1.] [When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the mail service [Prescription Drug] [Copayment,][,] [and] [or] [Prescription Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurnace] [,] [and] [or] [Contracted Rate] for that Generic Drug as shown in the [Benefit Summary] [Drug List].

[2.] [When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the mail service [Prescription Drug] [Copayment][,] [and] [or] [Prescription

Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurnace][,] [and] [or] [Contracted Rate] for that Brand Name Drug as shown in the [Benefit Summary] [Drug List].]

[3.] [If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the mail service [Prescription Drug] [Copayment] [,] [and] [or] [Prescription Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurnace][,] [and] [or] [Contracted Rate]for that Brand Name Drug, as shown in the [Benefit Summary] [Drug List], plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]

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

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

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

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

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

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

[We reserve the right to limit Covered Charges under this Outpatient Prescription Drug Benefits section to a single Participating Pharmacy to help ensure that quality services are provided to You [and Your Covered Dependents].]]
RXP: 010.001.001.GE

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

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

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

[For the purpose of the Coordination of Benefits section, the Outpatient Prescription Drug Benefits section will be considered a separate Plan and will be coordinated only with other Prescription Drug coverage. We will not provide any benefits for Prescription Drug charges that are paid by another Plan as the primary payor.]

[The Covered Person is responsible for any Prescription Drug] [Coinsurance,][,] [and] [or] [Prescription Drug] [Copayment][,] [and] [or] [Prescription Drug] [Deductible] that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen or Prescription Order. These charges will not be reimbursed by Us.]]]
RXP: 015.001.001.GE

[[IX.] [LIFE INSURANCE BENEFITS]

[The life insurance benefit[s] listed in this section [is] [are] optional.] The Benefit Summary will indicate if [any of] the [optional] coverage[s] listed in this section [is] [are] included in this plan for any Covered Persons. We will pay benefits for the [optional] life insurance benefit[s] that [is] [are] covered under this plan up to the maximum amount shown in the Benefit Summary. Benefits are not subject to any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] or any other fees under this plan. Benefits paid under this section will not be applied to the Maximum Lifetime Benefit. However, benefits are subject to all the other applicable terms, limits and conditions in this plan.

This plan provides coverage only for the following life insurance benefit[s] that [is] [are] purchased by You [and any Covered Dependents]:

[**Term Life Insurance**
[We will pay the term life insurance benefit to the Beneficiary if We receive proof of the Covered Person's death.] [We reserve the right to have an autopsy done where it is not prohibited by law before benefits are considered.]

[At age 65, the term life insurance coverage [terminates] [is reduced to [65%] of the original amount of term life insurance coverage that the Covered Person had on the Effective Date].] [On the date [term life insurance coverage] [any of the [optional] coverage[s] listed in this section] end[s] for the Certificate Holder, that coverage will also end for any Covered Dependents.]]

[Payment will be made to the designated Beneficiary.] If there is no surviving Beneficiary, payment will be made to the Covered Person's estate. The Beneficiary designation should be kept up-to-date so that benefits will be paid as the Covered Person wants them to be paid. The Beneficiary may be changed by sending Us written notice. No change is effective until We receive written notice. If the Covered Person would like a payment option other than lump sum, please contact Us.]

[Once an amount equal to the term life insurance benefit has been paid for a Covered Person, no other benefits are available for that Covered Person under this provision.]]

[**Accelerated Benefit**
We will pay an accelerated benefit for a Covered Person who has a terminal illness if all of the following requirements are met:

1. A claim for the accelerated benefit is sent to Us.

2. The Covered Person has a condition which will cause his or her life expectancy to be [12 months] or less.

3. We receive proof and a certification from a Health Care Practitioner that objectively documents the presence of a terminal illness and provides a prognosis that the Covered Person has [12 months] or less to live. The Health Care Practitioner cannot be a Covered Person, an Immediate Family Member[, employer of a Covered Person] or a person who ordinarily resides with a Covered Person.]

Payment of the accelerated benefit will be subject to any irrevocable Beneficiary designation or prior assignment of the term life insurance benefit under this plan. We will make only one accelerated benefit payment during each Covered Person's lifetime. [We reserve the right to obtain a second opinion from a Health Care Practitioner at Our expense before benefits are considered.]

Following payment of the accelerated benefit, the maximum amount for the term life insurance coverage will be reduced by an amount equal to the amount that is paid for the accelerated benefit. A new Benefit Summary will be sent to You reflecting the new benefit amount for the term life insurance coverage. Premium payments must be continued for the full amount of the term life insurance coverage that the Covered Person had prior to receiving the accelerated benefit payment.

Receipt of an accelerated benefit may be a taxable event. You may want to consult a tax advisor about any potential income tax consequences.]

[**Accidental Death Benefit**
We will pay an Accidental death benefit to the Beneficiary if all of the following requirements are met:

1. We receive proof of the Covered Person's death.

2. The proof shows that death resulted directly from bodily Injury caused solely as a result of an Accident and independent of disease, physical condition, bodily infirmity or any other cause.

3. Death occurred within the first [180 days] after the Covered Person's Effective Date.

The maximum accidental death benefit amount is in addition to the term life insurance coverage amount. [We reserve the right to have an autopsy done where it is not prohibited by law before benefits are considered.]]

[**Termination of Coverage**
The Certificate Holder's life insurance coverage terminates on the earliest of the date as determined in accordance with the termination date of this plan or the date of renewal occurring on or after his or her [65th] birthday. Dependent life insurance coverage terminates on the earliest of the date as determined in accordance with the termination date of this plan, or the date the Certificate Holder's life insurance coverage ceases, or, if a Covered Dependent spouse [or Domestic Partner], the date of renewal occurring on or after his or her [65th] birthday or the date on which the Certificate Holder and Covered Dependent spouse [or Domestic Partner] become legally divorced.]

[**General Provisions**
With the exception of the Extension of Benefits provision and the provisions stated below, this coverage is subject to applicable provisions in this plan, including the Eligibility and Effective Date of Certificate Holder, Eligibility and Effective Date of Dependents, termination date of this plan and Misstatements provisions. Nothing will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations in this plan, other than as stated in this Life Insurance Benefits section.

For purposes of this Life Insurance Benefits section only, the Assignment, Incontestability and Entire Plan provisions below are added.]

[**Assignment**
A Covered Person's right to benefits under this Life Insurance Benefits section is assignable. A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment. We are not responsible for the validity or effect of any assignment of life insurance benefits.]

[**Incontestability**
In the absence of fraud, all statements made on the enrollment form will be deemed representations and not warranties. Except for nonpayment of premium, no statement made in any enrollment form shall be used to void coverage after coverage has been in force for 2 years. In the event of the Covered Person's death or incapacity, no statement made in any enrollment form shall be used to void the coverage unless a copy of the enrollment form is furnished to the Covered Person's beneficiary or personal representative. This provision does not preclude defenses based upon provisions relating to eligibility.]

[**Entire Plan**
The entire agreement is made up of the group master Policy, a Covered Person's enrollment form, the certificate of insurance and any riders and endorsements. A copy of the enrollment form shall be included when the certificate is issued. All statements made by the group master Policyholder are considered to be representations, not warranties. This means that the statements are considered to have been made in good faith. No statement will void this certificate unless it is contained in a written enrollment form and a copy is furnished to the person making such statement.

For purposes of this Life Insurance Benefits section only, the Reinstatement provision is revised as follows:

Death occurring between the date the coverage lapses and coverage is reinstated will not be covered.]]
LIF: 005.001.GE

[**Life Insurance Conversion Privilege**
You have the right to convert Your life benefit to a life benefit conversion plan if Your life insurance coverage under the group Policy ceases due to termination of membership in the group or the group level eligible for this plan of coverage provided You have been covered under this plan for at least [5] years, or if You are a Covered Dependent and coverage ceases due to death of the Certificate Holder or termination of Your Covered Dependent status when You no longer meet the definition of Dependent in the certificate. Cancellation of this coverage due to non-payment of required premium does not result in a conversion right.

If Your loss of life benefit coverage is due to Your ceasing to be a Covered Dependent, benefits under a converted plan will not be in excess of the benefits under this certificate, without disability or other supplementary benefits. If Your loss of coverage is due to termination of the master group Policy, the maximum amount which can be converted is the lesser of 1) the face amount of Your death benefit under this certificate, or 2) [$2,000]. The amount of conversion coverage available will be reduced by all amounts of group life insurance coverage for which You are eligible within [31] days after termination of this coverage.

You must submit a written enrollment form and the required premium to Us within [31] days after coverage under this plan terminates to elect the life benefit conversion coverage. Evidence of insurability will not be required, however, rates may be affected.

If written enrollment is not made within [31] days following the termination of insurance under this plan, conversion coverage may not be available. If You have not received notice of the conversion privilege at least [15] days prior to the expiration of the [31] day conversion period, then You have an additional period within which to exercise the privilege. This additional period shall expire [15] days after You receive the conversion rights notice, but in no event shall the period extend beyond [60] days after the expiration of the initial [31] day conversion election period.

If written enrollment is not made within the timeframes specified above following the termination of life insurance under this plan, life conversion coverage will not be available.

If the life conversion election requirements are met, the conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates.

Type of Conversion Policy Available
The converted plan may be on any plan of life insurance then customarily offered by Us to individuals respective to the applicant's age and for the amount applied for, except plans of term life insurance. We will not include any supplementary benefits with the converted plan.

Death Benefit during Conversion Election Period
A death benefit will be paid to the Covered Person's Beneficiary if the Covered Person is entitled to a conversion right under this Rider, and dies within the conversion election period.

The death benefit will be the maximum amount of Life Insurance that the Covered Person could have converted. This amount will be paid whether or not the person applied for conversion life coverage or paid the first premium.]
LIF: 010.001.001.GE

[[**X.**] [**EXCLUSIONS**]

We will not pay benefits for any of the following:
EXC: 005.002.GE

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

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

EXC: 010.001.GE

[2.] [Charges for treatment of [Behavioral Health] [or] [Substance Abuse][, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement][, except as otherwise covered in the [Behavioral Health provision] [or] [Substance Abuse provision] [Behavioral Health and Substance Abuse provision] in the Medical Benefits section].]
EXC: 015.001.GE

[3.] [Charges that are related to or a complication of a Pre-Existing Condition.]
EXC: 020.001.GE

[4.] [Charges that:

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

EXC: 025.001.GE

[5.] [Charges that are:

[a.] [Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law.] [If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, the benefits under this plan will be reduced by any amount that would have been reimbursed by Medicare.]
[b.] [Payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California).]

[c.] [For free treatment provided in a federal, veteran's, state or municipal medical facility.]
[d.] [For free services provided in a student health center.]
[e.] [For services that a Covered Person has no legal obligation to pay or for which no charge would be made if the Covered Person did not have a health plan or insurance coverage.]]

EXC: 030.001.GE

[6.] [Charges for work-related Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits.] [Sickness or Injury that arises out of, or is the result of, any work for wage or profit.] [This exclusion will not apply to any of the following:

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

EXC: 035.001.GE

[7.] [Charges for which a Covered Person is entitled to payment under any motor vehicle medical payment or premises medical expense coverage. Coverage under this plan is secondary to medical payment or medical expense coverage available to the Covered Person, regardless of whether such other coverage is described as secondary, excess or contingent.]

EXC: 040.001.GE

[8.] [Charges caused by or contributed to by:

[a.] [War or any act of war, whether declared or undeclared.]
[b.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces].]
[c.] [Foreign [or domestic] acts of terrorism that result in a nationwide epidemic.]]

EXC: 045.001.GE

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

EXC: 050.001.GE

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

EXC: 055.001.GE

[11.] [Charges for foot conditions including, but not limited to, expenses for:

[a.] [Flat foot conditions.]
[b.] [Foot supportive devices, including orthotics and corrective shoes.]
[c.] [Foot subluxation treatment.]

[d.] [Care of corns; [bunions, except capsular or bone surgery;] calluses; toenails, except for ingrown toenails; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.]
[e.] [Hygienic foot care that is routine[, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section].]]

EXC: 060.001.GE

[12.] [Charges for: [dental care that is routine;] [dental charges;] [bridges, crowns, caps, dentures, dental implants or other dental prostheses;] [dental braces or dental appliances;] [extraction of teeth;] [orthodontic charges;] [odontogenic cysts;] [any other expenses for treatment or complications of the teeth and gum tissue[, except as otherwise covered in the Dental Services provision in the Medical Benefits section].]]

EXC: 065.001.GE

[13.] [Charges for treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction[, except as otherwise covered in the Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction provision in the Medical Benefits section, that include, but are not limited to:

[a.] [Any electronic diagnostic modalities.]
[b.] [Occlusal analysis.]
[c.] [Muscle testing].]]

EXC: 070.001.GE

[14.] [Charges for any appliance, medical or surgical expenses for:]

[a.] [Malocclusion or protrusion or recession of the mandible.]
[b.] [Maxillary or mandibular hyperplasia.]
[c.] [Maxillary or mandibular hypoplasia.]]

EXC: 075.001.GE

[15.] [Charges for: [any diagnosis, supplies, treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity [or morbid obesity], whether or not weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions;] [weight reduction] [or] [weight control surgery, treatment or programs;] [any type of gastric bypass surgery;] [suction lipectomy;] [physical fitness programs,] [exercise equipment] [or] [exercise therapy][, including health club membership fees or services;] [nutritional counseling][, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section].]

EXC: 080.001.GE

[16.] [Charges for Transplant services that are:

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

EXC: 085.001.GE

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

EXC: 090.001.GE

[18.] [Charges for:

[a.] [Hemorrhoids,] [hernia[, except as otherwise covered in the Medical Benefits section],] [varicose veins] [or] [spider veins].]

[b.] [Tonsils or adenoids[, except on an Emergency basis].]

EXC: 095.001.GE

[19.] [Charges for revision of breast surgery for capsular contraction, removal or replacement of a prosthesis or augmentation [or reduction] mammoplasty, except as otherwise covered in the Reconstructive Surgery provision in the Medical Benefits section.]

EXC: 100.001.GE

[20.] [Charges for prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.]

EXC: 105.001.GE

[21.] [Charges for:

[a.] [A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse or massage therapist; a rolfer; a home health aide or personnel with similar training and experience; a stand-by Health Care Practitioner] [, except as otherwise covered in the Outpatient Physical Medicine Services provision in the Medical Benefits section].]

[b.] [Home Health Care.]

[c.] [Treatment or services provided by a chiropractor.]

[d.] [Custodial Care; [respite care; rest care; supportive care;] homemaker services.]

[e.] [A Health Care Practitioner who is not properly licensed or authorized in the state where services are rendered.]

[f.] [[Phone consultations;] [internet consultations;] [e-mail consultations;] [Telemedicine Services;] [Telehealth Services].]

[g.] [Health Care Practitioner administrative expenses including, but not limited to, expenses for claim filing, contacting utilization review organizations or case management fees.]

[h.] [Missed appointments.]

[i.] [Sales tax; gross receipt tax.]

[j.] [Living expenses; travel; transportation[, except as otherwise covered in the [Professional Ground [or Air] Ambulance Services provision,] [Medical Evacuation Services provision,] [Repatriation Services provision] [or] [Transplants provision] in the Medical Benefits section].]

[k.] [Treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.]]

EXC: 110.001.001.GE

[22.] [Charges for:

[a.] [Adjustments and manipulations.]

[b.] [Massage therapy.]

[c.] [Subluxation treatment and/or services.]

EXC: 115.001.GE

[23.] [Charges for growth hormone therapy[, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth][, except as otherwise covered in the Growth Hormone Therapy Services provision in the Medical Benefits section].]

EXC: 120.001.GE

[24.] [Charges related to [maternity or pregnancy,] [or] [routine well newborn care including nursery charges at birth,] [or] [non-spontaneous abortion][, except as otherwise covered in the Maternity Care Services provision] [or] [Complications of Pregnancy provision in the Medical Benefits section] [or a maternity rider to this plan].]

EXC: 125.001.AR

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

EXC: 130.001.GE

[26.] [Charges for:

[a.] [Genetic testing or counseling, genetic services and related procedures for screening purposes [including, but not limited to, amniocentesis and chorionic villi testing].]

[b.] [Infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any treatment to promote conception.]

[c.] [Sterilization.]

[d.] [Family planning.]

[e.] [Cryopreservation of sperm or eggs.]

[f.] [Surrogate pregnancy.]

[g.] [Fetal surgery, treatment or services.]

[h.] [Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury.]

[i.] [Circumcision.]]

EXC: 135.001.GE

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

EXC: 140.001.GE

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

EXC: 150.001.GE

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

EXC: 155.001.GE

[30.] [Charges for: [behavior modification or behavioral (conduct) problems;] [learning disabilities;] [developmental delays;] [attention deficit disorders;] [educational testing, training or materials;] [cognitive enhancement or training;] [vocational or work hardening programs;] [transitional living].]
EXC: 160.001.GE

[32.] [Charges for services provided by or through a school system.]
EXC: 165.001.GE

[33.] [Charges for preventive care[, except as otherwise covered in the Preventive Medicine Services provision in the Medical Benefits section.]]
EXC: 170.001.GE

[34.] [Charges for:

[a.] [Non-medical items, self-care or self-help programs.]
[b.] [Aroma therapy.]
[c.] [Meditation or relaxation therapy.]
[d.] [Naturopathic medicine.]
[e.] [Treatment of hyperhidrosis (excessive sweating).]
[f.] [Acupuncture; biofeedback; [neurotherapy;] electrical stimulation; or Aversion Therapy.]
[g.] [Inpatient treatment of chronic pain disorders.]
[h.] [Family or marriage counseling.]
[i.] [Applied behavior therapy treatment for autistic spectrum disorders.]
[j.] [Smoking cessation.]
[k.] [Snoring.]
[l.] [The treatment or prevention of hair loss.]
[m.] [Change in skin pigmentation.]
[n.] [Stress management.]]
EXC: 175.001.001.GE

[35.] [Charges for treatment or services required due to an Injury sustained [in operating a motor vehicle] while the Covered Person's blood alcohol level, as defined by law, [was [.08] or higher][, exceeded the blood alcohol level otherwise permitted by law or violated legal standards] [for a person operating a motor vehicle in the state where the Injury occurred]. [This exclusion applies whether or not [the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not] the Covered Person is [charged with] any violation in connection with the Accident.]]
EXC: 180.001.GE

[36.] [Charges for: [drugs that have not been fully approved by the FDA for marketing in the United States;] [drugs limited by federal law to investigational use;] [drugs that are used for Experimental or Investigational Services, even when a charge is made;] [drugs with no FDA-approved indications for use;] [FDA approved drugs used for indications, dosage or dosage regimens or administration outside of FDA approval; except for drugs recognized for the treatment of the specific type of cancer for which the drug has been prescribed in the American Medical Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network Drugs and Biologics Compendium, the Elsevier Gold Standard's Clinical Pharmacology, or the drug has been recognized as safe and effective for

treatment of that specific type of cancer in 2 articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature;] [drugs that are undergoing a review period, not to exceed [12 months], following FDA approval of the drug for use and release into the market;] [drugs determined by the FDA as lacking in substantial evidence of effectiveness for a particular condition, disease or for symptom control.]]

EXC: 185.001.AR

[37.] [Charges for a Sickness or an Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

EXC: 190.001.GE

[38.] [Charges for treatment or services Incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged[, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.]]

EXC: 195.001.GE

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

EXC: 200.001.GE

[40.] [Charges for treatment or services required due to Injury received while engaging in any hazardous activity [that would not be the Covered Person's primary occupation], including[, but not limited to,] the following: [Participating,] [or] [instructing,] [or] [demonstrating,] [or] [guiding] [or] [accompanying others] in [parachute jumping,] [or] [hang-gliding,] [or] [bungee jumping,] [or] [flight in an aircraft other than a regularly scheduled flight by an airline,] [or] [racing any [motorized] [or non-motorized vehicle,] [or] [operating a motorcycle,] [or] [operating an all-terrain vehicle,] [or] [rock or mountain climbing,] [or] [hunting,] [or] [[professional] [or semi-professional] [contact] sports of any kind]. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity[, unless otherwise noted as a Covered Charge in this plan].]

EXC: 205.001.GE

[41.] [Drugs administered or dispensed by a Health Care Practitioner, who is not a Participating Pharmacy [or Specialty Pharmacy Provider][, unless authorized by Us under the Medical

Benefits section before they are dispensed];] [drugs consumed, injected or otherwise administered at the prescribing Health Care Practitioner's office[,unless otherwise noted as a Covered Charge in the Medical Benefits section].]]

EXC: 210.001.GE

[42.] [Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is [a Covered Person,] an Immediate Family Member, [employer of a Covered Person] or a person who ordinarily resides with a Covered Person.] [Services provided by the Covered Person's Immediate Family Member, an employer, or anyone residing with the Covered Person.]

EXC: 215.001.GE

[43.] [Charges for any amount in excess of the Maximum Lifetime Benefit or any other maximum benefit for covered services.]

EXC: 220.001.GE

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

[a.] [Charges in excess of the Maximum Allowable Amount, [as determined by Us under this plan] [except as otherwise shown in the Benefit Summary].]

[b.] [Charges that are not Medically Necessary.]]

EXC: 225.001.GE

[45.] [Charges Incurred for Experimental or Investigational Services.]

EXC: 230.001.GE

[46.] [Charges Incurred outside of the United States, unless traveling for pleasure or business and the services would have been covered under this plan if the services had been received in the United States.] [Charges Incurred outside of the United States, unless the services would have been covered under this plan if the services had been received in the United States.] [Charges Incurred outside of the United States, except for services that are received for Emergency Treatment.] [Charges Incurred outside of the United States or its possessions or Canada[, unless the optional Travel Benefit is in effect as shown in the Benefit Summary] [except as otherwise covered in the [Medical Evacuation Services provision] [or] [Repatriation Services provision] in the Medical Benefits section]. [Charges Incurred outside of the United States.]]

EXC: 235.001.GE

[47.] [Charges for drugs obtained from pharmacy provider sources outside the United States, except as otherwise covered in the [International Coverage,] [Travel Benefit,] [or] [World Wide Coverage] provision[s] in the Medical Benefits section.]

EXC: 240.001.001.GE

[48.] [Charges for Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury[, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury].]

EXC: 245.001.GE

[49.] [Charges related to Health Care Practitioner assisted suicide.]

EXC: 250.001.GE

[50.] [Charges for vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner] [except for:] [a) Legend prenatal vitamin Prescription Drugs if the Covered Person has the [optional] Maternity Care Services provision in the Medical Benefits section coverage in effect, as shown in the Benefit Summary, and the prenatal vitamins are prescribed during pregnancy][; or] [b) Clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake].]
EXC: 255.001.GE

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

[a.] [Herbal or homeopathic medicines or products.]
[b.] [Minerals.]
[c.] [Health and beauty aids.]
[d.] [Batteries.]
[e.] [Appetite suppressants.]
[f.] [Dietary or nutritional substances or dietary supplements.]
[g.] [Nutraceuticals.]
[h.] [Tube feeding formulas and infant formulas.]
[i.] [Medical foods.]]
EXC: 260.001.GE

[52.] [Charges for cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry, except following cranial surgery.]
EXC: 265.001.GE

[53.] [Charges for: [home traction units;] [home defibrillators;] [or other medical devices designed to be used at home[, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section]].]
EXC: 270.001.GE

[54.] [Charges for: [Durable Medical Equipment;] [Personal Medical Equipment].]
EXC: 275.001.GE

[55.] [Charges for: [Diagnostic Imaging services;] [laboratory services].]
EXC: 280.001.GE

[56.] [Charges for a temporary interim prosthesis.]
EXC: 285.001.GE

[57.] [Charges for: [[any injectable medications] [or] [Specialty Pharmaceuticals] that are not specifically authorized by Us under the [Medical Benefits section] [or] [Outpatient Prescription Drug Benefits section];] [any administrative charge for drug injections].]
EXC: 290.001.GE

[58.] [Charges for: [drugs administered or dispensed by a Health Care Practitioner, who is not a Participating Pharmacy [or Specialty Pharmacy Provider], unless authorized by Us before they are dispensed;] [drugs consumed, injected or otherwise administered at the prescribing Health Care Practitioner's office;] [drugs dispensed at or by a Health Care Practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the Covered Person;]

[drugs dispensed at a Pharmacy that is not a [Mail Service Prescription Drug Vendor,] [Participating Pharmacy,] [or] [Specialty Pharmacy Provider;] [Specialty Pharmaceuticals that are dispensed and/or distributed through a provider that is not a [Participating Pharmacy] [or] [Specialty Pharmacy Provider];] [amounts above the Contracted Rate for Participating Pharmacy [or Specialty Pharmacy Provider] reimbursement;] [the difference between the cost of the Prescription Order at a Non-Participating Pharmacy and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy [or Specialty Pharmacy Provider] been used;] [Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by Us before they are dispensed;] [injectable Prescription Drugs [or Specialty Pharmaceuticals], unless authorized by Us before they are dispensed;] [any administrative charge for drug injections or administrative charges for any other drugs;] [drugs dispensed by a Non-Participating Pharmacy, except when needed for Emergency Treatment].]

EXC: 295.001.GE

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

EXC: 300.001.001.GE

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

EXC: 325.001.GE

[1.] [Charges for that part of any Prescription Order exceeding a [15 consecutive day] supply per Prescription Order.] [Charges for that part of any Prescription Order exceeding a [90 consecutive day] supply if the Prescription Drug is dispensed through a Mail Service Prescription Drug Vendor.]

EXC: 330.001.GE

[2.] [Charges for that part of any Prescription Order exceeding [3 vials] or a [15 consecutive day] supply of one type of insulin.] [Charges for that part of any Prescription Order exceeding [9 vials] or a [90 consecutive day] supply if it is dispensed through a Mail Service Prescription Drug Vendor.]

EXC: 335.001.GE

[3.] [Charges for that part of any Prescription Order exceeding [100] disposable insulin syringes or needles, [100] disposable blood/urine/glucose/acetone testing agents or [100] lancets or a [15 consecutive day] supply.] [Charges for that part of any Prescription Order exceeding [300] disposable blood/urine/glucose/acetone testing agents or [300] lancets or a [90 consecutive day] supply if the supplies are dispensed through a Mail Service Prescription Drug Vendor.]

EXC: 340.001.GE

[4.] [Charges for drugs that are paid under another Plan sponsor or payor as primary payor.]
EXC: 345.001.GE

[5.] [Charges for drugs that are not listed in a Drug List.] [Charges for any Ancillary Charge or any difference between the cost of the Prescription Order at a Non-Participating Pharmacy and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy [or Specialty Pharmacy Provider] been used.]
EXC: 350.001.GE

[6.] [Charges for [contraceptive drugs] [or devices] [oral contraceptives] [,except as [otherwise covered in the Family Planning Services provision in the Medical Benefits section] [or as] [required by law]].]
EXC: 355.001.GE

[7.] [Charges for Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed.] [Charges for any injectable Prescription Drugs [or Specialty Pharmaceuticals], unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed.] [Any administrative charge for drug injections or administrative charges for any other drugs.]
EXC: 360.001.GE

[8.] [Charges for devices or supplies including, but not limited to, blood/urine/glucose/acetone testing devices, needles and syringes, support garments, bandages and other non-medical items regardless of intended use, except as described under a Prescription Order.]
EXC: 365.001.GE

[9.] [Charges for over-the-counter (OTC) medications that can be obtained without a Health Care Practitioner's Prescription Order, except for injectable insulin;] [or] [drugs that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us[, unless specifically authorized for coverage] [by Us] [on Our Drug List].]
EXC: 370.001.GE

[10.] [Charges for drugs that are not considered Generic Drugs including, but not limited to, [Brand Name Drugs,] [Compounded Medication] [or] [Specialty Pharmaceuticals].]
EXC: 375.001.GE

[11.] [Charges for: [Compounded Medications that contain one or more active ingredients that are not covered under this plan;] [combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this plan;] [combination drugs or drug products that are manufactured and/or packaged together, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed.]]
EXC: 380.001.GE

[12.] [Charges for: [Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order;] [prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order;] [amounts in excess of the Generic Drug prescription cost;] [amounts in excess of the Reference Price for a Prescription Drug or Prescription Drug Class;] [amounts above the Contracted Rate for Participating Pharmacy [or Specialty Pharmacy Provider] reimbursement].]
EXC: 385.001.GE

[13.] [Charges for: [drugs administered or dispensed by an Acute Medical Facility, rest home, sanitarium, extended care facility, convalescent care facility, Subacute Rehabilitation Facility or similar institution;] [drugs administered or dispensed by a Health Care Practitioner, who is not a Participating Pharmacy [or Specialty Pharmacy Provider], unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed;] [drugs consumed, injected or otherwise administered at the prescribing Health Care Practitioner's office;] [drugs that are dispensed at or by a Health Care Practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the Covered Person;] [drugs dispensed by a Non-Participating Pharmacy, except when needed for Emergency Treatment].]
EXC: 390.001.GE

[14.] [Charges for: [any drug used for Cosmetic Services as determined by Us;] [drugs used to treat onychomycosis (nail fungus);] [botulinum toxin and its derivatives].]
EXC: 395.001.GE

[15.] [Charges for: [drugs prescribed for dental services, or unit-dose drugs;] [drugs used in the treatment of chronic fatigue or related syndromes or conditions;] [drugs containing nicotine or its derivatives].]
EXC: 400.001.GE

[16.] [Charges for DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a Covered Person under the age of [8].]
EXC: 405.001.GE

[17.] [Charges for Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne, rosacea or related conditions for a Covered Person age [30 or older].]
EXC: 410.001.GE

[18.] [Charges for: [duplicate prescriptions;] [replacement of lost, stolen, destroyed, spilled or damaged prescriptions;] [prescriptions refilled more frequently than the prescribed dosage indicates.]]
EXC: 415.001.GE

[19.] [Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: [smoking deterrence or cessation;] [athletic performance;] [body conditioning, strengthening, or energy;] [prevention or treatment of hair loss;] [prevention or treatment of excessive hair growth or abnormal hair patterns].]
EXC: 420.001.GE

[20.] [Charges for drugs used to treat, impact or influence: [obesity;] [morbid obesity;] [weight management;] [sex transformation;] [gender dysphoric disorder;] [gender reassignment;] [sexual function, dysfunction or inadequacy;] [sexual energy, performance or desire;] [skin coloring or pigmentation;] [social phobias;] [slowing the normal processes of aging;] [memory improvement or cognitive enhancement;] [daytime drowsiness;] [overactive bladder;] [dry mouth;] [excessive salivation;] [or] [hyperhidrosis (excessive sweating)].]
EXC: 425.001.GE

[21.] [Charges for: [drugs used for Inpatient or Outpatient treatment of [Behavioral Health] [or] [Substance Abuse] [that exceed the maximum limit shown in the Benefit Summary for coverage under the [Behavioral Health provision] [or] [the Substance Abuse provision] [in the Medical Benefits section];]] [drugs used to treat hyperactivity, attention deficit and related disorders].]
EXC: 430.001.GE

[22.] [Charges for drugs or drug categories that exceed any maximum benefit limit under this plan.]
EXC: 435.001.GE

[23.] [Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition[, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed].]
EXC: 440.001.GE

[24.] [Charges for prescriptions, dosages or dosage forms used for the convenience of the Covered Person or the Covered Person's Immediate Family Member or Health Care Practitioner.]
EXC: 445.001.GE

[25.] [Drug charges Incurred outside of the United States;] [charges for drugs obtained from pharmacy provider sources outside the United States, except for Covered Charges that are received for Emergency Treatment.]
EXC: 450.001.GE

[26.] [Charges for: postage, handling and shipping charges for any drugs.]
EXC: 455.001.GE

[27.] [Charges for drugs prescribed by a [Non-[Select] Participating Provider] [or a] [[Non-Network] [Non-Participating] Provider];] [Charges for drugs dispensed at a Pharmacy that is a [Non-Participating] Pharmacy] [or a] [Specialty Pharmacy Provider].] [Charges for drugs dispensed at a Pharmacy that is not a [Mail Service Prescription Drug Vendor,] [Participating Pharmacy,] [or] [Specialty Pharmacy Provider].]
EXC: 460.001.GE

[28.] [Charges for Prescription Maintenance Drugs that are dispensed through a provider that is not a Mail Service Prescription Drug Vendor.] [Charges for Specialty Pharmaceuticals that are dispensed and/or distributed through a provider that is not a [Participating Pharmacy] [or] [Specialty Pharmacy Provider].]

EXC: 465.001.GE

[29.] [Charges for: [vaccines and other immunizing agents;] [biological sera;] [blood or blood products].]
EXC: 470.001.GE

[30.] [Charges for drugs for which prior authorization is required by Us and is not obtained.]
EXC: 475.001.GE

[31.] [Prescription Drugs previously classified with non-prescription status.]]
EXC: 485.001.GE

[**The following additional exclusions apply only to the Life Insurance Benefits section.**

We will not pay term life insurance benefits for death caused by any of the following:

[1.] [War or any act of war[, whether declared or undeclared.]

[2.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces.]

[3.] [[Suicide,] attempted suicide or self-inflicted Sickness or Injury[, while sane or insane,] [even if the Covered Person did not intend to cause the harm which resulted in death from the action which led to the self-inflicted Sickness or Injury].] [Attempted suicide or self-inflicted Injury, during the first two years coverage is in force.]

[4.] [Taking part in a riot or insurrection, or an act of riot or insurrection.]

[5.] [Participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]

[6.] [Voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

[7.] Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.

[8.] [Intoxication that includes, but is not limited to, operating a motor vehicle while intoxicated. Intoxication and intoxicated mean that the Covered Person's blood alcohol level at the time of the incident exceeded the blood alcohol level otherwise permitted by law or violates legal standards [for a person operating a motor vehicle] in the state where death occurs.]

We will not pay benefits under the Accidental Death Benefit provision for death caused directly from any of the following:

[1.] [War or any act of war, whether declared or undeclared.]

[2.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces.]

[3.] [[Suicide,] attempted suicide or self-inflicted Sickness or Injury[, while sane or insane,] [even if the Covered Person did not intend to cause the harm which resulted in death from the action which led to the self-inflicted Sickness or Injury].]

[4.] [Taking part in a riot or insurrection, or an act of riot or insurrection.]

[5.] [Participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]

[6.] [Voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

[7.] [Injury while riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]

[8.] [Injury while acting as pilot, student pilot, crew member, flight instructor, or examiner on any aircraft.]

[9.] [Voluntarily taking, absorbing, or inhaling any gas, poison or drugs.]

[10.] [Disease, other than bacterial infection, occurring through an Accidental injury, or medical or surgical treatment of disease or infirmity.]]

EXC: 480.001.GE

[[**XI.**] [**PRE-EXISTING CONDITIONS LIMITATION**]

PRX: 005.002.GE

[**Pre-Existing Conditions Limitation**
We will not pay benefits under this plan for an otherwise Covered Charge that is related to a Pre-Existing Condition until the Covered Person has been continuously covered under this plan for [12 months]. [A condition that has been specifically excluded from coverage will continue to be excluded after [12 months] of continuous coverage].]
PRX: 010.002.GE

[**Credit for Deductible**
For a Covered Person who was covered under a prior plan on the day that plan was replaced by Our policy, We will credit [the full amount] [a partial amount] that was Incurred and applied to the Covered Person's deductible under the prior plan for the same Calendar Year under this plan. A Covered Person must provide Us with proof of the deductible amount that was satisfied under the prior plan.]]
PRX: 020.001.GE

[[XII.] [COORDINATION OF BENEFITS (COB)]

[You [or Your Covered Dependents] may have insurance coverage under more than one Plan. If benefits are available through any other Plan, We will take those benefits into account in calculating the amount of Covered Charges that may be payable by Us so that benefits from both Us and any other Plan are limited to the actual charges Incurred.

If a Covered Person is entitled to benefits provided by another Plan but does not claim them, We will consider the benefits to which a Covered Person is entitled as benefits that were provided. All claims should be submitted to Us and all other Plans at the same time so that proper benefits can be determined and paid.]

[**Definitions**
In addition to any specific terms that are defined under the Definitions [for Medical and Outpatient Prescription Drug Coverage] section, the following capitalized terms have the meanings given below:

[1.] [**Allowable Charge:** An Allowable Charge is any charge which is a Covered Charge under this plan and is, at least in part, covered under any other Plan. If a Plan provides benefits in the form of services rather than cash payments, We will determine a reasonable cash value for each service that is provided and that cash value will be considered the Allowable Charge and the amount paid by the other Plan. The difference between an Acute Medical Facility's semi-private room rate and private room rate is not an Allowable Charge unless the private room is Medically Necessary. Benefit reductions due to failure to comply with Plan provisions of the Primary Plan are not an Allowable Charge. [If both the Primary Plan and the Secondary Plan have contractual discount arrangements, the Allowable Charge will be determined by applying the greater of the two discounts.]]

[2.] [**Coordination of Benefits (COB):** Coordination of Benefits (COB) means that benefits are paid so that no more than 100% of the Allowable Charges for which the Covered Person is liable will be covered under the combined benefits received from all Plans.]

[3.] [**Insured:** The person in whose name the Plan is in force.]

[4.] [**Plan:** Any Plan which provides medical [or dental] benefits or services including, but not limited to:

[a.] [Group,] [blanket] [or] [franchise] insurance [that provides major medical benefits].]
[b.] [Group-type insurance which can be obtained and maintained only as the result of membership in or connection with a specific group or organization.]
[c.] [A service plan or contract, group or individual practice or other prepayment plan.]
[d.] [Any employer or employee self-insurance plan.]
[e.] [Coverage arranged by or through any trustee, union, employer or association.]
[f.] [The medical or dental benefits coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts (but only where permitted by law) or other medical or dental pay coverage.]
[g.] [Health coverage, whether issued or administered on a group or individual basis.]
[h.] [Group Blue Cross, group Blue Shield, group practice or prepaid group coverage.]
[i.] [Coverage under trust or association plans or plans sponsored by unions, employer groups, or employee benefit groups.]
[j.] [Medical coverage under automobile or no fault insurance, if coordination of benefits with such coverage is allowed by law.]]

[Plan does not include any of the following:

[a.] [An accident insurance plan.]

[b.] [Medicaid.]
[c.] [A group hospital indemnity insurance plan of [$100] per day or less.]
[d.] [A plan covering only ancillary benefits.]
[e.] [A limited benefit insurance plan.]]

[5.] [**Primary Plan:** A Plan in which benefits must be determined without considering the benefits of any other Plan. A Plan is primary if:

a. The Plan either has no rules for determining the order of benefits or has rules which differ from the rules in this plan; or
b. According to the Order of Benefit Determination provision, the Plan considers its benefits first.]

[6.] [**Secondary Plan:** A Plan in which benefits are determined after the benefits of the Primary Plan have been determined.]

[**How Benefits Are Paid**
If We are the Primary Plan, according to the Order of Benefit Determination provision in this section, We will pay benefits for Covered Charges that would have been paid under this plan without regard to this COB section.

If We are the Secondary Plan, according to the Order of Benefit Determination provision below, We will pay the lesser of:

1. The difference between the Allowable Charge and the amount paid by the Primary Plan; or

2. Benefits for Covered Charges that would have been paid under this plan without regard to this COB section.

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, they do not exceed the total Allowable Charge for any services or equipment.]

[**Order of Benefit Determination**
The Primary Plan and Secondary Plan are determined by using the following rules. Whichever rule below is the first to apply to the Covered Person's situation is the rule that will be used to determine which Plan is the Primary Plan and which is the Secondary Plan.

1. A Plan that does not have a COB provision, or has a provision that differs from this one, pays its benefits first.

2. A Plan that covers the person as the Insured pays its benefits before a Plan that covers the person as a dependent.

3. For a child whose parents are not divorced or separated:

   a. The Plan of the parent whose birthday (month and day only) falls earlier in the year pays its benefits first. It does not matter which parent is older.
   b. If both parents have the same birthday (month and day only), the Plan covering the parent for the longer time period pays its benefits first.
   c. If one Plan has this birthday rule and the other Plan does not and, as a result, the Plans do not agree on the order of benefits, the Plan that does not have the birthday rule pays its benefits first.

4. For a child whose parents are separated or divorced:

   a. If a court decree establishes which parent is responsible for the child's medical or dental expenses, the Plan of that parent pays its benefits before any other Plan that

covers the child as a dependent. This applies only if the Plan has actual knowledge of the terms of the court decree.

b. Otherwise, the Plan of the parent with custody pays its benefits before the Plan of the spouse of the parent with custody; and the Plan of the spouse of the parent with custody pays its benefits before the Plan of the parent without custody.

c. If a court decree establishes joint custody, without stating which one of the parents is responsible for the medical or dental expenses of the child, the Plans covering the child will follow the rules in item 3 above.

5. A Plan that covers the person as the Insured, who is neither laid off nor retired, or as a dependent of such an Insured pays its benefits before those of a Plan covering the person as a laid off or retired Insured or as a dependent of such an Insured. However, if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

6. If a person is covered under a right of continuation pursuant to federal or state law and is also covered under another Plan, the Plan covering the person as the Insured or as a dependent of such an Insured pays its benefits before the Plan providing the continued coverage.

7. If none of the above rules apply, the Plan covering the person for the longer time pays its benefits first.]

[**Rights Under This Section**
We have the right to:

1. Release or obtain claim information from any Plan, individual or entity.

2. Pay Our covered benefits to any Plan or entity which has paid benefits that We should have paid.

3. Recover any overpayment made by Us from the person or entity to whom the payment was made.

We may obtain or release any information needed to carry out the intent of this section. You must inform Us if You [or Your Covered Dependents] have coverage under any other Plans when the Covered Person makes a claim.]]
COB: 005.002.GE

[[XIII.] [CLAIM PROVISIONS]

CLP: 005.002.GE

[**Proof of Loss**

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

We must receive written or electronic notice of the services that were received due to a Sickness or an Injury for which the claim is made. Notice must be provided to Us within [60 days] after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, proof of loss must be sent to Us within [12 months] of the date of loss.

The proof of loss must include all of the following:

1. Your name and [certificate] [or] [policy] number.

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

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

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

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

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

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

CLP: 010.002.GE

[**Right to Collect Information**

To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within [30 days] of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

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

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

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

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

5. Have any examination completed as requested by Us.

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

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.]
CLP: 015.001.GE

[**Physical Examination**
We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits or when authorization is requested under the Utilization Review Provisions section. These exams will be paid by Us. [We also have the right, in case of death, to have an autopsy done where it is not prohibited by law.]]
CLP: 020.001.GE

[**Payment of Benefits**
When We receive due written proof of loss, benefits [for services provided by a [Non-Network] [Non-Participating] Provider] will be paid to the Covered Person [unless they have been assigned to a Health Care Practitioner, facility or other provider]. [Assignment of medical [and Prescription Drug] benefits to Health Care Practitioners, facilities and other providers is only allowed under this plan [if a Negotiated Rate or Contracted Rate is in effect with the provider rendering the services or supplies].] [We pay [Network] [Participating] Providers directly for Covered Charges.] Any benefits unpaid at Your death will be paid at Our option to Your spouse, [Your Domestic Partner,] Your estate or the providers of the services.

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

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

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may

be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.]
CLP: 025.001.GE

[**Rights of Administration**
We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.]
CLP: 035.001.GE

[**Claims Involving Fraud or Misrepresentation**
Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved fraud or misrepresentation, We will be entitled to a refund from You, the Beneficiary or the person receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly file a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.]
CLP: 040.001.GE

[**Claim Appeal**
You have the right to request a review of all adverse claim decisions. A review must be requested in writing within [180 days] following Your receipt of the notice that the claim was denied or reduced.]]
CLP: 045.001.GE

[[XIV.] [PREMIUM PROVISIONS]
PRE: 005.002.GE

[**Consideration**
This plan is issued based on the statements and agreements in the Covered Person's enrollment form, [any exam of a Covered Person that is required, any other amendment or supplements to the enrollment form] and payment of the required premium. [Each renewal premium is payable on the due date [subject to the Grace Period provision in this section].]]
PRE: 010.002.GE

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

[Your premium may be adjusted from time to time based on different factors including, but not limited to, Your [geographic area,] [and] [gender,] [and] [age] [and] [plan design]. All premium adjustments will be made to individuals on the basis of shared characteristics. After Your first year of coverage, You may request a review to reduce Your current premium. If a lower rate is available, a supplemental form may be required and You must meet our eligibility criteria to qualify for a reduced premium.] [The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.]

[The premium will not change during the first [1-12 month[s]] this plan is in force unless You change the coverage[, add or delete Covered Dependents,] or move to another zip code.]
PRE: 015.001.GE

[**Grace Period**
There is a grace period of [31 days] [10 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the unpaid premium was due.

Coverage will continue during the grace period unless You call Our office or give Us written notice to cancel the coverage. If a claim is payable for charges Incurred during the grace period, any unpaid premiums due will be deducted from the claim payment.]
PRE: 025.002.GE

[**Grace Period**
There is a grace period of [31 days] [10 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the unpaid premium was due and no charges Incurred during the grace period will be considered for benefits. If the premium is received during or by the end of the grace period, coverage will continue without interruption.]
PRE: 025.003.GE

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

[1.] [The lapse was not more than [30 days].]

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

[3.] [We approve Your [supplemental] enrollment form for reinstatement.]

The coverage will be reinstated on the date We approve Your enrollment form for reinstatement. [If We have not responded to Your enrollment form for reinstatement by the 45th day after We receive the enrollment form, the coverage will be reinstated on that date.]

[If the coverage is reinstated, loss resulting from an [Injury] [or] [Sickness] will be covered only if the [Injury] [or] [Sickness] is sustained on or after the date of reinstatement.] [Loss due to a Sickness will be covered only if the Sickness begins [more than] [10 days] after the date of reinstatement.] No benefits will be paid for such condition and related complications if during the time between the lapse date and the reinstatement date:

[1.] [Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] regardless of whether the condition was diagnosed or not diagnosed; or]

[2.] [The condition produced signs or symptoms.]

[The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

[a.] [The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or]
[b.] [The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.]

This limitation will apply until coverage has been in force for [12 months] after the reinstatement date, unless the condition has been specifically excluded from coverage.

In addition, death occurring between the lapse date and the reinstatement date will not be covered under the Life Insurance Benefits section.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed[, subject to any provisions included with or attached to this plan in connection with the reinstatement].]]
PRE: 030.001.001.GE

[[XV.] [RECOVERY PROVISIONS]
REC: 005.002.GE

[**Overpayment**
If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You, the Beneficiary or the provider of the medical treatment, services or supplies. We may offset the overpayment against future benefit payments.]
REC: 010.001.GE

[**Subrogation Right**
Subrogation is the process by which We seek reimbursement from another person or entity for a claim We have already paid. When benefits are paid on a Covered Person's behalf under this plan, We are subrogated to all rights of recovery a Covered Person has against any person, entity or other insurance coverage. This includes, but is not limited to, recoveries against:

[1.] [A third party.]

[2.] [Any liability coverage for a third party.]

[3.] [Other insurance that a Covered Person has, including uninsured or underinsured motorist coverage.]

This subrogation right extends to the proceeds of any settlement or judgment but is limited to the amount of benefits We have paid.

A Covered Person must:

1. Do nothing to prejudice or hinder any right of recovery; and

2. Execute and deliver any instruments and papers that may be required by Us; and

3. Cooperate with Us to assist Us in securing Our subrogation rights.

If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with a Sickness or an Injury for which We have paid benefits under this plan, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our subrogation right under this plan. We reserve the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect Our subrogation right.

Upon recovery of any portion of Our subrogation interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs incurred by the Covered Person and/or the Covered Person's attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our subrogation right, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.

If We are precluded from exercising Our subrogation right, We may exercise Our Right to Reimbursement provision in this plan.]

REC: 015.001.GE

[**Right to Reimbursement**
When We pay benefits under this plan, We have the right to recover an amount equal to the amount We paid if the Covered Person:

1. Seeks recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise; and

2. Recovers payment, in whole or in part, from any person, entity or other insurance coverage for the benefits that We previously paid under this plan.

This right to reimbursement extends to the proceeds of any settlement or judgment. This includes, but is not limited to, recoveries against:

[1.] [A third party.]

[2.] [Any liability coverage for a third party.]

[3.] [Other insurance that a Covered Person has, including uninsured or underinsured motorist coverage.]]

Reimbursement to Us will not exceed either the amount of benefits that We paid under this plan which the Covered Person recovered from any other person, entity or other insurance coverage or the amount recovered from any other person, entity or other insurance coverage as payment for the same Sickness or Injury, whichever is less.

You must reimburse Us for any payments that We make prior to a determination as to whether a Sickness or an Injury is work-related at the time that the Covered Person receives payment for the Sickness or Injury from another source. You must agree to:

1. Notify Us of any workers' compensation claim that a Covered Person makes; and

2. Reimburse Us even when workers' compensation benefits are provided by means of a settlement or compromise.

3. Cooperate with Us to assist Us in securing Our right to reimbursement.

The Covered Person must provide Us with timely written notification in the event that he or she suffers a Sickness or an Injury in which a third party might be responsible and the Covered Person seeks recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise.

Such a notice must inform Us of:

1. The nature of the Sickness or Injury; and

2. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Covered Person; and

3. A description of the Accident or occurrence that the Covered Person reasonably believes was responsible for the Sickness or Injury at issue and the approximate date(s) upon which such Accident or occurrence happened; and

4. The name of any legal counsel retained by a Covered Person in connection with any such Accident or occurrence.

If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with any such Accident or occurrence, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our right to reimbursement under this plan. We reserve the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect Our right to reimbursement under this plan.

Upon recovery of any portion of Our right to reimbursement interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs incurred by the Covered Person and/or the Covered Person's attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our right to reimbursement, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.]
REC: 020.001.GE

[**Workers' Compensation Not Affected**
Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.]]
REC: 025.001.GE

[[XVI.] [CONVERSION]

CNV: 005.002.GE

[**Enrollment, Premium and Effective Date for Conversion Coverage**
An eligible person who wants to obtain conversion coverage must submit a written enrollment form and the required premium to Us within [31 days] after coverage under this plan terminates. Evidence of insurability will not be required. However, rates may be affected.

If written enrollment is not made within [31 days] following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates.]
CNV: 005.005.GE

[**Enrollment, Premium and Effective Date for Conversion Coverage**
An eligible person who wants to obtain conversion coverage must submit a written enrollment form and the required premium to Us within [31 days] after coverage under this plan terminates. The plan may provide different benefit levels, covered services and premium rates. Coverage will be provided on a form that We use for providing conversion coverage at that time.

If written enrollment is not made within [31 days] following the termination of insurance under this plan, converting to an individual medical insurance plan may not be permitted.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates.]
CNV: 005.006.GE

[**Covered Dependent Conversion**
A Covered Dependent may be eligible to convert to another plan of medical insurance We offer if:

1. The Covered Dependent's insurance terminates due to a valid decree of divorce between the Certificate Holder and the Covered Dependent; or

2. The Covered Dependent's insurance terminates due to the death of the Certificate Holder; or

3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.]]

CNV: 015.002.GE

[[XVII.] [OTHER PROVISIONS]
OTH: 005.002.GE

[**Certificate Changes**
No change in the certificate will be valid unless approved by one of Our executive officers and included with this certificate. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.]
OTH: 010.002.GE

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

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

The premium charges will be adjusted as required, but not for more than [two years] prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within [60 days] of Our notifying You of the error.]
OTH: 015.002.GE

[**Conformity with State Statutes**
If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.]
OTH: 020.001.GE

Continuation of Coverage
A Covered Dependent may be eligible to continue coverage under this plan after coverage would otherwise terminate due to loss to dependency or change in marital status. The benefits will be the same as those in effect on the date of termination. You must furnish written request for continuation to Us within 10 days after ceasing to be eligible for coverage. The continued coverage will end on the earliest of:

1. full coverage under any other group accident and health policy or contract. This includes being covered for conditions deemed to be pre-existing conditions under that plan;
2. the end of the period for which premiums are paid;
3. the period ending 120 days from the date continuation began;
4. the premium due date following the date the dependent becomes eligible for Medicare;
5. the date coverage under the plan would have otherwise terminated;
6. the date the Life Time Maximum Benefit amount is reached; or
7. the date the Master Group Policy ends.

The individual shall be eligible for conversion after exhaustion of continuation of coverage.
OTH: 021.002.AR

[**Enforcement of Plan Provisions**

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.]
OTH: 025.001.GE

[**Entire Contract**
This certificate is issued to the Certificate Holder]. The entire contract of insurance includes the group [master] Policy, a Covered Person's enrollment form, the Covered Person's certificate of insurance and any riders and endorsements.]
OTH: 030.002.GE

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

Medical documentation verifying the Covered Person's Total Disability must be submitted to Us within [60] days of termination. The extension will end when the Covered Person is no longer Totally Disabled, or at the end of a [365-day] period after the date the Covered Person's coverage terminated, whichever occurs first.]
OTH: 035.001.GE

[**Extension of Benefits** [**for Medical Coverage Only**]
If a Covered Person is Totally Disabled on the date this coverage terminates, We may extend benefits only for Covered Charges Incurred to treat the Sickness or Injury that directly caused the Total Disability provided that the Sickness commenced or the Injury was sustained while this plan was in force. Benefits are subject to all the terms, limits and conditions in this plan. [Premium payment will not be required during the extension of benefits period.] Medical documentation verifying Total Disability must be sent to Us within [60 days] after termination.

The extension will end on the earliest of:

[1.] [The date on which services are no longer required to treat the Sickness or Injury that caused the Total Disability.]

[2.] [The date the Covered Person is no longer Totally Disabled.]

[3.] [Payment of the Maximum Lifetime Benefit or any other maximum benefit for those services under this plan.]

[4.] [[90 days] from the date coverage would have terminated under this plan if there was no extension of benefits.]

[5.] [The date the Covered Person is eligible for Medicare.]

[6.] [The earliest date otherwise permitted by law.]]
OTH: 035.004.GE

[**Incentives, Rebates and Contributions**

[We may elect to furnish [or participate in programs with other organizations that furnish] [group applicants for coverage] [members of groups applying for coverage][individual applicants for coverage][Covered Persons] [individuals] [that meet common criteria or requirements determined by Us] [not to include health or claims history] with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted [or] [where other gifts or items of value may be offered or provided to You at no charge or a discount] [at a time or times] [or] [for a period] determined by Us.]]
OTH: 040.002.GE

[**Deductible Credit Program**
[[Beginning the earlier of the [January 1st –December 31st] [or] [January 1st –December 31st] that next follows the [[30th-365th] [day] [[0-12] [months] after Your Effective Date, You will receive a [5%-20%][$XXX] credit to Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible for each [[0-12]-month] period during which the Deductible less any accumulated credits has gone unsatisfied.] [Each [5%-20%][$XXX] credit will be based on Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [less any accumulated credits].] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits be less than [$XXX].]]

[When Covered Charges equal to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits have been Incurred and processed by Us, the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible will be satisfied for the remainder of that Calendar Year.] [On January 1st of the following Calendar Year, You will return to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible amount, as shown on Your Benefit Summary.]]]

[This Deductible Credit Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.001.GE

[**Deductible Reward Program**
[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied].] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Deductible Reward Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.002.GE

[**Multi Year Deductible**

[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [for a [18-60][-month period] [for the period shown on the benefit summary] [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied].] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Multi Year Deductible Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.003.GE

[**Misstatements**
If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.]
OTH: 045.001.GE

[**Rescission of Insurance and/or Denial of Claim**
[Within the first two years after the Effective Date of coverage,] We have the right to rescind or modify Your certificate of insurance coverage and/or deny a claim for a Covered Person if the enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a certificate of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.
OTH: 055.003.GE

[**Legal Action**
No suit or action at law or in equity may be brought to recover benefits under this plan until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process. No suit or action at law or in equity can be brought later than [3 years] from the date the expenses were Incurred.]
OTH: 060.001.GE

[**Forum**
[Any lawsuits or disputes arising under the terms of the group master Policy must be brought in the United States District Court for the Eastern District of Wisconsin.]
OTH: 065.001.GE

[**Modification of Your Coverage**
[The group master Policy may be changed at any time. We will give the [trust] [Policyholder] [30 days] notice prior to any change.]

[We may modify the health insurance coverage for You [and Your Covered Dependents]. This modification will be consistent with state law and will apply uniformly to all certificates with Your plan of coverage. [You will be notified of any change.]]]]
OTH: 075.001.GE

BENEFIT SUMMARY

[POLICYHOLDER INFORMATION]

[**POLICYHOLDER**]	[Health Advocates Group Insurance **Trust**]
[**LOCATION**]	[**City/State**]

[CERTIFICATE HOLDER] INFORMATION

[**CERTIFICATE HOLDER**] [Dependents]	[John Doe] [Jane Doe] [Mary Doe] [James Doe]
[**CERTIFICATE NUMBER**]	[0000001]
[**EFFECTIVE DATE**] [of this schedule]	[00/00/0000]
[**PLAN ID**] [**PLAN TYPE**]	[Plan name inserted here – CoreMed, MaxPlan, etc.]
[**PARTICIPATING EMPLOYER**]	[ABC Company]
[**GROUP NUMBER**]	[1900AK0000]
[**LOCATION NUMBER**]	[001]
[**BENEFIT PERIOD**]	[35 days]
[**BENEFIT PERIOD TERMINATION DATE**]	[05/05/2006]
[**PAYMENT OPTION**]	[Single Payment][Monthly Payment]
[[**BENEFIT**] **WAITING PERIOD**]	[A Sickness that occurs within the first [0-180 days] after the Covered Person's Effective Date of coverage will not be covered for a period of [12 months] after the Effective Date.]]

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

The Utilization Review Provisions [and the [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider] [Network]] must be utilized, to be eligible to receive the maximum benefits available under the policy. Refer to the Utilization Review Provisions for the medical benefits that must be reviewed.

Major Medical Benefits for [Single Plan/Family Plan] [Certificate Holder-Spouse Plan] [Certificate Holder-Children Plan].

[The [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider is [PPO].]

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

[[**BENEFIT PERIOD**] [**MAXIMUM** [**LIFETIME**] **BENEFIT**]] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100,000 - $100,000,000]
[**CALENDAR YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[[**ACCIDENT**] [**SICKNESS**] **MAXIMUM BENEFIT**]	

[for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$500 - $5,000]
[**DAILY MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100 - $10,000]
[**PLAN YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[**PER CAUSE MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $200,000]
[**OUTPATIENT** [**CALENDAR YEAR**] [**PLAN YEAR**] [**BENEFIT PERIOD**] [**TIME PERIOD**] **MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $50,000]
[**MONTHLY MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1.000 - $50,000]

BEN: 005.001.001.GE

PLAN DEDUCTIBLES

[[Annual]Carryover Deductible]
Covered Charges Incurred by a Covered Person [due to an Accident] [for Inpatient services] [for Inpatient services received on December 31st of a Calendar Year] [during the last [3] months of a [Plan Year] [Calendar Year] [Benefit Period]] that count toward satisfying a Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [Non-Participating][Non-Network] Provider Deductible,] [but do not satisfy the [Network] [Participating] Provider Deductible] [Individual Out-of-Pocket Limit] for that [Plan Year,] [Calendar Year,] [Benefit Period,] will also count toward satisfying the Covered Person's [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] for the next [Plan Year] [Calendar Year] [Benefit Period]. [This Carryover Deductible [does not count toward satisfying the [maximum] Family Deductible] [and] [only applies in the first [Plan Year] [Calendar Year] [Benefit Period].] [For the purpose of determining whether a Carryover Deductible applies, Covered Charges will be considered to apply toward the [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] in the order the Covered Charges are processed.]]

[The [Select Network,] [Network] and [[Non-Network] [Non-Participating Provider]] Deductibles are calculated separately.] [[For example,] Amounts applied toward Your [Select Network] Deductible will not be credited toward Your [Network] Deductible, and amounts credited toward Your [[Non-Network] [Non-Participating Provider]] Deductible will not be credited toward Your [Network] Deductible.]

[All Deductibles are calculated separately. Applicable Deductibles must be satisfied prior to any payment of Covered Charges.]

[Deductibles may apply to specific types of services. Please review the Benefit Summary for additional Deductible information.]

	[[Select] Participating Provider Benefits / [Select] Network]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
Individual Plan Deductible [*] [each] [every] [XX] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $50,000]	[None / $0 - $50,000]	[$0 - $50,000]
[[Maximum] [Family] Plan [Integrated] [Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $50,000]	[None / $0 - $50,000]	[None / $0 - $50,000]
[[Maximum] [Common][Accident] [Per Cause] Deductible][*] [each]	[None / $0 - $50,000]	[None / $0 - $50,000]	[None / $0 - $50,000]

[every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]			
[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [XX] [Calendar Year[s]] [Plan Year[s]] [Benefit Period[s]] [Time Period[s]].]			

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]
BEN: 010.001.002.GE

[[**Deductible**] [**Credit**] [**Reward**] [**Multi Year Deductible**] **Program**:]	
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM EFFECTIVE DATE**]	[00/00/0000]
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM TERMINATION DATE**]	[00/00/0000]
[[Amounts may be credited to Your Deductibles based on the [Deductible] [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [and] [or] [reward] [and] [or] [Multi Year Deductible] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]	

BEN: 010.002.GE

[**Plan**] **Coinsurance**] [**and**] [[**Total**] [**Plan**] **Out-of-Pocket Limits**] [The Coinsurance is listed below unless specified elsewhere in the Benefit Summary]			
[Once the [Total] Out-of-Pocket limit is met the plan pays at [100%][unless otherwise specified]]			
[The Out-of-Pocket maximums for [Select Participating Providers,] [Select Network,] [Participating Providers,] [Network Provider] [and] [[Non-Participating] [Non-Network] Providers] are calculated separately. [For example,] Amounts credited toward Your [Participating][Network] Provider Out-of-Pocket maximum will [not] be credited toward Your Non-Participating Provider[Non-Network] Out-of-Pocket maximum, and amounts credited toward Your [Non-Participating] [Non-Network] Provider Out-of-Pocket maximum will [not] be credited toward Your [Participating] [Network] Provider Out-of-Pocket maximum.]			
[All Out-of-Pocket Limits are calculated separately. Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges. [Out-of-Pocket Limits do not include Deductible.]			
[[Coinsurance] [and] [Out-of--Pocket Limits] may apply to specific types of services. Please review the Benefit Summary for additional [Coinsurance] [and] [Out-of--Pocket Limits] information.]			
[Any applicable Prescription Drug Deductible, Coinsurance, Copayment [or Ancillary Charge] are calculated separately from the Plan Out-of-Pocket and do not count toward the plan Out-of-Pocket.]			
	[[Select] Participating Provider [Benefits]/ [Select] Network]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Tier [1]] [*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $75,000 / Not	[$0 - $75,000 / Not	[$0 - $75,000 / an

[Family][*]	applicable] [$0 - $150,000 / Not applicable]	applicable] [$0 - $150,000 / Not applicable]	additional $0 - $50,000] [$0 - $150,000 / an additional $0 - $100,000]
[Tier [2]][*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $50,000]
[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $100,000]
[Tier [X]][*] [Plan][Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]
[Tier [X]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $10,000]
[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $100,000]
[Total] [Plan] [Out-of-Pocket (OOP) Limits][*] [Individual Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $100,000 / Not applicable]	[$0 - $100,000 / Not applicable]	[$0 - $100,000 / an additional $0 - $10,000]
[Common] [Family Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $250,000 / Not applicable]	[$0 - $250,000 / Not applicable]	[$0 - $250,000 / an additional $0 - $100,000]
[Total][Out-of-Pocket (OOP) Limits each [Calendar Year] [Plan Year][*]			[$0 - $250,000]
[[All Out-of-Pocket Limits are calculated separately.] [Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges.] [Out-of-Pocket Limits do not include Deductible.] [Amounts may be credited to Your			

Out-of-Pocket Limits based on the Deductible [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.]]

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]

BEN: 015.001.002.GE

[**Inpatient Medical Facility Services**]:				
[Subject to [Plan] [Integrated] [Per Cause] Deductible] and [Plan] Coinsurance [unless otherwise specified]]				
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]				
	[Participating Provider [Benefits] / Network Provider [Benefits]]	**[[Select] Participating Provider [Benefits]]**	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Medical Facility Services] Maximum Benefit]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	$XXX] [Per Covered Person	$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Medical Facility Services Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible or Total [Plan] Out-of-Pocket Limits.]				
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the Participating Provider Deductible.]				
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]				
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]				
[[Facility] [Copayment]]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]
[Facility] [Access] [Fee]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]
[Emergency Room] [Access]	[[$XXX] per	[[$XXX] per	[[$XXX] per	[[$XXX] per

[Fee]	Emergency Room visit] [Waived if admitted]	Emergency Room visit] [Waived if admitted]	Emergency Room visit] [Waived if admitted]	Emergency Room visit] [Waived if admitted]
[Emergency Room] [Copayment]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Medical Facility Services] [Out-of-Pocket Limits] [each] [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$XXX]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]	[$XXX]

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[**Outpatient Medical Facility Services**:]
[All Outpatient services, supplies and treatments apply to the [Outpatient] [Plan Year] [Per Cause] [Calendar Year] Maximum Benefit [including] [excluding] Outpatient Prescription Drugs.]
[Limited to Outpatient Services associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]
[Subject to [Plan] [and] [Outpatient Services] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient Services] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient [Calendar Year] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] per [Covered Person] [covered child] [Family] [unless due to an] [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a[$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]]
[We will pay [up to] an Outpatient Maximum of [$XXX] [per][Covered Person] [covered child] per [day] [episode] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] per [day] [episode]]

[Emergency Room] Benefits are limited to a [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] [per] [episode] Maximum Benefit of [$XXX] [per] [Covered Person] [covered child] [Family]]
[The [Emergency Room] [Access] [Fee] [Copayment] will [not] apply toward any Out-of-Pocket Limit]
[The [Emergency Room] [Access] [Fee] [Copayment] will be waived if the Covered Person is subsequently admitted to the hospital for an Inpatient Stay.]
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]
[Non-Emergency use of an Emergency Room will result in a [30%] reduction in Covered Charges]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient [Services] Maximum Benefit]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient [Surgical] [Services] [Per Cause] Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	[$XXX / None] [$XXX / None]	[$XXX / None] [$XXX / None]	[$XXX / None] [$XXX / None]
[The [Outpatient [Surgical] Services] Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible] or Total [Plan] Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Facility] [Access] [Fee]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]
[Emergency Room [Access] [Fee]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]
[Facility] [Emergency Room] [Copayment]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [1]]	[0% - 100% [until the [[Outpatient [Surgical] Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100%[then Tier [X + [1]];] [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] Out-of-Pocket Limits] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]

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[**Physician**][**Doctor**] [**Office Visit**]:
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Primary Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Primary Care Provider] Copayment, Covered Charges for [Primary Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan],[and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Designated Specialty Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Designated Specialty Care Provider] Copayment, Covered Charges for [Designated Specialty Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Mid-Level Practitioner] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Mid-Level Practitioner] Copayment, Covered Charge for [Mid-Level Practitioner] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit[s]] Copayment, Covered Charges [for Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] [Copayment] Includes the first [$50 - $200] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause].]
[Benefits for [Physician][Doctor] Office Visits [or] [Retail Health Clinic visits] are limited to [[2] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $100] per visit.] [After that, Office Visits [or] [Retail Health Clinic visits] are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visits] [or] [Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]

Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]			
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visits] paid at 100%] [Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Year] [Additional Office Visits are][Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Outpatient] [Coinsurance]
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visit] paid at 100%]			

Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Coinsurance]

	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the] [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 030.001.001.GE

[**Retail Health Clinic Visit**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit] Copayment, Covered Charges for [Retail Health Clinic visits] will be subject to the [Plan][,] [and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[[Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits]
[[Retail Health Clinic visit] [Copayment] includes the first [$50 - $2,100] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]]
[Benefits for [Retail Health Clinic visits] are limited to [[XX] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child with] a maximum payment of [$25 - $5,100] per visit.] [After that, Retail Health Clinic visits are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance]].
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] [XX visits] of Covered Services performed [by a [Retail Health Clinic] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period] [subject to a [$XX] copayment].]
[[Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating	**[Participating Provider**	**[Non-[Select]**

	Provider [Benefits]]	[Benefits] / Network Provider [Benefits]]	Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment:][After Copayment, Retail Health Clinic visits paid at 100%]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[Subject to [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

BEN: 032.001.GE

[**Preventive Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] Benefit Waiting Period][subject to a [$XX] copayment] [for Mammograms] [and] [, Pap Smears] [and] [Prostate Specific Antigen Screenings] [and] Stool for occult blood testing [and] Flexible sigmoidoscopy and barium enema or colonoscopy [and] Fasting glucose testing] [and] [Lipid profile testing] [and] [Complete blood count (or component parts) testing] [and] [Urinalysis testing] [and] [Tuberculin skin testing with purified protein derivative] [and] [Other diagnostic services as recommended by the United States Preventative Services Task Force on the date the service is Incurred].]
[Benefits for Preventive Medicine Services are limited [to a [$XX] per visit] [up to [XX] visits per] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] [per] [Covered Person] [covered child] [Family].]
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum [Lifetime] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per [Covered Person] [covered child] [Family].]

[[Mammograms] [Pap Smears] [and] [Prostate Specific Antigen Screenings] Colorectal Cancer Examination [and] [child immunizations up to age [12]] are not subject to the [Preventive Services] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum [Lifetime] Benefit]			
Prostate specific antigen screenings are exempt from any Deductible.			
[Preventive Medicine Services Benefit Waiting Period is [12] [months] [[365] days].]			
]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Preventive Medicine Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Preventive Medicine Services Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Preventive Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] [Retail Health Clinic] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Preventive Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Preventive Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Preventive Medicine Services] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Preventive Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 035.001.001.AR

Children's Preventive Health Care Services
Preventive Medicine Services shall include children's preventive health care services which shall include 20 visits at approximately the following ages: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 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.
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]] Deductible and Coinsurance will be waived for child immunizations.
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$500] [per [Covered Person] [covered child] [Family].] The maximum will not apply to child immunizations.
[Preventive Medicine Services Benefit Waiting Period is [12] [months].] The waiting period will not apply to child immunizations.

BEN: 036.001.AR

[**Loss or Impairment of Speech or Hearing**]:

[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
	[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[[Loss or Impairment of Speech or Hearing] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Loss or Impairment of Speech or Hearing] Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Loss or Impairment of Speech or Hearing] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Loss or Impairment of Speech or Hearing] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
Loss or Impairment of Speech or Hearing] [Tier [2]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [P Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Loss or Impairment of Speech or Hearing]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Loss or Impairment of Speech or Hearing]] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Loss or Impairment of Speech or Hearing Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider			

BEN: 037.001.AR

Medical Foods:			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
No benefits are available for the first {$2,400] of Covered Charges incurred by a Covered Person in a calendar year.			
	[Select Participating	**[Participating**	**[Non-[Select]**

	Provider Benefits]	Provider Benefits / Network Provider Benefits]	Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]
[Medical Foods] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 038.001.AR

[**Accident Medical Expense** [**Reduced Plan Deductible**] **Benefit**:]			
[All services, supplies and treatments apply to the [Plan] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[We will pay up to [$XXX] per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause][Accidental Injury] [Injury] for Covered Charges Incurred due to an Accidental Injury. After payment of this amount, Covered Charges will be subject to the [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance.]			
[Covered charges must be Incurred within [90] days of the Accident] [Injury]. [Covered Charges in excess of the Accident Medical Expense Benefit or rendered after the 90-day period will be subject to all the terms, limits and conditions of the plan.]			
[Accident Medical Expense is subject to the Accident Medical Expense Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX]. Covered Charges are then subject to the [Plan] [and][Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[Your [Plan] [Individual] [Integrated] [Family] [Per Cause] Deductible] will be reduced by [$XXX] for Covered Charges Incurred due to an [Accidental Injury] [Injury],] [then subject to [Plan] [and][Outpatient] [and] [Inpatient] [Coinsurance]]			
[Accident Medical Expense Benefit Waiting Period is [XX days]]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Accident Medical Expense Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Accident Medical Expense Benefit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]

[The [Accident Medical Expense Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Accident Medical Expense Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Accident Medical Expense] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 040.001.001.GE

[[**Diagnostic Imaging Services**] [**and**] [**Laboratory Services**]:]			
[All services, supplies and treatments apply to the [Inpatient][Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient][Inpatient] [Integrated] Deductible and [Plan] [Outpatient] [Inpatient]Coinsurance [unless otherwise specified]]			
[[Plan] [Integrated] [Per Cause] Deductible] [and Co-insurance] will be waived for the first [$XXX] of Covered Services] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]] [after a [12 month] [365 day] Benefit Waiting Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services] Benefit Waiting Period is [[12] [months] [[365] days].]			
[Limited to [Diagnostic Imaging Services] [and] [Laboratory Services] associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]			
[Includes [1] screening mammography exam per Benefit Period for a covered female age [35] or over.] [The maximum benefit for a mammography screening is [$50 - $500].]			
[Diagnostic Imaging Services] [and] [Laboratory Services] are limited to a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person] [covered child] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Diagnostic Imaging Services] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX][[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Per Cause]			

Deductible]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Diagnostic Imaging Services] [and] [Laboratory Services] Deductible] does [not] apply to the [Plan][Outpatient][Inpatient][Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[[Diagnostic Imaging Services] [and] [Laboratory Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Diagnostic Imaging Services] [and] [Laboratory Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.]] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

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[**Outpatient Physical Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient Physical Medicine Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [covered child] [Family] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [per] [Covered Person] [covered child] [Family]]
[We will pay [up to] an Outpatient Physical Medicine Services Maximum of [$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]][unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] [per [day] [episode]]
[Benefits for Outpatient Physical Medicine Services are limited to [1-20] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered Person with a maximum payment of [$25 - $200] per visit]
[Chiropractic Coverage is] [Adjustments and manipulations are] limited to a Maximum [Lifetime] [Calendar Year][Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person][Family]]
[Outpatient Physical Medicine Services Benefits Waiting Period is [[12] months]][[365] days]

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient Physical Medicine Services] Maximum Benefit]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[[Outpatient Physical Medicine Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[Outpatient Physical Medicine Services [Per Cause] Deductible]]			
[Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Outpatient Physical Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Outpatient Physical Medicine Services] [Copayment]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]]			
[Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]

[Outpatient Physical Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Physical Medicine Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Outpatient Physical Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

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[**Outpatient Alternative Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$20 - $5,000]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit[up to [XX] visits]] [up to [$XXX] each [Calendar] [Plan] Year] [Benefit Period] [per Covered Person]]			
[Outpatient Alternative Medicine Services Benefit Waiting Period is [[6] [months] [[180] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Outpatient Alternative Medicine Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Outpatient Alternative Medicine Services Deductible] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Outpatient Alternative Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[Copayment]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Outpatient Alternative Medicine Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% -			

50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 055.001.001.GE

[**Durable Medical Equipment and Personal Medical Equipment**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[[Durable Medical Equipment] [and] [Personal Medical Equipment] Benefits are limited to a [Lifetime][Calendar Year][Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person][Covered Child].]			
[Wheelchairs, Prosthetic Devices and Orthotic Devices apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Wheelchairs, Prosthetic Devices and Orthotic Devices will be subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[Durable Medical Equipment and Personal Medical Equipment [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Durable Medical Equipment and Personal Medical Equipment Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Personal Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Initial] [Permanent] [Temporary] [Basic] [Artificial] [Eye]	[$[XXXX] Maximum [Lifetime] [Calendar	[$[XXXX] Maximum [Lifetime] [Calendar	[$[XXXX] Maximum [Lifetime] [Calendar

	Year] [Plan Year] [Monthly] Benefit	Year] [Plan Year] [Monthly] Benefit	Year] [Plan Year] [Monthly] Benefit
[Durable Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket

[Tier [X]]	Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Durable Medical Equipment and Personal Medical Equipment] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[[Benefits for [Durable Medical Equipment and Personal Medical Equipment] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 060.001.001.AR

[**Maternity Care Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified] [and any other plan provisions in the Benefit Summary].]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Maternity Care Services] Benefit Waiting Period is [[12] months] [[30-365] days]]			
[Benefits will be reduced by [50%] if conception occurs during the [Benefit Waiting Period][first Calendar Year of the policy]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

[Monthly] [Daily] Benefit]			
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Maternity Care Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Maternity Care Services Deductible][if conception occurs after the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[Maternity Care Services Deductible] if conception occurs before the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[The [Maternity Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Maternity Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Maternity Care Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services y] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Maternity Care Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 065.001.001.GE

[**Complications of Pregnancy**:]
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]
[Not Covered]

BEN: 070.001.GE

[**Infertility Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]

[Benefits for Infertility Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Infertility Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-network Provider [Benefits]]**
[[Infertility Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Infertility Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Infertility Services are payable at [0-100%] [with a [$10-$100] copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 075.001.001.GE

[**Health Care Practitioner Services**:]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [and any other [Plan] [Inpatient] [or] [Outpatient] provision in the Benefit Summary] [unless otherwise specified].]
[Benefits for Covered Charges rendered by an Anesthesiologist are limited to a [Calendar Year] [Plan Year] [Benefit Period] Maximum of [$XXX] for Inpatient services and [$XXX] for Outpatient Services.]

BEN: 080.001.GE

[**Professional Ground [or Air] Ambulance Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Benefits are limited to a[n] [Professional Ground] [or] [Air] Ambulance Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [limited to] [[one] trip] [per Sickness or Injury] [per Covered Person].]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[Professional Ground [or Air] Ambulance Services] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit [per Covered Person]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]
[Professional Ground [or Air] Ambulance Services] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]

BEN: 085.001.GE

[**Home Health Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] Benefit of [20 - 200 hours] [or] [10-100 visits][per Covered Person]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Home Health Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services [Per Cause] Deductible]] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Home Health Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Home Health Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Home Health Care Services][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Home Health Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for Home Health Care Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 090.001.001.GE

[**Hospice Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient][and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Inpatient] [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Inpatient] [Outpatient] [Plan] Coinsurance [unless otherwise specified].]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Hospice Care Services include [2] visits for counseling services and [1] visit for bereavement counseling after a Covered Person's death] [[per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Hospice Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Hospice Care Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[Hospice Care Services Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Hospice Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Hospice Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not	[$0 - $25,000 / Not	[$0 - $25,000 / an

[Family]	applicable] [$0 - $75,000 / Not applicable]	applicable] [$0 - $75,000 / Not applicable]	additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Hospice Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[Benefits for Hospice Care Service are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network			

Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 095.001.001.GE

[**Inpatient Rehabilitation Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is less] [greater]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select} Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Rehabilitation Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]
[Inpatient Rehabilitation Services [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Rehabilitation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Inpatient Rehabilitation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Rehabilitation Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[Benefits for Inpatient Rehabilitation Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 100.001.GE

[[**Subacute Rehabilitation Facility**] [**and/or**] [**Skilled Nursing Facility Care**]:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] [Integrated] [Per Cause] Deductible] [and][Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is [less] [greater].]			
[Benefits are limited to a Maximum of [$XXX] per day, up to [50] Days per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX]	[$XXX]	[$XXX]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Subacute Rehabilitation Facility and Skilled Nursing Facility Care Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Subacute Rehabilitation Facility and Skilled Nursing Facility Care are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 105.001.GE

[**Family Planning Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Family Planning Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Family Planning Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Family Planning Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Family Planning Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 110.001.001.GE

[**Sterilization**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]
[Benefits for Sterilization Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,500] [per Covered Person].]
[Sterilization Services Benefit Waiting Period is [[12] months] [[365] days]].

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Sterilization Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Sterilization Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 115.001.001.GE

[**Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for [surgical and] nonsurgical treatment are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[Temporomandibular Joint (TMJ) or			

Craniomandibular Joint (CMJ) Dysfunction Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Deductible] does [not] apply to the [Plan][Outpatient] [Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 120.001.001.GE

[**Diabetic Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Covered Charges include: • [Eye Examinations: [Both eyes] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Foot Examination: [Both feet] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Nutritional Counseling: [When first diagnosed] [or] [and] [when changes in condition occur] [per Covered Person]]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider**	**[Non-[Select] Participating Provider [Benefits]/ Non-**

		[Benefits]]	Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Diabetic Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Diabetic Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Diabetic Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 125.001.001.GE

[**Growth Hormone Therapy Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Growth Hormone Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX]] [per Covered Person].]			
[Growth Hormone Therapy Services Benefit Waiting Period is [[12] months] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Growth Hormone Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 130.001.001.GE

[**Tonsils and Adenoids**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Benefits for Tonsils and Adenoids Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]]
[[Tonsils and Adenoids Services] Benefit Waiting Period is [[12] months] [[365] days].]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	[Participating Provider [Benefits] / Network Provider [Benefits]]	[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Tonsils and Adenoids Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Tonsils and Adenoids Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 135.001.001.GE

[**Bunions,**] [**Hemorrhoids**] [**and**] [**Varicose Veins**]:			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Bunions,] [Hemorrhoids] [and] [Varicose Veins]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 140.001.001.GE

[**Inguinal Hernia**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[Benefits for Inguinal Hernia Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,000] [per Covered Person].]			
[Inguinal Hernia Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inguinal Hernia]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Inguinal Hernia Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 145.001.001.GE

[**Blood Product Transfusions**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [and] [Per Cause] Maximum Benefit]			
[Subject to[Integrated] [Plan][Inpatient][and] [Outpatient] [Per Cause] Deductible] and [Plan][Inpatient][and] [Outpatient] [and] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Blood Product Transfusions Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Blood Product Transfusions Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Blood Product Transfusions Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per	[None / $XXX per	[None / $XXX per

	Blood Product Transfusions]	Blood Product Transfusions]	Blood Product Transfusions]
[Copayment]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]
[Blood Product Transfusions] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Blood Product Transfusions] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Blood Product Transfusions] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Blood Product Transfusions] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 150.001.001.GE

[**Transplants**:]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefit for Transplants are limited to [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]			
[Donor Expenses are limited to a Maximum Benefit of [$5,000 - $25,000]]			
[Not Covered]			
[The following Covered Transplants are subject to the [Outpatient] [and] [Calendar Year] [and] [Plan Year and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]: • [Kidney] • [Cornea] • [Skin]]			
[The following Covered Transplants subject to the [Maximum Transplant Benefit] [Outpatient] and [Calendar Year] and [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] [Maximum Benefit]: • Lung(s) • Heart • Simultaneous heart/lung • Liver • Simultaneous kidney/pancreas • Allogeneic and autologous bone marrow transplant/stem cell rescue]			
	[Designated Specialty Service Provider /[Select] Participating Provider /Designated Transplant Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]] [and Non-Participating/Non-Network Provider]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Maximum Transplant Benefit]	[Lifetime Maximum	[$100,000] [Lifetime]	[$100,000] [Lifetime]

	Benefit] [[$100,000] Benefit Period Maximum] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]
[Travel Expenses] will be covered up to a [$5,000 - $20,000] Maximum Benefit when a [Designated Specialty Service Provider][Select Participating Provider][Designated Transplant Provider Benefits] is used as described in the Covered Medical Benefits section]			

BEN: 155.001.001.GE

[**Behavioral Health** [**and Substance Abuse**]:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] [and] [Plan] [and] [Inpatient] [and] [Outpatient] [Coinsurance] [unless otherwise specified].]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$50] for each visit up to [[XX] visits] [$250 - $1,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$2,000 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $25,000] [per] [Covered Person] [Family]]
[Behavioral Health [and Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]
[The [Behavioral Health] [and Substance Abuse] [Deductible] [and] [Coinsurance] does [not] apply to the [Plan Deductible] [or] [Total Out-of-Pocket Limits.]]
[The [Behavioral Health] [and Substance Abuse] Coinsurance] will [not] increase to 100% after the Plan Out of Pocket is satisfied.] [The Behavioral Health Coinsurance, not paid by us, will not apply toward any Out of Pocket Limit.]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Behavioral Health [and Substance Abuse] Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]][Coinsurance] [Tier [2]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are

	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Behavioral Health [and Substance Abuse]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Behavioral Health [and Substance Abuse Services]] [Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[Benefits for Behavioral Health [and Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 160.001.001.GE

[**Substance Abuse**]:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$25 - $100] for each visit up to [[XX] visits] [$250 - $100] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$1,500 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $20,000] [per] [Covered Person] [Family]]
[Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Substance Abuse Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Substance Abuse Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Substance Abuse] Coinsurance [Tier [1]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse Services] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 165.001.001.GE

[**Reconstructive Surgery**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Integrated] [Inpatient] [Outpatient] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 170.001.001.GE

[**Dental Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Dental Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$1,000 - $5,000] [unless due to an Accidental Injury [Injury] [or underlying Sickness] [per Covered Person]]			
[Benefits are limited to conditions present at birth or diagnosed before age [5]]			
[Treatment must begin within [90 days] and be completed within [365 days] of the Dental Injury.]			
[Dental Services Benefit Waiting Period is [12][Months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Dental Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Dental Services are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 175.001.001.GE

[**Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified]]			
[Benefits for [Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating	**[Participating**	**[Non-[Select]**

	Provider [Benefits]]	Provider [Benefits] / Network Provider [Benefits]]	Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Intravenous Injectable Parenteral Drug Therapy Service] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 180.001.001.GE

[**Non-Intravenous Injectable Parenteral Drug Therapy**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] and [Inpatient] Coinsurance [unless otherwise specified]			
[Benefits for Non-Intravenous Injectable Drug Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Non-Intravenous Injectable Drug Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Non-Intravenous Injectable Drug Therapy Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 185.001.001.GE

[[**Telemedicine Services**] [**and**] [**Telehealth Services**]:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]

[Benefits for [[Telemedicine Services] [and] [Telehealth Services]]are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$1,000 - $5,000] [per Covered Person]]
[Benefits for [[Telemedicine Services] [and] [Telehealth Services]] are limited to a Maximum Benefit of [[$XX] for each visit] [0-12 visits] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per Covered Person].]
[[Telemedicine Services] [and] [Telehealth Services]] Benefit Waiting Period is [[6] months] [[180] days]]]
[Not Covered]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$50 - $500] [0-12 visits] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period][subject to a [$5 - $75] copayment].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Telemedicine Services] [and] [Telehealth Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Telemedicine Services] [and] [Telehealth Services]]Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
The [[Telemedicine Services] [and] [Telehealth Services]] Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[Copayment]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[[Telemedicine Services] [and] [Telehealth Services]][Coinsurance] [Tier [1]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [2]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and]			

[Telehealth Services]] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[Benefits for [Telemedicine Services] [and] [Telehealth Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 190.001.001.GE

[[**Out of Network**][**Travel Benefit**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$250 - $1,000] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Out of Network] [Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Out of Network] [Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Out of Network] [Travel Benefit Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Out of Network] Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]

[Out of Network] [Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an

	applicable]	applicable]	additional $0 - $30,000]
[[Out of Network] [Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

BEN: 195.001.001.GE

[**Choice of Network Service Area Benefit**:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 200.001.GE

[Nationwide Network Benefit:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 205.001.GE

[**International Coverage**:]			
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and][International Coverage] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]			
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]			
[International Coverage Benefits are limited to a Maximum of [$XXX][for services rendered outside the United States of America]].			
[International Coverage is subject to the International Coverage Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX], Covered Charges are then subject the [Plan] [and][Outpatient] [and] [Inpatient] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[International Coverage Benefit Waiting Period is [90 days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[International Coverage] Maximum[Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]

Benefit]			
[[International Coverage] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[International Coverage Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [International Covered Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[Copayment]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[International Coverage] [Coinsurance] [Tier [1]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [2]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	$0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [X]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[International Coverage] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 210.001.001.GE

[**Travel Benefit**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$500] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Travel Benefit Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 215.001.001.GE

[**Repatriation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Repatriation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Repatriation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Repatriation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[]Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Repatriation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Repatriation Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Repatriation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]
[[Repatriation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100%	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

		thereafter.]]	
[Tier [1]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Repatriation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 275.001.GE

[**Medical Evacuation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Medical Evacuation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Medical Evacuation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Medical Evacuation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Medical Evacuation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Medical Evacuation Services Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Medical Evacuation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]
[[Medical Evacuation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for [Medical Evacuation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 280.001.GE

[**Outpatient**] **Prescription Drug Benefits**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] Maximum Benefit]
[Subject to [Plan][and][Outpatient][Integrated] [Per Cause] Deductible] and [Plan][and][Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Prescription Drugs are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit of [$1,000 - $10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]
[Benefits for Prescription Drugs are limited to a Maximum [Lifetime] [Benefit Period] Benefit of [$1,000 -$10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]
[For Prescription Drugs and medicines Covered Charges are limited to [$2,000] per [Calendar Year][Plan Year][Benefit Period] [Time Period] for: • [Legend drugs and medicines that by Federal law can only be obtained with a prescription;] • [Injectable insulin with a prescription;] • [Disposable insulin syringes, and disposable blood/urine, glucose/acetone testing agents or lancets.]]
[[$20] maximum per [Outpatient] Prescription Drug[, limited to $1,000 - $5,000] [limited to [XX] prescriptions] Maximum Benefit per [Calendar Year][Plan Year][Benefit Period] [Time Period] [Month][for] [Anti-Infective Prescription Drugs] [per Covered Person] [Per Covered Child]]
[[Outpatient] Prescription Drugs Benefit Waiting Period is [[12] months] [[365] days].]
[Outpatient] Prescription Drugs Benefits do [not] apply to the [Plan][Inpatient][Outpatient] Out of Pocket Limits]
[Not Covered]
[Participating Pharmacy Plan:] [PBM]
[Prescription Drug [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit] [[$XXX] per [Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Lifetime] Maximum Benefit] [[$XXX] [per Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5,000]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Individual] [Integrated] Deductible:] [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-Preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to Plan [Individual] Deductible and Coinsurance.] **[Prescription Drug [Integrated] Family Maximum Deductible:]** [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Prescription Drug [Deductible] [per Covered Person] [Covered Child]:] [$0 - $9750]

[**Designated Specialty Pharmacy Provider**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Individual] [Integrated] Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-Preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to Plan [Individual] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Integrated] Family Maximum Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Tier 1] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Participating Pharmacy**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Non-Participating Pharmacy**:] [$0 - $100]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Mail Service Prescription Drug Vendor**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[Tier 1] Coinsurance:

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[Tier 1] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]

[Tier 2] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[Tier 2] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 2] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[Tier 3] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[Tier 3] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 3] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[[$0-500] [Calendar Year] [Benefit Period] [Per Cause] [Time Period] [Plan Year] [Brand Name Drug] Deductible. [The Deductible applies to [level] [group][1][A][,] [level] [group] [2] [B] [,] [level] [group [3] [C] [and] [level] [group] [4] [D] [and] [level] [group] [5] [E]] [Brand Name] Drugs.]	
[[Therapeutic l] [Class] [1] [a] drugs] [Deductible] [Drugs appearing on the drug list]	[$0 - $9750]
[[Therapeutic l] [Class] [1] [a] drugs] [Drugs appearing on the drug list]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill.][for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [2] [B] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [2] [B] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [3] [C] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [3] [C] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [4] [D] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [4] [D] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

[[Therapeutic l] [Class] [5] [E] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [5] [E] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

BEN: 220.001.001.GE

[**Life Insurance**:]

[Certificate Holder	$[0-250,000]]
[Covered Dependent Spouse	$[0-250,000]]
[Covered Dependent Child(ren)	$[0-50,000]]

[This Amount of Life Insurance will be subject to the Age Reduction Percentages listed below:]

[Age Reduction Percentages:]

[Reduction Age:]	[Reduction Percentage:]
[[55]	Reduces to [70]% of the amount in force immediately prior to age [55]]
[[65]	Reduces to [60]% of the amount in force immediately prior to age [65]]
[[70]	Reduces to [60]% of the amount in force immediately prior to age [70]]

BEN: 225.001.GE

[**Accelerated Benefit**:]

[[Up to] [50%] of the Life Insurance Benefit.]

BEN: 230.001.GE

[**Accidental Death & Dismemberment Insurance**[**for Employee**]:]

[The Accidental Death Benefit will be] [[an amount equal to] [and in addition to]] the amount of Life Insurance [(including any applicable adjustment or reduction)] in effect on the date of loss.]

[Certificate Holder	$[10,000] [2X's] [3X's]]
[Dependent Covered Spouse	$[5,000] [2X's] [3X's]]
[Dependent Covered Child(ren)	$[2,000] [2X's] [3X's]]

BEN: 235.001.GE

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

MASTER GROUP POLICY

POLICYHOLDER: [Health Advocates Group Insurance Trust]
[Address: [1st National Bank, as Trustee
123 Main Street
Springfield, IL 60606]]

Policy Number	State of Delivery	Policy's Effective Date
[999999]	[Illinois]	[Date]

This Master Group Policy is issued to the Policyholder shown above. It is effective at 12:01 a.m. at the Policyholder's delivery address on the Policy's Effective Date shown above.

This Master Group Policy is issued in Illinois and, unless otherwise provided in this Master Group Policy, is governed by the laws of that state.

We will pay benefits under the terms of this Master Group Policy and the evidentiary certificates issued in consideration of the Covered Person's enrollment form for insurance and the timely payment of all premiums by the Certificate Holder as set forth in the Master Group Policy. Benefits will be paid according to the terms, limits and conditions of this Master Group Policy.

GENERAL POLICY PROVISIONS

Delivery
This Master Group Policy is delivered and issued in the [State of Illinois].

Entire Policy
The entire agreement is made up of this Master Group Policy, the provisions shown in the certificates of insurance for this plan, any amendments, endorsements or riders to the Master Group Policy or the certificates, the application of the Policyholder and the enrollment forms of all Certificate Holders who are covered participants of this plan and their Covered Dependents.

Benefits Available Under This Policy
We will deliver to the Policyholder copies of specimen certificates evidencing coverage that may be issued depending on the resident state of the members. The benefits available under this Policy vary by state. The certificate, and any riders and endorsements thereto, will describe the benefits provided under this Master Group Policy and the limitations contained herein.

Certificates of Coverage
Coverage under this plan will be individually underwritten by Time Insurance Company. Each member seeking a certificate of coverage under this Master Group Policy must complete an application/enrollment form containing individual representations. Coverage will not become effective unless such application/enrollment form is approved by Time Insurance Company. Upon underwriting acceptance of the applicant, Time Insurance Company will issue a Certificate of insurance to each person who is shown as a Certificate Holder for this plan. The Certificate, and any riders and endorsements thereto, will describe the benefits provided to that member under this Master Group Policy and the limitations contained herein. In cases of conflict between the provisions of the Master Group Policy and any individual Certificate, the provisions of the Certificate delivered to the individual member will prevail.

Benefits Contained in Individual Certificates
Certificates of coverage may be issued to a member only when the member's complete enrollment is accepted by and insurability/underwriting is satisfactory to Time Insurance Company. If coverage is issued, the specific benefits that apply to a member Certificate Holder are evidenced by the Certificate, and any Riders or endorsements that are delivered to that Certificate Holder. In cases of conflict between the provisions of the Master Group Policy and the Certificate, the Certificate provisions will prevail.

Changes to This Policy
The Master Group Policy may be changed at any time by agreement between the Policyholder and Time Insurance Company. We will give the Policyholder [30] days notice prior to any change. No change to this Master Group Policy will be valid unless made by an amendment or rider that has been approved and signed by an executive officer of Time Insurance Company. No employee of or other agent for Time Insurance Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

Authority
We have the authority to determine a person's eligibility for coverage or benefits and to interpret the terms of the Policy, subject to state and federal law.

Commencement of Coverage
On the Policy's Effective Date, as shown on the first page of this Master Group Policy, we agree to provide the coverage stipulated in this Policy to eligible applicants and their Covered Dependents, if any. Such coverage begins on the Certificate Holder's Effective Date, which will be set forth in the certificate of insurance issued by Us to the Covered Person. We accept no liability for benefits related to expenses Incurred prior to the Covered Person's Effective Date or after the Covered Person's termination date[except as described in the Extension of Benefits provision].

Termination of This Policy
We may terminate this Policy as of the first day of any month after providing notice, at least [30] days in advance, to the Policyholder, or earlier if with mutual consent of the Policyholder. If the Policyholder terminates the Master

Group Policy, the Master Group Policy will, for the benefit of the individual certificate holders, either: 1) automatically vest in a trust selected by Time Insurance Company or 2) Time Insurance Company will issue a replacement Master Group Policy, with each certificate transferred as if it was issued from the replacement Master Group Policy.

Renewal
This Master Group Policy automatically renews on the yearly anniversary of the Policy's Effective Date unless it is terminated by either the Policyholder or Time Insurance Company as discussed in the Termination Section above.

Assignment
Neither this Master Group Policy, nor the coverage provided hereunder may be assigned except by mutual agreement between the Policyholder and Time Insurance Company [or as provided under the Termination of This Policy provision for the benefit of members]. The benefits provided to certificate holders hereunder may not be assigned, except as otherwise specifically described in the Covered Person's certificate of insurance.

Certificate Provisions Made a Part of this Policy
The remainder of this Master Group Policy consists of the provisions shown in the state-specific specimen certificates of this Master Group Policy (but each individual certificate holder's benefits are governed by their individual certificate and any riders and endorsements thereto); specific benefits and levels of benefits to members are evidenced on the certificates and associated riders and endorsements delivered to the members.

[Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

OFFER of OPTIONAL HOSPICE COVERAGE

Group Policyholder: [Health Advocates Group Insurance Trust]
Group Policy Number: [TDT-MPO-001]

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

Hospice Coverage
Coverage shall be provided for terminally ill patients with coverage for prognosis and treatment of at least the rates of reimbursement as are provided for hospice care under Medicare, the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as in effect January 1, 1999.

Benefit Election
The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

q The Policyholder elects the optional Hospice coverage provided by this Offer.

q The Policyholder declines the optional Hospice coverage provided by this Offer.

_____ _____
Policyholder's Signature, Title Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.

Secretary

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

OFFER of OPTIONAL MAMMOGRAM SCREENING COVERAGE

Group Policyholder: [Health Advocates Group Insurance Trust]
Group Policy Number: [TDT-MPO-001]

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

Mammogram Screening
Coverage shall be provided for the following mammogram screening of occult breast cancer:

(1) A baseline mammogram for a woman covered by such policy who is thirty-five (35) to forty (40) years of age;

(2) A mammogram for a woman covered by such policy who is forty (40) to forty-nine (49) years of age, inclusive every one (1) to two (2) years based on the recommendation of such woman's physician;

(3) A mammogram each year for a woman covered by such policy who is at least fifty (50) years of age;

(4) Upon recommendation of a woman's physician, without regard to age, where such woman has had a prior history of breast cancer or where such woman's mother or sister has had a history of breast cancer.

Benefit Election
The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

q The Policyholder elects the optional Mammogram Screening coverage provided by this Offer.

q The Policyholder declines the optional Mammogram Screening coverage provided by this Offer.

_____ _____
Policyholder's Signature, Title Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.

Secretary

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

OFFER of OPTIONAL MENTAL ILLNESS COVERAGE

Group Policyholder: [Health Advocates Group Insurance Trust]
Group Policy Number: [TDT-MPO-001]

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

Mental Illness Coverage

Coverage shall be provided for partial hospitalization and confinement as an inpatient in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Mental Health Services of the Department of Human Services.

Benefit Election

The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

q The Policyholder elects the optional Mental Illness coverage provided by this Offer.

q The Policyholder declines the optional Mental Illness coverage provided by this Offer.

_____ _____
Policyholder's Signature, Title Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.

Secretary

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

OFFER of OPTIONAL PSYCHOLOGICAL EXAMINERS COVERAGE

Group Policyholder: [Health Advocates Group Insurance Trust]
Group Policy Number: [TDT-MPO-001]

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

Psychological Examiners Coverage
Coverage shall be provided for payment of services rendered by psychological examiners. The amount paid for services provided by psychological examiners shall be subject to the same limitations as set forth in the policy for mental health coverage.

Benefit Election
The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

q The Policyholder elects the optional Psychological Examiners coverage provided by this Offer.

q The Policyholder declines the optional Psychological Examiners coverage provided by this Offer.

_____ _____
Policyholder's Signature, Title Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.

Secretary

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

OFFER of OPTIONAL TREATMENT OF ALCOHOL AND OTHER DRUG DEPENDENCY COVERAGE

Group Policyholder: [Health Advocates Group Insurance Trust]
Group Policy Number: [TDT-MPO-001]

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

Treatment of Alcohol and Other Drug Dependency
Coverage shall be provided for necessary care and treatment in an alcohol or drug dependency treatment facility or care and treatment in a hospital. Treatment may include detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, and related services.

Benefit Election
The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

q The Policyholder elects the optional Treatment of Alcohol and Other Drug Dependency coverage provided by this Offer.

q The Policyholder declines the optional Treatment of Alcohol and Other Drug Dependency coverage provided by this Offer.

_____ _____
Policyholder's Signature, Title Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.

Secretary

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

OFFER of TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER COVERAGE

Group Policyholder: [Health Advocates Group Insurance Trust]
Group Policy Number: [TDT-MPO-001]

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

TMJ/CMJ Coverage
Coverage shall be provided for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures. This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a physician or dentist.

Benefit Election
The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

q The Policyholder elects the optional Temporomandibular Joint Disorder and Craniomandibular Disorder coverage provided by this Offer.

q The Policyholder declines the optional Temporomandibular Joint Disorder and Craniomandibular Disorder coverage provided by this Offer.

_____ _____
Policyholder's Signature, Title Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.

Secretary

TIme Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

Deleted: John Alden Life

OFFER of HEARING AID COVERAGE

Group Policyholder: [Health Advocates Group Insurance Trust]
Group Policy Number: [TDT-MPO-001]

The consideration for this Offer is payment of the additional premium required to provide the benefit. The policy or certificate to which this Offer is attached is amended as follows if elected.

Covered Charges are included in the plan for the benefits described below, if elected by the Policyholder in the space provided at the end of this Offer.

Hearing Aid Coverage

Coverage shall be provided for hearing aids and shall not be for less than one thousand four hundred dollars ($1,400) per ear for each three-year period; shall provide coverage of not less one thousand four hundred dollars ($1,400) per ear beginning on the first day of coverage; and is not subject to policy deductibles or copayment requirements.

"Hearing aid" means an instrument or device, including repair and replacement parts, that: (A) Is designed and offered for the purpose of aiding person with or compensating for impaired hearing; (B) Is worn in or on the body; and (C) Is generally not useful to a person in the absence of a hearing impairment.

Benefit Election

The optional benefits provided by this Offer are effective only to the extent they are elected by the Policyholder as indicated below.

q The Policyholder elects the optional Hearing Aid coverage provided by this Offer.

Deleted: Special Footwear

q The Policyholder declines the optional Hearing Aid coverage provided by this Offer.

Deleted: Special Footwear

_____ _____
Policyholder's Signature, Title Date

This Offer applies only to Covered Persons who reside in the State of Arkansas. The optional benefits provided by this Offer are effective only to the extent that the benefit is elected by the Policyholder as indicated in the Benefit Election section above. Nothing contained in this Offer will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

The Effective Date of this Offer is the Effective Date of the policy or certificate to which it is attached, or the endorsement date if later.

Secretary

TDT.4664

TDT.4664

BENEFIT SUMMARY

[POLICYHOLDER INFORMATION]

[**POLICYHOLDER**]	[Health Advocates Group Insurance **Trust**]
[**LOCATION**]	[**City/State**]

[CERTIFICATE HOLDER] INFORMATION

[**CERTIFICATE HOLDER**] [Dependents]	[John Doe] [Jane Doe] [Mary Doe] [James Doe]
[**CERTIFICATE NUMBER**]	[0000001]
[**EFFECTIVE DATE**] [of this schedule]	[00/00/0000]
[**PLAN ID**] [**PLAN TYPE**]	[Plan name inserted here – CoreMed, MaxPlan, etc.]
[**PARTICIPATING EMPLOYER**]	[ABC Company]
[**GROUP NUMBER**]	[1900AK0000]
[**LOCATION NUMBER**]	[001]
[**BENEFIT PERIOD**]	[35 days]
[**BENEFIT PERIOD TERMINATION DATE**]	[05/05/2006]
[**PAYMENT OPTION**]	[Single Payment][Monthly Payment]
[[**BENEFIT**] **WAITING PERIOD**]	[A Sickness that occurs within the first [0-180 days] after the Covered Person's Effective Date of coverage will not be covered for a period of [12 months] after the Effective Date.]]

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

The Utilization Review Provisions [and the [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider] [Network]] must be utilized, to be eligible to receive the maximum benefits available under the policy. Refer to the Utilization Review Provisions for the medical benefits that must be reviewed.

Major Medical Benefits for [Single Plan/Family Plan] [Certificate Holder-Spouse Plan] [Certificate Holder-Children Plan].

[The [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider is [PPO].]

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

[[**BENEFIT PERIOD**] [**MAXIMUM** [**LIFETIME**] **BENEFIT**]] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100,000 - $100,000,000]
[**CALENDAR YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[[**ACCIDENT**] [**SICKNESS**] **MAXIMUM BENEFIT**]	

[for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$500 - $5,000]
[**DAILY MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100 - $10,000]
[**PLAN YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[**PER CAUSE MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $200,000]
[**OUTPATIENT** [**CALENDAR YEAR**] [**PLAN YEAR**] [**BENEFIT PERIOD**] [**TIME PERIOD**] **MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $50,000]
[**MONTHLY MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1.000 - $50,000]

BEN: 005.001.001.GE

PLAN DEDUCTIBLES

[[Annual]Carryover Deductible]
Covered Charges Incurred by a Covered Person [due to an Accident] [for Inpatient services] [for Inpatient services received on December 31st of a Calendar Year] [during the last [3] months of a [Plan Year] [Calendar Year] [Benefit Period]] that count toward satisfying a Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [Non-Participating][Non-Network] Provider Deductible,] [but do not satisfy the [Network] [Participating] Provider Deductible] [Individual Out-of-Pocket Limit] for that [Plan Year,] [Calendar Year,] [Benefit Period,] will also count toward satisfying the Covered Person's [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] for the next [Plan Year] [Calendar Year] [Benefit Period]. [This Carryover Deductible [does not count toward satisfying the [maximum] Family Deductible] [and] [only applies in the first [Plan Year] [Calendar Year] [Benefit Period].] [For the purpose of determining whether a Carryover Deductible applies, Covered Charges will be considered to apply toward the [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] in the order the Covered Charges are processed.]]

[The [Select Network,] [Network] and [[Non-Network] [Non-Participating Provider]] Deductibles are calculated separately.] [[For example,] Amounts applied toward Your [Select Network] Deductible will not be credited toward Your [Network] Deductible, and amounts credited toward Your [[Non-Network] [Non-Participating Provider]] Deductible will not be credited toward Your [Network] Deductible.]

[All Deductibles are calculated separately. Applicable Deductibles must be satisfied prior to any payment of Covered Charges.]

[Deductibles may apply to specific types of services. Please review the Benefit Summary for additional Deductible information.]

	[[Select] Participating Provider Benefits / [Select] Network]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
Individual Plan Deductible [*] [each] [every] [XX] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $50,000]	[None / $0 - $50,000]	[$0 - $50,000]
[[Maximum] [Family] Plan [Integrated] [Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $100,000]	[None / $0 - $100,000]	[None / $0 - $100,000]
[[Maximum] [Common][Accident] [Per Cause] Deductible][*] [each]	[None / $0 - $50,000]	[None / $0 - $50,000]	[None / $0 - $50,000]

[every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]			
[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [XX] [Calendar Year[s]] [Plan Year[s]] [Benefit Period[s]] [Time Period[s]].]			

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]
BEN: 010.001.002.GE

[[**Deductible**] [**Credit**] [**Reward**] [**Multi Year Deductible**] **Program**:]
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM EFFECTIVE DATE**] [00/00/0000]
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM TERMINATION DATE**] [00/00/0000]
[[Amounts may be credited to Your Deductibles based on the [Deductible] [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [and] [or] [reward] [and] [or] [Multi Year Deductible] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

BEN: 010.002.GE

[**Plan**] **Coinsurance**] [**and**] [[**Total**] [**Plan**] **Out-of-Pocket Limits**] [The Coinsurance is listed below unless specified elsewhere in the Benefit Summary]			
[Once the [Total] Out-of-Pocket limit is met the plan pays at [100%][unless otherwise specified]]			
[The Out-of-Pocket maximums for [Select Participating Providers,] [Select Network,] [Participating Providers,] [Network Provider] [and] [[Non-Participating] [Non-Network] Providers] are calculated separately. [For example,] Amounts credited toward Your [Participating][Network] Provider Out-of-Pocket maximum will [not] be credited toward Your Non-Participating Provider[Non-Network] Out-of-Pocket maximum, and amounts credited toward Your [Non-Participating] [Non-Network] Provider Out-of-Pocket maximum will [not] be credited toward Your [Participating] [Network] Provider Out-of-Pocket maximum.]			
[All Out-of-Pocket Limits are calculated separately. Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges. [Out-of-Pocket Limits do not include Deductible.]			
[[Coinsurance] [and] [Out-of--Pocket Limits] may apply to specific types of services. Please review the Benefit Summary for additional [Coinsurance] [and] [Out-of--Pocket Limits] information.]			
[Any applicable Prescription Drug Deductible, Coinsurance, Copayment [or Ancillary Charge] are calculated separately from the Plan Out-of-Pocket and do not count toward the plan Out-of-Pocket.]			
	[[Select] Participating Provider [Benefits]/ [Select] Network]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Tier [1]] [*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $75,000 / Not	[$0 - $75,000 / Not	[$0 - $75,000 / an

[Family][*]	applicable] [$0 - $150,000 / Not applicable]	applicable] [$0 - $150,000 / Not applicable]	additional $0 - $50,000] [$0 - $150,000 / an additional $0 - $100,000]
[Tier [2]][*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $50,000]
[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $100,000]
[Tier [X]][*] [Plan][Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]
[Tier [X]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $50,000]
[Family][*]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / Not applicable]	[$0 - $150,000 / an additional $0 - $100,000]
[Total] [Plan] [Out-of-Pocket (OOP) Limits][*] [Individual Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $100,000 / Not applicable]	[$0 - $100,000 / Not applicable]	[$0 - $100,000 / an additional $0 - $50,000]
[Common] [Family Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $250,000 / Not applicable]	[$0 - $250,000 / Not applicable]	[$0 - $250,000 / an additional $0 - $100,000]
[Total][Out-of-Pocket (OOP) Limits each [Calendar Year] [Plan Year][*]			[$0 - $250,000]
[[All Out-of-Pocket Limits are calculated separately.] [Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges.] [Out-of-Pocket Limits do not include Deductible.] [Amounts may be credited to Your			

Out-of-Pocket Limits based on the Deductible [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.]]

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]

BEN: 015.001.002.GE

[**Inpatient Medical Facility Services**]:				
[Subject to [Plan] [Integrated] [Per Cause] Deductible] and [Plan] Coinsurance [unless otherwise specified]]				
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]				
	[Participating Provider [Benefits] / Network Provider [Benefits]]	**[[Select] Participating Provider [Benefits]]**	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Medical Facility Services] Maximum Benefit]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	$XXX] [Per Covered Person	$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Medical Facility Services Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible or Total [Plan] Out-of-Pocket Limits.]				
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the Participating Provider Deductible.]				
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]				
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]				
[[Facility] [Copayment]]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]
[Facility] [Access] [Fee]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]
[Emergency Room] [Access]	[[$XXX] per	[[$XXX] per	[[$XXX] per	[[$XXX] per

[Fee]	Emergency Room visit] [Waived if admitted]	Emergency Room visit] [Waived if admitted]	Emergency Room visit] [Waived if admitted]	Emergency Room visit] [Waived if admitted]
[Emergency Room] [Copayment]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Medical Facility Services] [Out-of-Pocket Limits] [each] [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$XXX]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]	[$XXX]

BEN: 020.001.GE

[**Outpatient Medical Facility Services**:]
[All Outpatient services, supplies and treatments apply to the [Outpatient] [Plan Year] [Per Cause] [Calendar Year] Maximum Benefit [including] [excluding] Outpatient Prescription Drugs.]
[Limited to Outpatient Services associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]
[Subject to [Plan] [and] [Outpatient Services] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient Services] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient [Calendar Year] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] per [Covered Person] [covered child] [Family] [unless due to an] [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a[$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]]
[We will pay [up to] an Outpatient Maximum of [$XXX] [per][Covered Person] [covered child] per [day] [episode] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] per [day] [episode]]

[Emergency Room] Benefits are limited to a [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] [per] [episode] Maximum Benefit of [$XXX] [per] [Covered Person] [covered child] [Family]]
[The [Emergency Room] [Access] [Fee] [Copayment] will [not] apply toward any Out-of-Pocket Limit]
[The [Emergency Room] [Access] [Fee] [Copayment] will be waived if the Covered Person is subsequently admitted to the hospital for an Inpatient Stay.]
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]
[Non-Emergency use of an Emergency Room will result in a [30%] reduction in Covered Charges]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient [Services] Maximum Benefit]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient [Surgical] [Services] [Per Cause] Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX / None] [$XXX / None]	 [$XXX / None] [$XXX / None]	 [$XXX / None] [$XXX / None]
[The [Outpatient [Surgical] Services] Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible] or Total [Plan] Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Facility] [Access] [Fee]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]
[Emergency Room [Access] [Fee]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]
[Facility] [Emergency Room] [Copayment]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [1]]	[0% - 100% [until the [[Outpatient [Surgical] Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100%[then Tier [X + [1]];] [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] Out-of-Pocket Limits] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]

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[**Physician**][**Doctor**] [**Office Visit**]:
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Primary Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Primary Care Provider] Copayment, Covered Charges for [Primary Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan],[and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Designated Specialty Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Designated Specialty Care Provider] Copayment, Covered Charges for [Designated Specialty Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Mid-Level Practitioner] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Mid-Level Practitioner] Copayment, Covered Charge for [Mid-Level Practitioner] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit[s]] Copayment, Covered Charges [for Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] [Copayment] Includes the first [$50 - $200] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause].]
[Benefits for [Physician][Doctor] Office Visits [or] [Retail Health Clinic visits] are limited to [[2] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $100] per visit.] [After that, Office Visits [or] [Retail Health Clinic visits] are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visits] [or] [Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]

Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]			
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visits] paid at 100%]			
[Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Year] [Additional Office Visits are][Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Outpatient] [Coinsurance]
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visit] paid at 100%]			

Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Coinsurance]

	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the] [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 030.001.001.GE

[**Retail Health Clinic Visit**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit] Copayment, Covered Charges for [Retail Health Clinic visits] will be subject to the [Plan][,] [and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[[Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits]
[[Retail Health Clinic visit] [Copayment] includes the first [$50 - $2,100] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]]
[Benefits for [Retail Health Clinic visits] are limited to [[XX] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child with] a maximum payment of [$25 - $5,100] per visit.] [After that, Retail Health Clinic visits are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance]].
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] [XX visits] of Covered Services performed [by a [Retail Health Clinic] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period] [subject to a [$XX] copayment].]
[[Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating	**[Participating Provider**	**[Non-[Select]**

	Provider [Benefits]]	[Benefits] / Network Provider [Benefits]]	Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment:][After Copayment, Retail Health Clinic visits paid at 100%]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[Subject to [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

BEN: 032.001.GE

[**Preventive Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] Benefit Waiting Period][subject to a [$XX] copayment] [for Mammograms] [and] [, Pap Smears] [and] [Prostate Specific Antigen Screenings] [and] Stool for occult blood testing [and] Flexible sigmoidoscopy and barium enema or colonoscopy [and] Fasting glucose testing] [and] [Lipid profile testing] [and] [Complete blood count (or component parts) testing] [and] [Urinalysis testing] [and] [Tuberculin skin testing with purified protein derivative] [and] [Other diagnostic services as recommended by the United States Preventative Services Task Force on the date the service is Incurred].]
[Benefits for Preventive Medicine Services are limited [to a [$XX] per visit] [up to [XX] visits per] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] [per] [Covered Person] [covered child] [Family].]
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum [Lifetime] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per [Covered Person] [covered child] [Family].]

[[Mammograms] [Pap Smears] [and] [Prostate Specific Antigen Screenings] Colorectal Cancer Examination [and] [child immunizations up to age [12]] are not subject to the [Preventive Services] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum [Lifetime] Benefit]			
Prostate specific antigen screenings are exempt from any Deductible.			
[Preventive Medicine Services Benefit Waiting Period is [12] [months] [[365] days].]			
]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Preventive Medicine Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Preventive Medicine Services Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Preventive Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] [Retail Health Clinic] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Preventive Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Preventive Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Preventive Medicine Services] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Preventive Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 035.001.001.AR

Children's Preventive Health Care Services
Preventive Medicine Services shall include children's preventive health care services which shall include 20 visits at approximately the following ages: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 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.
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]] Deductible and Coinsurance will be waived for child immunizations.
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$500] [per [Covered Person] [covered child] [Family].] The maximum will not apply to child immunizations.
[Preventive Medicine Services Benefit Waiting Period is [12] [months].] The waiting period will not apply to child immunizations.

BEN: 036.001.AR

[**Loss or Impairment of Speech or Hearing**]:

[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
	[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[[Loss or Impairment of Speech or Hearing] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Loss or Impairment of Speech or Hearing] Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Loss or Impairment of Speech or Hearing] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Loss or Impairment of Speech or Hearing] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
Loss or Impairment of Speech or Hearing] [Tier [2]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [P Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Loss or Impairment of Speech or Hearing]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Loss or Impairment of Speech or Hearing]] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Loss or Impairment of Speech or Hearing Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider			

BEN: 037.001.AR

Medical Foods:			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
No benefits are available for the first {$2,400] of Covered Charges incurred by a Covered Person in a calendar year.			
	[Select Participating	**[Participating**	**[Non-[Select]**

	Provider Benefits]	Provider Benefits / Network Provider Benefits]	Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]
[Medical Foods] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 038.001.AR

[**Accident Medical Expense** [**Reduced Plan Deductible**] **Benefit**:]			
[All services, supplies and treatments apply to the [Plan] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[We will pay up to [$XXX] per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause][Accidental Injury] [Injury] for Covered Charges Incurred due to an Accidental Injury. After payment of this amount, Covered Charges will be subject to the [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance.]			
[Covered charges must be Incurred within [90] days of the Accident] [Injury]. [Covered Charges in excess of the Accident Medical Expense Benefit or rendered after the 90-day period will be subject to all the terms, limits and conditions of the plan.]			
[Accident Medical Expense is subject to the Accident Medical Expense Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX]. Covered Charges are then subject to the [Plan] [and][Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[Your [Plan] [Individual] [Integrated] [Family] [Per Cause] Deductible] will be reduced by [$XXX] for Covered Charges Incurred due to an [Accidental Injury] [Injury],] [then subject to [Plan] [and][Outpatient] [and] [Inpatient] [Coinsurance]]			
[Accident Medical Expense Benefit Waiting Period is [XX days]]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Accident Medical Expense Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Accident Medical Expense Benefit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]

[The [Accident Medical Expense Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Accident Medical Expense Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Accident Medical Expense] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 040.001.001.GE

[[**Diagnostic Imaging Services**] [**and**] [**Laboratory Services**]:]			
[All services, supplies and treatments apply to the [Inpatient][Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient][Inpatient] [Integrated] Deductible and [Plan] [Outpatient] [Inpatient]Coinsurance [unless otherwise specified]]			
[[Plan] [Integrated] [Per Cause] Deductible] [and Co-insurance] will be waived for the first [$XXX] of Covered Services] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]] [after a [12 month] [365 day] Benefit Waiting Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services] Benefit Waiting Period is [[12] [months] [[365] days].]			
[Limited to [Diagnostic Imaging Services] [and] [Laboratory Services] associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]			
[Includes [1] screening mammography exam per Benefit Period for a covered female age [35] or over.] [The maximum benefit for a mammography screening is [$50 - $500].]			
[Diagnostic Imaging Services] [and] [Laboratory Services] are limited to a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person] [covered child] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Diagnostic Imaging Services] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX][[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Per Cause]			

Deductible]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Diagnostic Imaging Services] [and] [Laboratory Services] Deductible] does [not] apply to the [Plan][Outpatient][Inpatient][Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[[Diagnostic Imaging Services] [and] [Laboratory Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Diagnostic Imaging Services] [and] [Laboratory Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.]] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 045.001.001.GE

[**Outpatient Physical Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient Physical Medicine Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [covered child] [Family] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [per] [Covered Person] [covered child] [Family]]
[We will pay [up to] an Outpatient Physical Medicine Services Maximum of [$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]][unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] [per [day] [episode]]
[Benefits for Outpatient Physical Medicine Services are limited to [1-20] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered Person with a maximum payment of [$25 - $200] per visit]
[Chiropractic Coverage is] [Adjustments and manipulations are] limited to a Maximum [Lifetime] [Calendar Year][Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person][Family]]
[Outpatient Physical Medicine Services Benefits Waiting Period is [[12] months]][[365] days]

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient Physical Medicine Services] Maximum Benefit]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[[Outpatient Physical Medicine Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[Outpatient Physical Medicine Services [Per Cause] Deductible]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Outpatient Physical Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Outpatient Physical Medicine Services] [Copayment]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]

[Outpatient Physical Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Physical Medicine Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Outpatient Physical Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

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[**Outpatient Alternative Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$20 - $5,000]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit[up to [XX] visits]] [up to [$XXX] each [Calendar] [Plan] Year] [Benefit Period] [per Covered Person]]			
[Outpatient Alternative Medicine Services Benefit Waiting Period is [[6] [months] [[180] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Outpatient Alternative Medicine Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Outpatient Alternative Medicine Services Deductible] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Outpatient Alternative Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[Copayment]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Outpatient Alternative Medicine Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% -			

50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 055.001.001.GE

[**Durable Medical Equipment and Personal Medical Equipment**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[[Durable Medical Equipment] [and] [Personal Medical Equipment] Benefits are limited to a [Lifetime][Calendar Year][Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person][Covered Child].]			
[Wheelchairs, Prosthetic Devices and Orthotic Devices apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Wheelchairs, Prosthetic Devices and Orthotic Devices will be subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[Durable Medical Equipment and Personal Medical Equipment [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Durable Medical Equipment and Personal Medical Equipment Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Personal Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Initial] [Permanent] [Temporary] [Basic] [Artificial] [Eye]	[$[XXXX] Maximum [Lifetime] [Calendar	[$[XXXX] Maximum [Lifetime] [Calendar	[$[XXXX] Maximum [Lifetime] [Calendar

	Year] [Plan Year] [Monthly] Benefit	Year] [Plan Year] [Monthly] Benefit	Year] [Plan Year] [Monthly] Benefit
[Durable Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket

[Tier [X]]	Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Durable Medical Equipment and Personal Medical Equipment] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[[Benefits for [Durable Medical Equipment and Personal Medical Equipment] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 060.001.001.AR

[**Maternity Care Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified] [and any other plan provisions in the Benefit Summary].]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Maternity Care Services] Benefit Waiting Period is [[12] months] [[30-365] days]]			
[Benefits will be reduced by [50%] if conception occurs during the [Benefit Waiting Period][first Calendar Year of the policy]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

[Monthly] [Daily] Benefit]			
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Maternity Care Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Maternity Care Services Deductible][if conception occurs after the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[Maternity Care Services Deductible] if conception occurs before the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[The [Maternity Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Maternity Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Maternity Care Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services y] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Maternity Care Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 065.001.001.GE

[**Complications of Pregnancy**:]
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]
[Not Covered]

BEN: 070.001.GE

[**Infertility Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]

[Benefits for Infertility Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Infertility Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-network Provider [Benefits]]**
[[Infertility Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Infertility Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Infertility Services are payable at [0-100%] [with a [$10-$100] copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 075.001.001.GE

[**Health Care Practitioner Services**:]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [and any other [Plan] [Inpatient] [or] [Outpatient] provision in the Benefit Summary] [unless otherwise specified].]
[Benefits for Covered Charges rendered by an Anesthesiologist are limited to a [Calendar Year] [Plan Year] [Benefit Period] Maximum of [$XXX] for Inpatient services and [$XXX] for Outpatient Services.]

BEN: 080.001.GE

[**Professional Ground [or Air] Ambulance Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Benefits are limited to a[n] [Professional Ground] [or] [Air] Ambulance Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [limited to] [[one] trip] [per Sickness or Injury] [per Covered Person].]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[Professional Ground [or Air] Ambulance Services] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit [per Covered Person]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]
[Professional Ground [or Air] Ambulance Services] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]

BEN: 085.001.GE

[**Home Health Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] Benefit of [20 - 200 hours] [or] [10-100 visits][per Covered Person]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Home Health Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services [Per Cause] Deductible]] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Home Health Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Home Health Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Home Health Care Services][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Home Health Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for Home Health Care Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 090.001.001.GE

[**Hospice Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient][and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Inpatient] [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Inpatient] [Outpatient] [Plan] Coinsurance [unless otherwise specified].]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Hospice Care Services include [2] visits for counseling services and [1] visit for bereavement counseling after a Covered Person's death] [[per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Hospice Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Hospice Care Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[Hospice Care Services Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Hospice Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Hospice Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not	[$0 - $25,000 / Not	[$0 - $25,000 / an

[Family]	applicable] [$0 - $75,000 / Not applicable]	applicable] [$0 - $75,000 / Not applicable]	additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Hospice Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Hospice Care Service are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network			

Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 095.001.001.GE

[**Inpatient Rehabilitation Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is less] [greater]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select} Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Rehabilitation Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]
[Inpatient Rehabilitation Services [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Rehabilitation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Inpatient Rehabilitation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Rehabilitation Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[Benefits for Inpatient Rehabilitation Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 100.001.GE

[[**Subacute Rehabilitation Facility**] [**and/or**] [**Skilled Nursing Facility Care**]:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] [Integrated] [Per Cause] Deductible] [and][Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is [less] [greater].]			
[Benefits are limited to a Maximum of [$XXX] per day, up to [50] Days per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX]	[$XXX]	[$XXX]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Subacute Rehabilitation Facility and Skilled Nursing Facility Care Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Subacute Rehabilitation Facility and Skilled Nursing Facility Care are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 105.001.GE

[**Family Planning Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Family Planning Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Family Planning Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Family Planning Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Family Planning Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 110.001.001.GE

[**Sterilization**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]
[Benefits for Sterilization Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,500] [per Covered Person].]
[Sterilization Services Benefit Waiting Period is [[12] months] [[365] days]].

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Sterilization Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Sterilization Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 115.001.001.GE

[**Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for [surgical and] nonsurgical treatment are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[Temporomandibular Joint (TMJ) or			

Craniomandibular Joint (CMJ) Dysfunction Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Deductible] does [not] apply to the [Plan][Outpatient] [Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 120.001.001.GE

[**Diabetic Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Covered Charges include: • [Eye Examinations: [Both eyes] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Foot Examination: [Both feet] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Nutritional Counseling: [When first diagnosed] [or] [and] [when changes in condition occur] [per Covered Person]]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider**	**[Non-[Select] Participating Provider [Benefits]/ Non-**

		[Benefits]]	Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Diabetic Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Diabetic Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Diabetic Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 125.001.001.GE

[**Growth Hormone Therapy Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Growth Hormone Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX]] [per Covered Person].]			
[Growth Hormone Therapy Services Benefit Waiting Period is [[12] months] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Growth Hormone Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 130.001.001.GE

[**Tonsils and Adenoids**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Benefits for Tonsils and Adenoids Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]]
[[Tonsils and Adenoids Services] Benefit Waiting Period is [[12] months] [[365] days].]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	[Participating Provider [Benefits] / Network Provider [Benefits]]	[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Tonsils and Adenoids Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Tonsils and Adenoids Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 135.001.001.GE

[**Bunions,**] [**Hemorrhoids**] [**and**] [**Varicose Veins**]:			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Bunions,] [Hemorrhoids] [and] [Varicose Veins]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 140.001.001.GE

[**Inguinal Hernia**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[Benefits for Inguinal Hernia Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,000] [per Covered Person].]			
[Inguinal Hernia Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inguinal Hernia]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Inguinal Hernia Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 145.001.001.GE

[**Blood Product Transfusions**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [and] [Per Cause] Maximum Benefit]			
[Subject to[Integrated] [Plan][Inpatient][and] [Outpatient] [Per Cause] Deductible] and [Plan][Inpatient][and] [Outpatient] [and] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Blood Product Transfusions Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Blood Product Transfusions Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Blood Product Transfusions Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per	[None / $XXX per	[None / $XXX per

	Blood Product Transfusions]	Blood Product Transfusions]	Blood Product Transfusions]
[Copayment]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]
[Blood Product Transfusions] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Blood Product Transfusions] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Blood Product Transfusions] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Blood Product Transfusions] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 150.001.001.GE

[**Transplants**:]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefit for Transplants are limited to [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]			
[Donor Expenses are limited to a Maximum Benefit of [$5,000 - $25,000]]			
[Not Covered]			
[The following Covered Transplants are subject to the [Outpatient] [and] [Calendar Year] [and] [Plan Year and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]: • [Kidney] • [Cornea] • [Skin]]			
[The following Covered Transplants subject to the [Maximum Transplant Benefit] [Outpatient] and [Calendar Year] and [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] [Maximum Benefit]: • Lung(s) • Heart • Simultaneous heart/lung • Liver • Simultaneous kidney/pancreas • Allogeneic and autologous bone marrow transplant/stem cell rescue]			
	[Designated Specialty Service Provider /[Select] Participating Provider /Designated Transplant Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]] [and Non-Participating/Non-Network Provider]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Maximum Transplant Benefit]	[Lifetime Maximum	[$100,000] [Lifetime]	[$100,000] [Lifetime]

	Benefit] [[$100,000] Benefit Period Maximum] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]
[Travel Expenses] will be covered up to a [$5,000 - $20,000] Maximum Benefit when a [Designated Specialty Service Provider][Select Participating Provider][Designated Transplant Provider Benefits] is used as described in the Covered Medical Benefits section]			

BEN: 155.001.001.GE

[**Behavioral Health** [**and Substance Abuse**]:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] [and] [Plan] [and] [Inpatient] [and] [Outpatient] [Coinsurance] [unless otherwise specified].]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$50] for each visit up to [[XX] visits] [$250 - $1,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$2,000 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $25,000] [per] [Covered Person] [Family]]
[Behavioral Health [and Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]
[The [Behavioral Health] [and Substance Abuse] [Deductible] [and] [Coinsurance] does [not] apply to the [Plan Deductible] [or] [Total Out-of-Pocket Limits.]]
[The [Behavioral Health] [and Substance Abuse] Coinsurance] will [not] increase to 100% after the Plan Out of Pocket is satisfied.] [The Behavioral Health Coinsurance, not paid by us, will not apply toward any Out of Pocket Limit.]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Behavioral Health [and Substance Abuse] Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]][Coinsurance] [Tier [2]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are

	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Behavioral Health [and Substance Abuse]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Behavioral Health [and Substance Abuse Services]] [Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Behavioral Health [and Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 160.001.001.GE

[**Substance Abuse**]:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$25 - $100] for each visit up to [[XX] visits] [$250 - $100] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$1,500 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $20,000] [per] [Covered Person] [Family]]
[Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Substance Abuse Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Substance Abuse Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Substance Abuse] Coinsurance [Tier [1]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse Services] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 165.001.001.GE

[**Reconstructive Surgery**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Integrated] [Inpatient] [Outpatient] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 170.001.001.GE

[**Dental Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Dental Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$1,000 - $5,000] [unless due to an Accidental Injury [Injury] [or underlying Sickness] [per Covered Person]]			
[Benefits are limited to conditions present at birth or diagnosed before age [5]]			
[Treatment must begin within [90 days] and be completed within [365 days] of the Dental Injury.]			
[Dental Services Benefit Waiting Period is [12][Months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Dental Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Dental Services are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 175.001.001.GE

[**Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified]]			
[Benefits for [Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating	**[Participating**	**[Non-[Select]**

	Provider [Benefits]]	Provider [Benefits] / Network Provider [Benefits]]	Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Intravenous Injectable Parenteral Drug Therapy Service] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 180.001.001.GE

[**Non-Intravenous Injectable Parenteral Drug Therapy**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] and [Inpatient] Coinsurance [unless otherwise specified]			
[Benefits for Non-Intravenous Injectable Drug Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Non-Intravenous Injectable Drug Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Non-Intravenous Injectable Drug Therapy Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 185.001.001.GE

[[**Telemedicine Services**] [**and**] [**Telehealth Services**]:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]

[Benefits for [[Telemedicine Services] [and] [Telehealth Services]]are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$1,000 - $5,000] [per Covered Person]]
[Benefits for [[Telemedicine Services] [and] [Telehealth Services]] are limited to a Maximum Benefit of [[$XX] for each visit] [0-12 visits] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per Covered Person].]
[[Telemedicine Services] [and] [Telehealth Services]] Benefit Waiting Period is [[6] months] [[180] days]]]
[Not Covered]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$50 - $500] [0-12 visits] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period][subject to a [$5 - $75] copayment].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Telemedicine Services] [and] [Telehealth Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Telemedicine Services] [and] [Telehealth Services]]Deductible] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
The [[Telemedicine Services] [and] [Telehealth Services]] Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[Copayment]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[[Telemedicine Services] [and] [Telehealth Services]][Coinsurance] [Tier [1]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [2]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and]			

[Telehealth Services]] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Telemedicine Services] [and] [Telehealth Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 190.001.001.GE

[[**Out of Network**][**Travel Benefit**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$250 - $1,000] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Out of Network] [Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Out of Network] [Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Out of Network] [Travel Benefit Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Out of Network] Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]

[Out of Network] [Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an

	applicable]	applicable]	additional $0 - $30,000]
[[Out of Network] [Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

BEN: 195.001.001.GE

[**Choice of Network Service Area Benefit**:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 200.001.GE

[Nationwide Network Benefit:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 205.001.GE

[**International Coverage**:]			
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and][International Coverage] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]			
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]			
[International Coverage Benefits are limited to a Maximum of [$XXX][for services rendered outside the United States of America]].			
[International Coverage is subject to the International Coverage Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX], Covered Charges are then subject the [Plan] [and][Outpatient] [and] [Inpatient] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[International Coverage Benefit Waiting Period is [90 days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[International Coverage] Maximum[Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]

Benefit]			
[[International Coverage] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[International Coverage Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [International Covered Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[Copayment]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[International Coverage] [Coinsurance] [Tier [1]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [2]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	$0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [X]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[International Coverage] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 210.001.001.GE

[**Travel Benefit**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$500] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Travel Benefit Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 215.001.001.GE

[**Repatriation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Repatriation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Repatriation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Repatriation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[]Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Repatriation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Repatriation Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Repatriation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]
[[Repatriation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100%	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

		thereafter.]]	
[Tier [1]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Repatriation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 275.001.GE

[**Medical Evacuation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Medical Evacuation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Medical Evacuation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Medical Evacuation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Medical Evacuation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Medical Evacuation Services Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Medical Evacuation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]
[[Medical Evacuation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for [Medical Evacuation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 280.001.GE

[**Outpatient**] **Prescription Drug Benefits**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] Maximum Benefit]
[Subject to [Plan][and][Outpatient][Integrated] [Per Cause] Deductible] and [Plan][and][Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Prescription Drugs are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit of [$1,000 - $10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]
[Benefits for Prescription Drugs are limited to a Maximum [Lifetime] [Benefit Period] Benefit of [$1,000 -$10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]
[For Prescription Drugs and medicines Covered Charges are limited to [$2,000] per [Calendar Year][Plan Year][Benefit Period] [Time Period] for: • [Legend drugs and medicines that by Federal law can only be obtained with a prescription;] • [Injectable insulin with a prescription;] • [Disposable insulin syringes, and disposable blood/urine, glucose/acetone testing agents or lancets.]]
[[$20] maximum per [Outpatient] Prescription Drug[, limited to $1,000 - $5,000] [limited to [XX] prescriptions] Maximum Benefit per [Calendar Year][Plan Year][Benefit Period] [Time Period] [Month][for] [Anti-Infective Prescription Drugs] [per Covered Person] [Per Covered Child]]
[[Outpatient] Prescription Drugs Benefit Waiting Period is [[12] months] [[365] days].]
[Outpatient] Prescription Drugs Benefits do [not] apply to the [Plan][Inpatient][Outpatient] Out of Pocket Limits]
[Not Covered]
[Participating Pharmacy Plan:] [PBM]
[Prescription Drug [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit] [[$XXX] per [Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Lifetime] Maximum Benefit] [[$XXX] [per Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5,000]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Individual] [Integrated] Deductible:] [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-Preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to Plan [Individual] Deductible and Coinsurance.] **[Prescription Drug [Integrated] Family Maximum Deductible:]** [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Prescription Drug [Deductible] [per Covered Person] [Covered Child]:] [$0 - $9750]

[**Designated Specialty Pharmacy Provider**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Individual] [Integrated] Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-Preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to Plan [Individual] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Integrated] Family Maximum Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Tier 1] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Participating Pharmacy**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Non-Participating Pharmacy**:] [$0 - $100]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Mail Service Prescription Drug Vendor**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[Tier 1] Coinsurance:

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[Tier 1] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]

[Tier 2] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[Tier 2] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 2] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[Tier 3] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[Tier 3] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 3] Out-of-Pocket Limits	[Individual]	[Common][Integrated][Family]
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[[$0-500] [Calendar Year] [Benefit Period] [Per Cause] [Time Period] [Plan Year] [Brand Name Drug] Deductible. [The Deductible applies to [level] [group][1][A][,] [level] [group] [2] [B] [,] [level] [group [3] [C] [and] [level] [group] [4] [D] [and] [level] [group] [5] [E]] [Brand Name] Drugs.]	
[[Therapeutic l] [Class] [1] [a] drugs] [Deductible] [Drugs appearing on the drug list]	[$0 - $9750]
[[Therapeutic l] [Class] [1] [a] drugs] [Drugs appearing on the drug list]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill.][for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [2] [B] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [2] [B] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [3] [C] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [3] [C] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [4] [D] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [4] [D] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

[[Therapeutic l] [Class] [5] [E] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [5] [E] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

BEN: 220.001.001.GE

[**Life Insurance**:]

[Certificate Holder	$[0-250,000]]
[Covered Dependent Spouse	$[0-250,000]]
[Covered Dependent Child(ren)	$[0-50,000]]

[This Amount of Life Insurance will be subject to the Age Reduction Percentages listed below:]

[Age Reduction Percentages:]

[Reduction Age:]	[Reduction Percentage:]
[[55]	Reduces to [70]% of the amount in force immediately prior to age [55]]
[[65]	Reduces to [60]% of the amount in force immediately prior to age [65]]
[[70]	Reduces to [60]% of the amount in force immediately prior to age [70]]

BEN: 225.001.GE

[**Accelerated Benefit**:]

[[Up to] [50%] of the Life Insurance Benefit.]

BEN: 230.001.GE

[**Accidental Death & Dismemberment Insurance**[**for Employee**]:]

[The Accidental Death Benefit will be] [[an amount equal to] [and in addition to]] the amount of Life Insurance [(including any applicable adjustment or reduction)] in effect on the date of loss.]

[Certificate Holder	$[10,000] [2X's] [3X's]]
[Dependent Covered Spouse	$[5,000] [2X's] [3X's]]
[Dependent Covered Child(ren)	$[2,000] [2X's] [3X's]]

BEN: 235.001.GE

Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

CERTIFICATE AMENDMENT RIDER

The following matrix paragraph/provision amendments will be incorporated into the certificate of medical insurance (form TDT.CER.AR), which was previously approved by your Department on September 29, 2009.

The bulleted headers (in bold/italics) will identify if the language will be added, removed or replaced/modified.

FORM TDT.CER.AR AMENDMENTS:

- ***DEF: 065.001.001.GE is replaced with DEF: 065.001.002.GE, which reads as follows:***

[**Benefit Waiting Period**
The period of consecutive days [or months] that must pass after the Effective Date of coverage before a Covered Person is eligible to be covered for [a Sickness,] [and] [specific benefits as shown in the Benefit Summary] [and] [or] [preventive medicine services] under the terms of this plan. Each Covered Person is responsible for payment of all services that are received during the Benefit Waiting Period. [The Benefit Waiting Period applies separately to each Covered Person.] [Benefits are available from the first day Covered Charges are Incurred for an Injury that is sustained on or after the Covered Person's Effective Date.]

[A Sickness that occurs within the first [~~15~~0-180 days] after the Covered Person's Effective Date of coverage will not be covered for a period of [12 months] after the Effective Date.]

A Benefit Waiting Period only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Benefit Waiting Periods are along with the Covered Charges to which they apply.]
DEF: 065.001.002.GE

- ***PAR: 010.001.001.GE is replaced with PAR: 010.001.002.GE, which reads as follows:***

[**Receiving Ancillary Services**
Please note that certain ancillary services, such as lab tests or services performed by anesthesiologists, radiologists, pathologists or Emergency Room physicians, that are ordered by a [Network] [Participating] Provider are sometimes out-sourced to a [Non-Network] [Non-Participating] Provider. [Covered Charges for such services will be processed as [Non-Network] [Non-Participating] Provider benefits.] [To obtain [Network] [Participating] Provider benefits, it is important that such services be referred to another [Network] [Participating] Provider when possible.] [[Covered Charges for such services rendered in association with direct treatment from a [Network] [Participating] Provider will be paid at the corresponding benefit level][.]] [and may be subject to the Maximum Allowable Amounts for [Network] [Participating] Providers and Maximum Allowable Amounts for [[Non-Network] [Non-Participating]] Providers provisions.]] [A higher benefit level may be available if the Covered Person uses a Designated Specialty

Provider for ancillary services that are designated by Us to be specialty services from that provider.]]]
PAR: 010.001.002.GE

- ***MED: 025.001.GE is replaced with MED: 025.001.001amended to reads as follows:***

[**Preventive Medicine Services**

[1.] [Preventive medicine services for well child care and adult care, including immunizations as recommended by the United States Prevent~~at~~ive Services Task Force or the Advisory Committee on Immunization Practices on the date the service is Incurred.] [This does not include routine well newborn care at birth [unless the Maternity Care Services coverage is included in this plan as shown in the Benefit Summary].]

[2.] [The following diagnostic services:]

[a.] [Pap smears with chlamydia screening.]
[b.] [Mammography screening.]
[c.] [Stool for occult blood testing.]
[d.] [Prostate specific antigen screening.]
[e.] [Fasting glucose testing.]
[f.] [Lipid profile testing.]
[g.] [Complete blood count (or component parts) testing.]
[h.] [Urinalysis testing.]
[i.] [Tuberculin skin testing with purified protein derivative.]
[j.] [Other diagnostic services as recommended by the United States Prevent~~at~~ive Services Task Force on the date the service is Incurred, except for genetic testing or genetic counseling.]]

Preventive medicine services also include an annual prostate cancer specific antigen screening for covered males who are 40 years of age or older.

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.] [The Benefit Waiting Period will be waived if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan.] [The maximum benefit for preventive medicine services is shown in the Benefit Summary.]
MED: 025.001.001.GE

- ***RXP: 015.001.001.GE is replaced with RXP: 015.001.002.GE, which reads as follows:***

[**Miscellaneous Provisions**

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

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

[Payment by Us for a Prescription Drug under this section does not constitute any assumption of

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

[~~For the purpose of the Coordination of Benefits section, the Outpatient Prescription Drug Benefits section will be considered a separate Plan and will be coordinated only with other Prescription Drug coverage.~~ We will not provide any benefits for Prescription Drug charges that are paid by another Plan as the primary payor.]

[The Covered Person is responsible for any Prescription Drug] [Coinsurance,][,] [and] [or] [Prescription Drug] [Copayment][,] [and] [or] [Prescription Drug] [Deductible] that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen or Prescription Order. These charges will not be reimbursed by Us.]]]
RXP: 015.001.002.GE

- ***EXC: 075.001.GE is replaced with EXC: 075.001.001.GE, which reads as follows:***

[14.] [Charges for any appliance, medical or surgical expenses for:]

[a.] [Malocclusion or Mandibular P~~p~~rotrusion or R~~r~~ecession~~ of the mandible~~.]
[b.] [Maxillary or M~~m~~andibular H~~h~~yperplasia.]
[c.] [Maxillary or M~~m~~andibular H~~h~~ypoplasia.]]
EXC: 075.001.001.GE

- ***EXC: 345.001.GE is replaced with EXC: 345.001.001.GE, which reads as follows:***

[4.] [Charges for drugs that are paid under another p~~P~~lan sponsor or payor as primary payor.]
EXC: 345.001.001.GE

- ***OTH: 035.004.GE is replaced with OTH: 035.004.001.GE, which reads as follows:***

[**Extension of Benefits** [**for Medical Coverage Only**]
If a Covered Person is Totally Disabled on the date this coverage terminates, We may extend benefits only for Covered Charges Incurred to treat the Sickness or Injury that directly caused the Total Disability provided that the Sickness commenced or the Injury was sustained while this plan was in force. Benefits are subject to all the terms, limits and conditions in this plan. [Premium payment will not be required during the extension of benefits period.] Medical documentation verifying Total Disability must be sent to Us within [60 days] after termination.

The extension will end on the earliest of:

[1.] [The date on which services are no longer required to treat the Sickness or Injury that caused the Total Disability.]

[2.] [The date the Covered Person is no longer Totally Disabled.]

[3.] [Payment of the Maximum Lifetime Benefit or any other maximum benefit for those services under this plan.]

[4.] [[90 days] from the date coverage would have terminated under this plan if there was no extension of benefits.]

[5.] [The date the Covered Person is eligible for Medicare or any other medical coverage.]

[6.] [The earliest date otherwise permitted by law.]]

OTH: 035.004.001.GE

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/29/2009

Comments:

Attachment:

Readability Certification.PDF

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/29/2009

Bypass Reason: NA

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter, Trust Agreement, Variability Statement, Marked Benefit Summary, Marked Certificate	Approved-Closed	09/29/2009

Comments:

Attachments:

Trust Agreement.PDF

Variability Statement.PDF

Cover Letter.PDF

Marked Benefit Summary.PDF

Marked Certificate.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
TDT.CER.AR	50.2
CSD.001.XX	46.6
SER.001.XX	48.9
TDT.BNC.AR	52.5

Signed: _____

Name: Julia Hix-Royer

Title: Vice President

Date: August 27, 2009

TRUST AGREEMENT

THIS AGREEMENT is entered into between FORTIS INSURANCE COMPANY (hereinafter called "Insurer") as Trustor, and Marine Bank, Springfield, State a ~~national~~ banking ~~association~~ corporation, (hereinafter called "Trustee").

WHEREAS, the Trustor desires to establish a plan or plans of group insurance benefits for those person who shall qualify for such benefits according to the terms of this Agreement and,

WHEREAS, the Trustor hereby desires to create and continue a Trust for such purpose, and,

WHEREAS, the Marine Bank has agreed to act as Trustee in accordance with the provisions hereof,

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

ARTICLE I - GENERAL PROVISIONS

A. NAME OF TRUST

This Trust shall be known as The Health Advocates Group Insurance Trust.

B. DEFINITIONS

The following words as used in this Agreement shall have the meaning indicated unless otherwise required by context:

1. Administrator - The person or corporation which will provide administrative services under this Trust and/or any policy or contract of insurance.

2. Benefit Plans - Insurance benefits of any kind approved by the Administrator and the Trustor and underwritten by a duly licensed insurance carrier and having been filed as necessary.

3. Covered Person - All eligible persons participating in the group insurance plan.

4. Dependent - Any person or persons designated by any Covered Person to receive any benefits which may be payable under the provisions of any contract obtained through this Agreement.

5. Issuing Company - Any duly licensed life or other Insurance Company.

6. Policy - The policy or policies of insurance secured and held by the Trustee in accordance with the purpose of this Trust.

7. Trustee - The Marine Bank, or any successor thereof appointed and qualified by the Trust.

8. Trust Fund - All property, moneys, and contract rights held by the Trustee pursuant to this Agreement.

ARTICLE II

A. TRUSTEE'S APPOINTMENT

The Marine Bank is appointed as Trustee of this Trust.

B. COMPENSATION AND LIABILITY: INDEMNIFICATION AND REIMBURSEMENT

1. The Trustee shall incur no liability or responsibility whatsoever other than to act as the holder of the master policy or policies.

2. The Trustee shall receive no remuneration in the form of commissions or otherwise for its services as holder of the aforementioned master policy or policies, but shall be reimbursed by the Administrator for its proper expenses and disbursement and such other normal fees appropriate to the performance of its services as Trustee.

3. Indemnification. The Trustor and the Administrator will indemnify and hold harmless the Trustee for and against any and all claims, judgments, losses, costs and expenses, including court costs and attorney's fees, that arise out of or result from the operation and administration of the trust, unless it is alleged that the Trustee has acted in an improper or improvident manner.

4. Reimbursement of Attorney Fees. The Trustor and the Administrator will reimburse the Trustee for the attorney's fees incurred by the Trustee whenever the Trustee reasonably deems it is necessary to consult legal counsel regarding the operation and administration of this trust.

ARTICLE III

Powers and Duties of the Trustee

A. GENERAL

1. The Trustee shall have no duty to collect or enforce payment of any premium contributions provided for in this Agreement, or any contract issued hereunder. All premium payments and refunds, claims and payments of members under the policies, correspondence regarding premiums, refunds or claims shall be handled or accounted for directly by the Administrator with the participating members, the insurer or others involved; and the Trustee shall have no responsibility therefor, except to forward to the Administrator any correspondence, remittance, inquiries and like material which it may receive. The Trustee shall not be required to endorse any checks.

2. Premiums collected will be handled as agreed to by the Administrator and Issuing Company.

3. No liability shall be incurred by the Trustee or Administrator should the Trust Fund be insufficient to pay the premium on such policies.

B. PAYMENT OF CLAIMS

The Issuing Company shall be responsible for payment of all proper claims on behalf of all Covered Persons and the Trustee shall not be liable in any manner for payment of such claims. The Trustee shall not be required to make any payment of any kind to any Covered Person or Dependent, nor shall the Trustee be liable in any manner whatsoever for any failure of any Issuing Company to make payment of any benefits.

C. TRUSTEE'S PROTECTION

1. The Trustee shall not be liable for any action taken or omitted upon the instruction of the Trustor or Administrator. Nor shall the Trustee be liable for any action taken in good faith. The Trustee shall not be required to give any bond or other security for the faithful performance of its duties hereunder.

2. The Trustee shall be entitled to rely on any information furnished to it by the Administrator or Trustor.

D. RESIGNATION, REMOVAL AND SUCCESSION OF TRUSTEE

The Trustee shall continue to serve until resignation or removal as herein provided.

1. The Trustee may resign at any time upon delivering to the Administrator a written notice of its resignation, to take effect not less than sixty (60) days after the delivery thereof, unless such notice shall be waived.

2. The Trustor may remove the Trustee at any time by delivering to the Trustee a written notice of removal to take effect not less than sixty (60) days after the delivery thereof, unless such notice shall be waived.

3. Upon resignation or removal of a Trustee, the Trustor shall forthwith appoint a bank or trust company organized under the laws of the United States, or a state thereof, or any other appropriate party or entity as successor Trustee. Any successor Trustee so appointed may qualify by executing and delivering to the Trustor any instrument accepting such appointment and agreeing to be bound by all of the terms of this Agreement. Without further act, the successor Trustee shall then become vested with all the estate, rights, powers, discretion and duties of its predecessor Trustee.

4. The Trustor or the Administrator shall notify the Issuing Company of any change in Trustee.

ARTICLE IV

The Covered Persons

A. PARTICIPATION IN TRUST

Certain persons as designated and approved by the Issuing Company become a Covered Person hereunder by making application for insurance to be issued pursuant to the terms of this Agreement and under the uniformly applied underwriting rules and regulations of any policy issued to and by the Trustee, and by further making the required premium contribution, providing the underwriting insurance company will accept such person under a master policy or contract issued to the Trust and held by this Trustee. Nothing herein constitutes any form or obligation whatsoever to the Trustee, the Trustor or the Administrator to obtain any particular policy or type of insurance for the Covered Person generally or for any individual Covered Person individually, nor for the Administrator or Issuing Company to accept any applicant, offer any particular benefit plan, pay any benefits, or set any specific premium levels. All terms and limits of the insurance coverage, including but not limited to, benefits, premiums, coverage and eligibility shall be governed solely by the terms of the insurance contracts.

B. PREMIUM CONTRIBUTION

Each Covered Person accepted for insurance coverage under any master policy held by this Trust shall be required to pay the appropriate premium contribution under the terms of any such policy or contract of insurance issued hereunder, and, in order to keep any such insurance coverage in force, shall be required to timely pay each premium contribution thereafter due and payable and his failure to do so shall constitute full authority to all parties to terminate any insurance coverage he may have had in the usual manner and after the appropriate grace period, if any. It is clearly understood that any and all premium contributions shall include therein the pro rata share of the commissions and fees agreed upon by the Administrator and the Issuing Company as proper compensation to the Administrator for performance of its duties.

C. INFORMATION FROM COVERED PERSONS

Each Covered Person may be required to furnish to the Administrator such evidence of eligibility for participation as shall be required together with any other information required by the Issuing Company.

ARTICLE V

The Trustor

A. PROPER FUNCTIONS OF THE TRUSTOR

1. The Trustor may recommend to the Administrator such rules, regulations and procedures as it may deem to be proper and necessary for the sound and effective administration of this Trust, and such recommendations will be accepted by the Administrator providing any such rules, regulations and procedures shall not be inconsistent with the provisions of this Agreement, applicable laws and regulations of state regulatory agencies, and further are not inconsistent with accepted sound underwriting practices.

2. The Administrator shall provide the Trustor, the Trustee and each Issuing Company with a copy of this Agreement together with any amendments thereto.

3. The Trustor shall have the power, by resolution, to provide for a successor Trustee according to the provisions of Article VI of this Agreement.

4. The Trustor shall have the power, by resolution, to appoint the Administrator or any successor thereto according to the provisions of Article VI of this Agreement.

5. The Trustor, at its discretion, may delegate any and all of its functions and responsibilities which arise as a result of this Agreement to whomsoever, in its opinion, it determines will carry out the purposes of this Agreement. If such delegation is made, the instructions, judgments or any other actions taken by the delegatee shall be considered to have come directly from the Trustor and anyone acting pursuant thereto may rely thereon.

B. EXPENSES

Any and all legally assessed taxes, special assignments, counsel-fees and any other necessary and reasonable expenses incurred in connection with this Trust by the Trustor or its members shall be paid by the Administrator.

ARTICLE VI

The Administrator

A. APPOINTMENTS AND FUNCTIONS OF ADMINISTRATOR

The Trustor hereby appoints Fortis Insurance Company as the Administrator. Whereas, Fortis Insurance Company has consented to act as Administrator in accordance with the provisions hereof. The Administrator shall have such responsibilities as may be determined by the Trustor, which shall include the following and such other responsibilities as may be agreeable to Trustor:

1. The Administrator shall have the power to select and apply for a program in accordance with purposes of the Agreement;

2. Collection of contributions from the Covered Persons;

3. Maintenance of eligibility records and any other records pertinent to the insurance as requested by the Trustor;

4. Promotion of the Insurance Plan or Plans;

5. Performance for the Trustor any and all duties which the Trustor, in its discretion, delegates to the Administrator.

B. In the event of a delegation by the Trustor to the Administrator of the duties which this Agreement imposes upon the Trustor, the Administrator is empowered to perform such functions, including but not limited to giving written instructions to the Trustee and those receiving such instructions may rely thereon. The Trustor hereby delegates all of its duties as Trustor to Fortis Insurance Company, as Administrator.

C. The Administrator may resign at any time by delivering to the Trustor and any and all Issuing Companies a written notice of its resignation to take effect not less than thirty (30) days after delivery thereof, unless such notice shall be waived.

D. Upon resignation of the Administrator, the Trustor, by resolution, shall forthwith appoint an individual, firm or corporation to act as successor Administrator. Any successor Administrator so appointed may qualify by executing and delivering to the Trustor an instrument accepting such appointment and agreeing to be bound by the terms of this Agreement.

ARTICLE VII

Miscellaneous

A. RIGHTS IN THE TRUST

No Covered Person or Dependent shall have any rights or claim to benefits under this Trust except as specified in a policy or contract of insurance procured or entered into pursuant hereto. Any dispute as to eligibility type, amount, or duration of benefit shall be resolved by the Administrator and the appropriate Issuing Company under and pursuant to the policy or contract. The Covered person or Dependent shall have no right to claim with respect thereto against the Trust Fund. The Trustor, the Administrator and the Trustee, shall not be liable for the failure or omission of an Issuing Company for any reason to pay any benefit or furnish any services under the policies or contracts of insurance.

B. RESPONSIBILITY OF THE ISSUING COMPANY

No Issuing Company shall, for any purpose, be deemed a party to this Trust to be responsible for its validity or sufficiency. The obligations of the Company shall be measured and determined solely by the terms and conditions of the policy or contract it may issue, and there shall be no obligation to any person whatsoever other than that stated in such policy or contract. The Issuing Company shall not be required to take cognizance of the provisions of the Trust, or to question the authority of the Trustee or any successor Trustee. The Issuing Company shall not be required to make an inquiry as to whether the Administrator has instructed the Trustee or as to whether the Trustee is otherwise authorized; therefore, the Issuing Company may take or allow any action solely upon any application, waiver, request, directions or other instrument, without exceptions, executed by the Administrator.

C. NOTICES

All notices, contributions, and other information required hereunder shall be mailed or directed to the Administrator, who shall be deemed the agent of the Trustor for all purposes with respect to this Trust.

D. SITUS OF TRUST

This Trust is accepted by the Trustee in the State of Illinois and all questions pertaining to its validity, construction and administration shall be determined in accordance with the laws of such state.

E. GENDER AND FORM

Wherever any words are used in this Agreement in the masculine gender they should be construed as though they were also used in the feminine or neutral gender in all situations where they would so apply, and wherever any words are used in this Agreement in the singular form they shall be construed as though they were also used in the plural form in all situations where they would so apply, and wherever any words are used in this Agreement in the plural form they should be construed as though they were used in the singular form in all situations where they would so apply.

F. INVALID PROVISIONS

If any provisions of this Trust Agreement, the Benefit Plan, the rules and regulations made pursuant hereto, or any step in the administration of the Plan is held to be illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining portions of this Trust Agreement and the Benefit Plan or the rules and regulations, unless such illegality or invalidity prevents accomplishment of the objectives and purposes of the Trust Agreement.

G. SPENDTHRIFT CLAUSE

No Covered Person or Dependent or other person whosoever with an interest in this Trust shall have any right to alienate, encumber or hypothecate his interest in any policy or contract of insurance issued hereunder or to any claim of interest in the Trust in any manner, nor shall such interest of any Covered Person or any other person be subject to claims of his creditors or liable to attachment, execution or other process of law, provided however, that nothing herein shall be construed to forbid the assignment of insurance benefits by a Covered Person or Dependent to a hospital or doctor for services rendered, nor shall the foregoing prohibit a Covered Person from assigning or transferring the ownership of his interest under the policy or contract in accordance with the provisions of said policy or contract and the rules and regulations of the Issuing Company.

H. AMENDMENT CLAUSE

The provisions of this Agreement may be amended to any extent and at any time by an instrument in writing executed by the Trustor and by a duly authorized officer of the Trustee.

I. TERMINATION CLAUSE

This Trust shall terminate at such time that all of the policies shall be canceled, such that the purposes of this Trust shall cease to exist.

ARTICLE VIII

Counterpart

This indenture may be executed subsequent but retroactive to the date hereof in as many counterparts (duplicates and reproductions of the original) as may be necessary and required to accomplish the purposes of this Indenture, each of which shall be deemed to be an original, but all of which together at any given time, shall constitute one and the same instrument for all purposes.

IN WITNESS WHEREOF, the parties hereto have caused this Indenture to be executed as of the first day of March, 2001.

TRUSTOR

Fortis Insurance Company

BY: A. Mayberry

Its: Senior Vice President & General Counsel

ADMINISTRATOR

Fortis Insurance Company

BY: A. Mayberry

Its: Senior Vice President & General Counsel

TRUSTEE

Marine Bank, Springfield (VPe)

BY: Kathrina A Stewart

Its: Trust Officer

MAILING ADDRESS

Fortis Insurance Company
501 West Michigan
Milwaukee, WI 53201-3050

MAILING ADDRESS:

Marine Bank, Springfield ATT: Trust Dept.
3050 West Wabash Avenue
Springfield, Illinois 62704

RECEIVED
OCT 3 1 2005
LEGAL DEPT.

AMENDMENT TO TRUST AGREEMENT

The Trust Agreement for The Health Advocates Group Insurance Trust, to which this Amendment is attached, is hereby amended as follows:

1. The name of the Administrator is hereby changed to Time Insurance Company.

2. The name of the Trustor is hereby changed to Time Insurance Company.

This Amendment is effective as of September 6, 2005.

Counterpart

This Amendment may be executed subsequent but retroactive to the date stated above in as many counterparts (duplicates and reproductions of the original) as may be necessary and required to accomplish the purposes of this Amendment, each of which shall be deemed to be an original, but all of which together at any given time, shall constitute one and the same instrument for all purposes.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be executed as of the day and year first above written.

TRUSTOR

Time Insurance Company

BY: CRPal

Christina R. Palme-Krizak

Its: Senior Vice President, General Counsel & Secretary

MAILING ADDRESS

Time Insurance Company
501 W. Michigan
Milwaukee, WI 53203

ADMINISTRATOR

Time Insurance Company

BY: CRPal

Christina R. Palme-Krizak

Its: Senior Vice President, General Counsel & Secretary

MAILING ADDRESS

Time Insurance Company
501 W. Michigan
Milwaukee, WI 53203

TRUSTEE

Marine Bank, Springfield

BY: Victoria A. Howard TO

Its: Trust Officer

MAILING ADDRESS

Marine Bank, Springfield
3050 W. Wabash Avenue
Springfield, IL 62704

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

STATEMENT OF VARIABILITY

Each distinct paragraph/provision/section has been assigned a number to facilitate the filing review. The assigned filing numbers will not appear in the final, printed version of the form, but are included in the matrix filing for informational use and reference only.

The variable and adaptable items in the form(s) have been bracketed to provide:

- A number of benefit options and/or items which customarily vary according to the Policyholder's specific plan of insurance, which will allow us to deliver a customized contract to our customers reflecting all benefit options selected, helping to alleviate any ambiguity on the part of the customers as to what is covered and how it is covered.
- Flexibility in utilizing provisions when filing diverse products.
- Future flexibility to adjust to changing regulatory and market needs.

1. All bracketed numbers (excluding form numbers) are variable, subject to the confines of state and federal law. Bracketed benefit amounts, illustrated as a range, list of amounts or otherwise, are variable and can fluctuate to provide a richer benefit to the insured than what is represented in the approved document.

2. All bracketed text varies to the extent that such language may be:

   a. included as shown;
   b. omitted in its entirety;
   c. rearranged; or
   d. transferred to another provision, section or page.

3. All bracketed numbers and/or text will be varied only:

   a. within any statutory or regulatory requirements; and
   b. under the condition that the numerical value(s) and benefit language is within the intent and framework of the actual approved provision.

We also reserve the right to amend the form(s) to correct any minor clerical or typographical errors we may have overlooked prior to approval, and to revise any phraseology to clarify the intent within the confines of the law.

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

September 24 , 2009

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, AR 72201

Re: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Master Policy: TDT.MPO.XX
Certificate of Medical Insurance : TDT.CER.AR
Benefit Summary : TDT.BNC.AR
JOHN ALDEN LIFE INSURANCE COMPANY (NAIC #65080; FEIN 41-0999752)
Master Policy: JDT.MPO.XX
Certificate of Medical Insurance: JDT.CER.AR
Benefit Summary: JDT.BNC.AR

Dear Rosalind Minor,

Per our phone conversation of September 24, 2009, I withdraw Insurance Department # 43359, Serf Filing ID#ASWX-126284502 which was submitted using an incorrect category. As you instructed this resubmission will not require a new filing fee.

The enclosed medical insurance forms are hereby submitted for your review seeking approval. All forms are new and do not replace any forms currently on file with your Department. Master Policy form TDT.MPO.XX will be issued and delivered to a trust in the State of Illinois and the certificate forms will be issued to individuals under the trust policy. Coverage is issued on an individually underwritten basis and is not employer sponsored. A copy of the trust agreement is enclosed herewith.

Certificate of Medical Insurance form TDT.CER.AR and Benefit Summary form TDT.BNC.AR mirror Certificate of Medical Insurance form TIM.CER.AR (05/2008) and Benefit Summary form TIM.BNC.AR (05/2008) with the exception of SIG: 025.001.GE, SIG: 030.002.001.GE and EFF: 010.005.GE. Certificate of Medical Insurance form TIM.CER.AR (05/2008) and Benefit Summary form TIM.BNC.AR (05/2008) were approved by your Department on July 7, 2008 via SERFF Filing ID ASWX-125719472.

For your ease in review, the differences between the Certificate of Medical Insurance form and the form previously approved on July 7, 2008 are demarcated in the attached “marked/redlined”.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for both Time Insurance Company and John Alden Life Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Assurant Health is comprised of Time Insurance Company and John Alden Life Insurance Company. We are submitting identical forms for each company. The only differences are to the form numbers and company names. Because the forms are identical, we respectfully request that the same analyst review both filings.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Karen Griglak
Contract Compliance Analyst
Legal Department
karen.griglak@assurant.com
T 800.800.1212 Ext. 8687
F 414.299.7915

BENEFIT SUMMARY

[POLICYHOLDER INFORMATION]

[POLICYHOLDER]	[Health Advocates Group Insurance ~~ABC~~ **Trust~~/Association~~**]
[LOCATION]	**[City/State]**

[CERTIFICATE HOLDER] INFORMATION

[CERTIFICATE HOLDER] [Dependents]	[John Doe] [Jane Doe] [Mary Doe] [James Doe]
[CERTIFICATE NUMBER]	[0000001]
[EFFECTIVE DATE] [of this schedule]	[00/00/0000]
[PLAN ID] [PLAN TYPE]	[Plan name inserted here – CoreMed, MaxPlan, etc.]
[PARTICIPATING EMPLOYER]	[ABC Company]
[GROUP NUMBER]	[1900AK0000]
[LOCATION NUMBER]	[001]
[BENEFIT PERIOD]	[35 days]
[BENEFIT PERIOD TERMINATION DATE]	[05/05/2006]
[PAYMENT OPTION]	[Single Payment][Monthly Payment]
[[BENEFIT] WAITING PERIOD]	[A Sickness that occurs within the first [0-180 days] after the Covered Person's Effective Date of coverage will not be covered for a period of [12 months] after the Effective Date.]~~3 days from Effective Date for Sickness~~]

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

The Utilization Review Provisions [and the [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider] [Network]] must be utilized, to be eligible to receive the maximum benefits available under the policy. Refer to the Utilization Review Provisions for the medical benefits that must be reviewed.

Major Medical Benefits for [Single Plan/Family Plan] [Certificate Holder-Spouse Plan] [Certificate Holder-Children Plan].

[The [Select Participating Provider Network] [Select Network] [Participating Provider Network] [Network Provider is [PPO].]

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

[[BENEFIT PERIOD] [MAXIMUM [LIFETIME] BENEFIT]] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100,000 - $100,000,000]
[CALENDAR YEAR MAXIMUM BENEFIT] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]

[[**ACCIDENT**] [**SICKNESS**] **MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$500 - $5,000]
[**DAILY MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$100 - $10,000]
[**PLAN YEAR MAXIMUM BENEFIT**] [for each [Covered Person] [Family] [Accident] [Injury] [Sickness]]	[$25,000 - $500,000]
[**PER CAUSE MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $200,000]
[**OUTPATIENT** [**CALENDAR YEAR**] [**PLAN YEAR**] [**BENEFIT PERIOD**] [**TIME PERIOD**] **MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1,000 - $50,000]
[**MONTHLY MAXIMUM BENEFIT**] [for each [Covered Person] [Family]]	[$1.000 - $50,000]

BEN: 005.001.001.GE

PLAN DEDUCTIBLES
[[Annual]Carryover Deductible] Covered Charges Incurred by a Covered Person [due to an Accident] [for Inpatient services] [for Inpatient services received on December 31st of a Calendar Year] [during the last [3] months of a [Plan Year] [Calendar Year] [Benefit Period]] that count toward satisfying a Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [Non-Participating][Non-Network] Provider Deductible,] [but do not satisfy the [Network] [Participating] Provider Deductible] [Individual Out-of-Pocket Limit] for that [Plan Year,] [Calendar Year,] [Benefit Period,] will also count toward satisfying the Covered Person's [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] for the next [Plan Year] [Calendar Year] [Benefit Period]. [This Carryover Deductible [does not count toward satisfying the [maximum] Family Deductible] [and] [only applies in the first [Plan Year] [Calendar Year] [Benefit Period].] [For the purpose of determining whether a Carryover Deductible applies, Covered Charges will be considered to apply toward the [Individual Deductible] [or] [Non-Participating][Non-Network] Provider Deductible] in the order the Covered Charges are processed.]]
[The [Select Network,] [Network] and [[Non-Network] [Non-Participating Provider]] Deductibles are calculated separately.] [[For example,] Amounts applied toward Your [Select Network] Deductible will not be credited toward Your [Network] Deductible, and amounts credited toward Your [[Non-Network] [Non-Participating Provider]] Deductible will not be credited toward Your [Network] Deductible.]
[All Deductibles are calculated separately. Applicable Deductibles must be satisfied prior to any payment of Covered Charges.]
[Deductibles may apply to specific types of services. Please review the Benefit Summary for additional Deductible information.]

	[[Select] Participating Provider Benefits / [Select] Network]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
Individual Plan Deductible [*] [each] [every] [XX] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $~~30~~50,000]	[None / $0 - $~~30~~50,000]	[$0 - $~~30~~50,000]
[[Maximum] [Family] Plan [Integrated] [Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]	[None / $0 - $~~30~~50,000]	[None / $0 - $~~30~~50,000]	[None / $0 - $~~30~~50,000]
[[Maximum] [Common][Accident]	[None / $0 - $~~30~~50,000]	[None / $0 - $~~30~~50,000]	[None / $0 - $~~30~~50,000]

[Per Cause] Deductible][*] [each] [every [XX]] [Calendar Year[s]] [Benefit Period[s]] [Per Cause] [Time Period[s]] [Plan Year[s]]			
[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [XX] [Calendar Year[s]] [Plan Year[s]] [Benefit Period[s]] [Time Period[s]].]			

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]

BEN: 010.001.002~~1~~.GE

[[**Deductible**] [**Credit**] [**Reward**] [**Multi Year Deductible**] **Program**:]
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM EFFECTIVE DATE**] [00/00/0000]
[[**DEDUCTIBLE**] [**CREDIT**] [**REWARD**] [**MULTI YEAR DEDUCTIBLE**] **PROGRAM TERMINATION DATE**] [00/00/0000]
[[Amounts may be credited to Your Deductibles based on the [Deductible] [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [and] [or] [reward] [and] [or] [Multi Year Deductible] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

BEN: 010.002.GE

[**Plan**] **Coinsurance**] [**and**] [[**Total**] [**Plan**] **Out-of-Pocket Limits**] [The Coinsurance is listed below unless specified elsewhere in the Benefit Summary]			
[Once the [Total] Out-of-Pocket limit is met the plan pays at [100%][unless otherwise specified]]			
[The Out-of-Pocket maximums for [Select Participating Providers,] [Select Network,] [Participating Providers,] [Network Provider] [and] [[Non-Participating] [Non-Network] Providers] are calculated separately. [For example,] Amounts credited toward Your [Participating][Network] Provider Out-of-Pocket maximum will [not] be credited toward Your Non-Participating Provider[Non-Network] Out-of-Pocket maximum, and amounts credited toward Your [Non-Participating] [Non-Network] Provider Out-of-Pocket maximum will [not] be credited toward Your [Participating] [Network] Provider Out-of-Pocket maximum.]			
[All Out-of-Pocket Limits are calculated separately. Applicable Out-of-Pocket Limits must be satisfied prior to any payment of Covered Charges. [Out-of-Pocket Limits do not include Deductible.]			
[[Coinsurance] [and] [Out-of--Pocket Limits] may apply to specific types of services. Please review the Benefit Summary for additional [Coinsurance] [and] [Out-of--Pocket Limits] information.]			
[Any applicable Prescription Drug Deductible, Coinsurance, Copayment [or Ancillary Charge] are calculated separately from the Plan Out-of-Pocket and do not count toward the plan Out-of-Pocket.]			
	[[Select] Participating Provider [Benefits]/ [Select] Network]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Tier [1]] [*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]			

[Individual][*] [Family][*]	[$0 - $~~50~~75,000 / Not applicable] [$0 - $150,000 / Not applicable]	[$0 - $~~50~~75,000 / Not applicable] [$0 - $150,000 / Not applicable]	[$0 - $~~50~~75,000 / an additional $0 - $~~10~~50,000] [$0 - $150,000 / an additional $0 - $~~30~~100,000]
[Tier [2]][*] [Plan] [Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*] [Family][*]	[$0 - $~~50~~75,000 / Not applicable] [$0 - $150,000 / Not applicable]	[$0 - $~~50~~75,000 / Not applicable] [$0 - $150,000 / Not applicable]	[$0 - $~~50~~75,000 / an additional $0 - $~~10~~50,000] [$0 - $150,000 / an additional $0 - $~~30~~100,000]
[Tier [X]][*] [Plan][Coinsurance]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier [X]] Out-of-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]	[[0% - 100%] [until the [Plan] [Tier X]] Out-of-Pocket Limits are satisfied; [then Tier [X + [1];] [100% thereafter.]]
[Tier [X]][*] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual][*] [Family][*]	[$0 - $~~25~~75,000 / Not applicable] [$0 - $~~75~~150,000 / Not applicable]	[$0 - $~~25~~75,000 / Not applicable] [$0 - $~~75~~150,000 / Not applicable]	[$0 - $~~25~~75,000 / an additional $0 - $10,000] [$0 - $~~75~~150,000 / an additional $0 - $~~30~~100,000]
[Total] [Plan] [Out-of-Pocket (OOP) Limits][*] [Individual Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*] [Common] [Family Out-of-Pocket Limit each [Calendar Year] [Plan Year][Benefit Period][*]	[$0 - $~~25~~100,000 / Not applicable] [$0 - $~~75~~250,000 / Not applicable]	[$0 - $~~25~~100,000 / Not applicable] [$0 - $~~75~~250,000 / Not applicable]	[$0 - $~~25~~100,000 / an additional $0 - $10,000] [$0 - $~~75~~250,000 / an additional $0 - $~~30~~100,000]
[Total][Out-of-Pocket (OOP) Limits each [Calendar Year] [Plan Year][*]			[$0 - $250,000]
[[All Out-of-Pocket Limits are calculated separately.] [Applicable Out-of-Pocket Limits must be satisfied prior to any			

payment of Covered Charges.] [Out-of-Pocket Limits do not include Deductible.] [Amounts may be credited to Your Out-of-Pocket Limits based on the Deductible [Credit] [and] [or] [Reward] [and] [or] [Multi Year Deductible] Program.]]

[* We may adjust this amount periodically to ensure that it is not less than the [minimum] [maximum] amount permitted by federal law.]

BEN: 015.001.0021.GE

[**Inpatient Medical Facility Services**]:				
[Subject to [Plan] [Integrated] [Per Cause] Deductible] and [Plan] Coinsurance [unless otherwise specified]]				
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]				
	[Participating Provider [Benefits] / Network Provider [Benefits]]	**[[Select] Participating Provider [Benefits]]**	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Medical Facility Services] Maximum Benefit]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	$XXX] [Per Covered Person	$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[[Inpatient Medical Facility Services Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Medical Facility Services Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible or Total [Plan] Out-of-Pocket Limits.]				
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the Participating Provider Deductible.]				
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]				
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]				
[[Facility] [Copayment]]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]	[None / $XXX per Inpatient confinement]
[Facility] [Access] [Fee]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]	[[$XXX] per Inpatient confinement] [Per Day] [up to [xx] days]]

[Emergency Room] [Access] [Fee]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]
[Emergency Room] [Copayment]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[[$XXX] per Emergency Room visit] [Waived if admitted]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	$0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Medical Facility Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Medical Facility Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Medical Facility Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Medical Facility Services] [Out-of-Pocket Limits] [each] [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual]	[$XXX]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]	[$XXX]

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[**Outpatient Medical Facility Services**:]
[All Outpatient services, supplies and treatments apply to the [Outpatient] [Plan Year] [Per Cause] [Calendar Year] Maximum Benefit [including] [excluding] Outpatient Prescription Drugs.]
[Limited to Outpatient Services associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]
[Subject to [Plan] [and] [Outpatient Services] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient Services] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient [Calendar Year] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] per [Covered Person] [covered child] [Family] [unless due to an] [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a[$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]]
[We will pay [up to] an Outpatient Maximum of [$XXX] [per][Covered Person] [covered child] per [day] [episode] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] per [day] [episode]]

[Emergency Room] Benefits are limited to a [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] [per] [episode] Maximum Benefit of [$XXX] [per] [Covered Person] [covered child] [Family]]
[The [Emergency Room] [Access] [Fee] [Copayment] will [not] apply toward any Out-of-Pocket Limit]
[The [Emergency Room] [Access] [Fee] [Copayment] will be waived if the Covered Person is subsequently admitted to the hospital for an Inpatient Stay.]
[[Emergency Room Copayment applies only to the Emergency Room charges.] [Once this amount is paid, We will pay the remaining Emergency Room charge at [100%].] [All other covered charges associated with the Emergency Room visit will be subject to the [Plan] [Integrated] [Per Cause] [and] [Inpatient Medical Facility Services] [Deductible] and [Plan] [and] [Inpatient Medical Facility Services] Coinsurance [unless otherwise specified.]]
[Non-Emergency use of an Emergency Room will result in a [30%] reduction in Covered Charges]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient [Services] Maximum Benefit]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]	$[XXX] [Per Covered Person]
[[Outpatient [Surgical] [Services] [Per Cause] Deductible] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Integrated] [Family]	 [$XXX / None] [$XXX / None]	 [$XXX / None] [$XXX / None]	 [$XXX / None] [$XXX / None]
[The [Outpatient [Surgical] Services] Deductible] does [not] apply to the [Plan] [Integrated] [Per Cause] Deductible] or Total [Plan] Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Facility] [Access] [Fee]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]
[Emergency Room [Access] [Fee]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]	[None] [[$XXX] [per Emergency Room Visit]]
[Facility] [Emergency Room] [Copayment]	[None] [[$XXX] [per Outpatient Surgical Service]]	[None] [[$XXX] [per Outpatient Surgical Service]]	[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [1]]	[0% - 100% [until the [[Outpatient [Surgical] Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100%[then Tier [X + [1]];] [until the [[Outpatient [Surgical] Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient [Surgical] Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient [Surgical] Services] Out-of-Pocket Limits] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]

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[**Physician**][**Doctor**] [**Office Visit**]:
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Primary Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Primary Care Provider] Copayment, Covered Charges for [Primary Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan],[and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Designated Specialty Care Provider] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Designated Specialty Care Provider] Copayment, Covered Charges for [Designated Specialty Care Provider] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Mid-Level Practitioner] Office Visit[s] [or] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Mid-Level Practitioner] Copayment, Covered Charge for [Mid-Level Practitioner] Office Visits [or] [Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit[s]] Copayment, Covered Charges [for Retail Health Clinic visits] will be subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits].]
[[Physician][Doctor] [Office Visit] [or] [Retail Health Clinic visit] [Copayment] Includes the first [$50 - $200] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause].]
[Benefits for [Physician][Doctor] Office Visits [or] [Retail Health Clinic visits] are limited to [[2] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $100] per visit.] [After that, Office Visits [or] [Retail Health Clinic visits] are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[[Physician][Doctor] [Office Visits] [or] [Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]

Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]			
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit] [Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Physician][Doctor] [Mid-Level Practitioner] [Office Visit Deductible] [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visits] paid at 100%] [Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Year] [Additional Office Visits are][Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Outpatient] [Coinsurance]
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are] [subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Tiered] [Copayment:][After Copayment, [Participating] [Network] [Select] Office Visits [Retail Health Clinic visit] paid at 100%]			

Primary Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Designated Specialty Care Provider]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible] [and] [Coinsurance]

	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause [Deductible]] [and] [Outpatient] [Coinsurance]]	Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Mid-Level Practitioner]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65][for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]
[Retail Health Clinic]	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[None] [$5 - $65 per office visit] [for up to [X] visits] [per Calendar Year] [for the first [1-30] visits] [in the first [[Calendar] [Plan] [Year] [Benefit Period]] [and] [,] [$5-$65] [for the next [1-30] visits] [in the second [[Calendar] [Plan] Year] [Benefit Period]] [and [$5-$65] [for the next [1-30] visits] [in the subsequent [[Calendar] [Plan] Years] [Benefit Period]] [per [Covered	[Subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	Person] [covered child]] [per [Calendar] [Plan] Year] [Additional Office Visits are] [Additional Retail Health Clinic visits are][subject to [Designated Specialty Provider] [Integrated] [Plan] [Outpatient] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]]	
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the] [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Office Visit] [Retail Health Clinic visit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Physician][Doctor] [Office Visit] [Retail Health Clinic visit] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 030.001.001.GE

[**Retail Health Clinic Visit**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit.]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[After [XX] [Retail Health Clinic visit[s]] in a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [month] [per] [Covered Person] [per covered child], Covered Charges will be subject to the [Plan [Per Cause] Deductible,] [and] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance].]
[After application of the [Retail Health Clinic visit] Copayment, Covered Charges for [Retail Health Clinic visits] will be subject to the [Plan][,] [and] [Outpatient] [Per Cause] Deductible,] [and] [Outpatient] [Coinsurance].]
[[Retail Health Clinic visit] Copayments will [not] apply toward any Out-of-Pocket Limits]
[[Retail Health Clinic visit] [Copayment] includes the first [$50 - $2,100] of a [Select Participating Provider] [Participating Provider] Diagnostic Imaging Services] [per Covered Person] [Per Covered Child] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]]
[Benefits for [Retail Health Clinic visits] are limited to [[XX] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered [Person][Child] with] a maximum payment of [$25 - $5,100] per visit.] [After that, Retail Health Clinic visits are subject to the [Plan [Per Cause] Deductible],] [Outpatient Deductible,] [and] [Outpatient] [Coinsurance]].
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] [XX visits] of Covered Services performed [by a [Retail Health Clinic] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period] [subject to a [$XX] copayment].]
[[Retail Health Clinic visits] [Copayment] Benefit Waiting Period is [[12] months] [[365] days].]

	[[Select] Participating	[Participating Provider	[Non-[Select]

	Provider [Benefits]]	[Benefits] / Network Provider [Benefits]]	Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[Retail Health Clinic visit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Retail Health Clinic visit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Retail Health Clinic visit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment:][After Copayment, Retail Health Clinic visits paid at 100%]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[None] [$5 - $65 per Retail Health Clinic visit] [for up to [X] visits] [per Calendar Year] [per [Covered Person] [covered child]] [per [Calendar] [Plan] Year]	[Subject to [Plan] [Outpatient] [Integrated] [[Per Cause] [Deductible]] [and] [Outpatient] [Coinsurance]

BEN: 032.001.GE

[**Preventive Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$XXX] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] Benefit Waiting Period][subject to a [$XX] copayment] [for Mammograms] [and] [, Pap Smears] [and] [Prostate Specific Antigen Screenings] [and] Stool for occult blood testing [and] Flexible sigmoidoscopy and barium enema or colonoscopy [and] Fasting glucose testing] [and] [Lipid profile testing] [and] [Complete blood count (or component parts) testing] [and] [Urinalysis testing] [and] [Tuberculin skin testing with purified protein derivative] [and] [Other diagnostic services as recommended by the United States Preventative Services Task Force on the date the service is Incurred].]
[Benefits for Preventive Medicine Services are limited [to a [$XX] per visit] [up to [XX] visits per] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] [per] [Covered Person] [covered child] [Family].]
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum [Lifetime] [Benefit] of [$XXX] [per [Covered Person] [covered child] [Family].]
[Benefits for Preventive Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per [Covered Person] [covered child] [Family].]

[[Mammograms] [Pap Smears] [and] [Prostate Specific Antigen Screenings] Colorectal Cancer Examination [and] [child immunizations up to age [12]] are not subject to the [Preventive Services] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum [Lifetime] Benefit]			
Prostate specific antigen screenings are exempt from any Deductible.			
[Preventive Medicine Services Benefit Waiting Period is [12] [months] [[365] days].]			
~~[Not Covered~~]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Preventive Medicine Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Preventive Medicine Services Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Preventive Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] [Retail Health Clinic] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Preventive Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Preventive Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Preventive Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Preventive Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Preventive Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Preventive Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Preventive Medicine Services] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Preventive Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 035.001.001.AR

Children's Preventive Health Care Services
Preventive Medicine Services shall include children's preventive health care services which shall include 20 visits at approximately the following ages: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 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.
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]] Deductible and Coinsurance will be waived for child immunizations.
[Benefit for Preventive Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Benefit] of [$500] [per [Covered Person] [covered child] [Family].] The maximum will not apply to child immunizations.
[Preventive Medicine Services Benefit Waiting Period is [12] [months].] The waiting period will not apply to child immunizations.

BEN: 036.001.AR

[**Loss or Impairment of Speech or Hearing**]:

[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
	[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[[Loss or Impairment of Speech or Hearing] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Loss or Impairment of Speech or Hearing] Deductible] [Individual] [Per Covered Child] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Loss or Impairment of Speech or Hearing] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Loss or Impairment of Speech or Hearing] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
Loss or Impairment of Speech or Hearing] [Tier [2]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [I Loss or Impairment of Speech or Hearing] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [P Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Loss or Impairment of Speech or Hearing]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Loss or Impairment of Speech or Hearing] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Loss or Impairment of Speech or Hearing]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Loss or Impairment of Speech or Hearing]] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Loss or Impairment of Speech or Hearing Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider			

BEN: 037.001.AR

Medical Foods:			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
No benefits are available for the first {$2,400] of Covered Charges incurred by a Covered Person in a calendar year.			
	[Select Participating	**[Participating**	**[Non-[Select]**

	Provider Benefits]	Provider Benefits / Network Provider Benefits]	Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]
[Medical Foods] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 038.001.AR

[**Accident Medical Expense** [**Reduced Plan Deductible**] **Benefit**:]			
[All services, supplies and treatments apply to the [Plan] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[We will pay up to [$XXX] per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause][Accidental Injury] [Injury] for Covered Charges Incurred due to an Accidental Injury. After payment of this amount, Covered Charges will be subject to the [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance.]			
[Covered charges must be Incurred within [90] days of the Accident] [Injury]. [Covered Charges in excess of the Accident Medical Expense Benefit or rendered after the 90-day period will be subject to all the terms, limits and conditions of the plan.]			
[Accident Medical Expense is subject to the Accident Medical Expense Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX]. Covered Charges are then subject to the [Plan] [and][Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[Your [Plan] [Individual] [Integrated] [Family] [Per Cause] Deductible] will be reduced by [$XXX] for Covered Charges Incurred due to an [Accidental Injury] [Injury],] [then subject to [Plan] [and][Outpatient] [and] [Inpatient] [Coinsurance]]			
[Accident Medical Expense Benefit Waiting Period is [XX days]]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Accident Medical Expense Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]	[$XXX] [per Covered Person] [Per Covered Child]
[Accident Medical Expense Benefit Deductible] [Individual] [Per Covered Child]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]

[The [Accident Medical Expense Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Accident Medical Expense Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Accident Medical Expense Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Accident Medical Expense] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Accident Medical Expense Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Per Covered Child] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Accident Medical Expense] Out-of-Pocket Limits] [Individual] [Per Covered Child] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 040.001.001.GE

[[**Diagnostic Imaging Services**] [**and**] [**Laboratory Services**]:]			
[All services, supplies and treatments apply to the [Inpatient][Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient][Inpatient] [Integrated] Deductible and [Plan] [Outpatient] [Inpatient]Coinsurance [unless otherwise specified]]			
[[Plan] [Integrated] [Per Cause] Deductible] [and Co-insurance] will be waived for the first [$XXX] of Covered Services] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]] [after a [12 month] [365 day] Benefit Waiting Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services] Benefit Waiting Period is [[12] [months] [[365] days].]			
[Limited to [Diagnostic Imaging Services] [and] [Laboratory Services] associated with an Inpatient Stay when Covered Charges are Incurred within [14 days] of admission.]			
[Includes [1] screening mammography exam per Benefit Period for a covered female age [35] or over.] [The maximum benefit for a mammography screening is [$50 - $500].]			
[Diagnostic Imaging Services] [and] [Laboratory Services] are limited to a [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person] [covered child] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Diagnostic Imaging Services] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX][[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [[per] [Covered Person][Covered Child].]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Per Cause]			

Deductible]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Diagnostic Imaging Services] [and] [Laboratory Services] Deductible] does [not] apply to the [Plan][Outpatient][Inpatient][Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] [Retail Health Clinic] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [2]]	[0% - 100% [until the [[[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[[Diagnostic Imaging Services] [and] [Laboratory Services] [Coinsurance]] [Tier [X]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services]] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Diagnostic Imaging Services] [and] [Laboratory Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Diagnostic Imaging Services] [and] [Laboratory Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[[Diagnostic Imaging Services] [and] [Laboratory Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Diagnostic Imaging Services] [and] [Laboratory Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.]] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 045.001.001.GE

[**Outpatient Physical Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]
[Benefits are limited to an Outpatient Physical Medicine Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [covered child] [Family] [unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to a [$XXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [per] [Covered Person] [covered child] [Family]]
[We will pay [up to] an Outpatient Physical Medicine Services Maximum of [$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]][unless due to an [Accidental Injury] [Injury] [or] [underlying Sickness] [then We will pay up to [$XXX] [per [day] [episode]]
[Benefits for Outpatient Physical Medicine Services are limited to [1-20] visits each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] per Covered Person with a maximum payment of [$25 - $200] per visit]
[Chiropractic Coverage is] [Adjustments and manipulations are] limited to a Maximum [Lifetime] [Calendar Year][Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person][Family]]
[Outpatient Physical Medicine Services Benefits Waiting Period is [[12] months]][[365] days]

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Outpatient Physical Medicine Services] Maximum Benefit]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[[Outpatient Physical Medicine Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]	[$XXX] [per] [Covered Person] [covered child] [Family] [per [day] [episode]]
[Outpatient Physical Medicine Services [Per Cause] Deductible]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Integrated] [Family]	[$XXX]	[$XXX]	[$XXX]
[The [Outpatient Physical Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Outpatient Physical Medicine Services] [Copayment]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]	[None / $XXX per Outpatient Physical Medicine Services]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]

[Outpatient Physical Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Outpatient Physical Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Physical Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Outpatient Physical Medicine Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Physical Medicine Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Outpatient Physical Medicine Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 050.001.001.GE

[**Outpatient Alternative Medicine Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$20 - $5,000]]			
[Benefits for Outpatient Alternative Medicine Services are limited to a Maximum Benefit of [[$XX] for each visit[up to [XX] visits]] [up to [$XXX] each [Calendar] [Plan] Year] [Benefit Period] [per Covered Person]]			
[Outpatient Alternative Medicine Services Benefit Waiting Period is [[6] [months] [[180] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Outpatient Alternative Medicine Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Outpatient Alternative Medicine Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Outpatient Alternative Medicine Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[Copayment]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]	[None / $XXX per Alternative Medical Care Service]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Outpatient Alternative Medicine Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Outpatient Alternative Medicine Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[Outpatient Alternative Medicine Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Outpatient Alternative Medicine Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% -			

50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 055.001.001.GE

[**Durable Medical Equipment and Personal Medical Equipment**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[[Durable Medical Equipment] [and] [Personal Medical Equipment] Benefits are limited to a [Lifetime][Calendar Year][Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum of [$XXX] [per] [Covered Person][Covered Child].]			
[Wheelchairs, Prosthetic Devices and Orthotic Devices apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]]			
[Wheelchairs, Prosthetic Devices and Orthotic Devices will be subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
~~[Not Covered~~]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit]	[$XXX] [[per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[[Durable Medical Equipment and Personal Medical Equipment] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]	[$XXX] [per] [Covered Person][Covered Child].]
[Durable Medical Equipment and Personal Medical Equipment [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Durable Medical Equipment and Personal Medical Equipment Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-Network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Personal Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Initial] [Permanent] [Temporary] [Basic] [Artificial] ~~[Limb] [or]~~ [Eye]	[$[XXXX] Maximum [Lifetime] [Calendar	[$[XXXX] Maximum [Lifetime] [Calendar	[$[XXXX] Maximum [Lifetime] [Calendar

	Year] [Plan Year] [Monthly] Benefit	Year] [Plan Year] [Monthly] Benefit	Year] [Plan Year] [Monthly] Benefit
[Durable Medical Equipment]	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit	[$[XXXX] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] Benefit
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Durable Medical Equipment and Personal Medical Equipment] [Coinsurance]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]]	[0% - 100% [until the [Durable Medical Equipment and Personal Medical Equipment] [Tier [X]] Out-of-Pocket

[Tier [X]]	Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Durable Medical Equipment and Personal Medical Equipment] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Durable Medical Equipment and Personal Medical Equipment] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[[Benefits for [Durable Medical Equipment and Personal Medical Equipment] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 060.001.001.AR~~GE~~

[**Maternity Care Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified] [and any other plan provisions in the Benefit Summary].]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Maternity Care Services] Benefit Waiting Period is [[12] months] [[30-365] days]]			
[Benefits will be reduced by [50%] if conception occurs during the [Benefit Waiting Period][first Calendar Year of the policy]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

[Monthly] [Daily] Benefit]			
[[Maternity Care Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Maternity Care Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Maternity Care Services Deductible][if conception occurs after the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[Maternity Care Services Deductible] if conception occurs before the Benefit Waiting Period expires] [Individual]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]	[$XXX] [Subject to plan Deductible and Coinsurance]
[The [Maternity Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Maternity Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Maternity Care Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Maternity Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services y] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Maternity Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Maternity Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Maternity Care Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 065.001.001.GE

[**Complications of Pregnancy**:]
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]
[Not Covered]

BEN: 070.001.GE

[**Infertility Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]

[Benefits for Infertility Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Infertility Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-network Provider [Benefits]]**
[[Infertility Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Infertility Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [or] [underlying Sickness]]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Infertility Services are payable at [0-100%] [with a [$10-$100] copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 075.001.001.GE

[**Health Care Practitioner Services**:]
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [and any other [Plan] [Inpatient] [or] [Outpatient] provision in the Benefit Summary] [unless otherwise specified].]
[Benefits for Covered Charges rendered by an Anesthesiologist are limited to a [Calendar Year] [Plan Year] [Benefit Period] Maximum of [$XXX] for Inpatient services and [$XXX] for Outpatient Services.]

BEN: 080.001.GE

[**Professional Ground [or Air] Ambulance Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Benefits are limited to a[n] [Professional Ground] [or] [Air] Ambulance Services Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [limited to] [[one] trip] [per Sickness or Injury] [per Covered Person].]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[Professional Ground [or Air] Ambulance Services] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit [per Covered Person]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]	[$XXX] [and] [or] [limited to] [1] [trip]
[Professional Ground [or Air] Ambulance Services] [Coinsurance]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]	[0% - 100% [until the Out-of-Pocket Limits are satisfied;] [100% thereafter.]]

BEN: 085.001.GE

[**Home Health Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Outpatient] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] Benefit of [20 - 200 hours] [or] [10-100 visits][per Covered Person]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Home Health Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[[Home Health Care Services [Per Cause] Deductible]] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Home Health Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Home Health Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Home Health Care Services][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Home Health Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Home Health Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Home Health Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Home Health Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for Home Health Care Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 090.001.001.GE

[**Hospice Care Services**:]			
[All services, supplies and treatments apply to the [Outpatient][and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Inpatient] [Outpatient] [Plan] [Integrated] [Per Cause] Deductible] and [Inpatient] [Outpatient] [Plan] Coinsurance [unless otherwise specified].]			
[Benefits are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Benefits are limited to a Maximum [Lifetime] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Hospice Care Services include [2] visits for counseling services and [1] visit for bereavement counseling after a Covered Person's death] [[per] [Covered Person] [Family]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Hospice Care Services] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Hospice Care Services] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX]	[$XXX]	[$XXX]
[Hospice Care Services Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Hospice Care Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Hospice Care Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not	[$0 - $25,000 / Not	[$0 - $25,000 / an

[Family]	applicable] [$0 - $75,000 / Not applicable]	applicable] [$0 - $75,000 / Not applicable]	additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Hospice Care Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Hospice Care Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Hospice Care Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Hospice Care Services] Out-of-Pocket Limits] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Hospice Care Service are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network			

Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 095.001.001.GE

[**Inpatient Rehabilitation Services**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is less] [greater]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select} Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inpatient Rehabilitation Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]	[$XXX] [or] [90][days] [per Covered Person] [whichever is [less] [greater]]
[Inpatient Rehabilitation Services [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Inpatient Rehabilitation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]

[Inpatient Rehabilitation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Inpatient Rehabilitation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Inpatient Rehabilitation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Inpatient Rehabilitation Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Inpatient Rehabilitation Services] [Out-of-Pocket Limits]] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Inpatient Rehabilitation Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 100.001.GE

[[**Subacute Rehabilitation Facility**] [**and/or**] [**Skilled Nursing Facility Care**]:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] [Integrated] [Per Cause] Deductible] [and][Outpatient] [and] [Inpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Plan] Coinsurance [unless otherwise specified]]			
[Benefits are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [or] [90 days] [per Covered Person] [whichever is [less] [greater].]			
[Benefits are limited to a Maximum of [$XXX] per day, up to [50] Days per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] Maximum Benefit]	[$XXX]	[$XXX]	[$XXX]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX]	[$XXX]	[$XXX]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care [Per Cause] Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Subacute Rehabilitation Facility and Skilled Nursing Facility Care Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Subacute Rehabilitation Facility and Skilled Nursing Facility Care] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for Subacute Rehabilitation Facility and Skilled Nursing Facility Care are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 105.001.GE

[**Family Planning Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] [and] [Monthly] [and] [Daily] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Family Planning Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per Covered Person]]			
[[Family Planning Services] Benefit Waiting Period is [[12] months]] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Family Planning Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Family Planning Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Family Planning Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 110.001.001.GE

[**Sterilization**:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]
[Benefits for Sterilization Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,500] [per Covered Person].]
[Sterilization Services Benefit Waiting Period is [[12] months] [[365] days]].

[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Sterilization Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Sterilization Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 115.001.001.GE

[**Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] Deductible and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for [surgical and] nonsurgical treatment are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX] [per] [Covered Person] [Family]]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] surgical and] non-surgical Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]	[$XXX] [per Covered Person] [per Family]
[Temporomandibular Joint (TMJ) or			

Craniomandibular Joint (CMJ) Dysfunction Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services Deductible] does [not] apply to the [Plan][Outpatient] [Integrated] [Per Cause] Deductible] or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 120.001.001.GE

[**Diabetic Services**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Covered Charges include: • [Eye Examinations: [Both eyes] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Foot Examination: [Both feet] [1] per [Calendar Year] [Plan Year] [per Covered Person]] • [Nutritional Counseling: [When first diagnosed] [or] [and] [when changes in condition occur] [per Covered Person]]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider**	**[Non-[Select] Participating Provider [Benefits]/ Non-**

		[Benefits]]	Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Diabetic Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Diabetic Services]l Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Diabetic Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 125.001.001.GE

[**Growth Hormone Therapy Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Growth Hormone Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$XXX]] [per Covered Person].]			
[Growth Hormone Therapy Services Benefit Waiting Period is [[12] months] [[365] days]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Growth Hormone Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 130.001.001.GE

[**Tonsils and Adenoids**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified].]
[Benefits for Tonsils and Adenoids Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]]
[[Tonsils and Adenoids Services] Benefit Waiting Period is [[12] months] [[365] days].]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	[Participating Provider [Benefits] / Network Provider [Benefits]]	[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Tonsils and Adenoids Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Tonsils and Adenoids Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 135.001.001.GE

[**Bunions,**] [**Hemorrhoids**] [**and**] [**Varicose Veins**]:			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$500 - $2,000] [per Covered Person]			
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Bunions,] [Hemorrhoids] [and] [Varicose Veins]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Bunions,] [Hemorrhoids] [and] [Varicose Veins] Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 140.001.001.GE

[**Inguinal Hernia**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit

Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified].]			
[Benefits for Inguinal Hernia Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$250 - $2,000] [per Covered Person].]			
[Inguinal Hernia Services Benefit Waiting Period is [[12] months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Inguinal Hernia]Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Inguinal Hernia Services are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 145.001.001.GE

[**Blood Product Transfusions**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [and] [Per Cause] Maximum Benefit]			
[Subject to[Integrated] [Plan][Inpatient][and] [Outpatient] [Per Cause] Deductible] and [Plan][Inpatient][and] [Outpatient] [and] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Blood Product Transfusions Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Blood Product Transfusions Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Blood Product Transfusions Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per	[None / $XXX per	[None / $XXX per

	Blood Product Transfusions]	Blood Product Transfusions]	Blood Product Transfusions]
[Copayment]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]	[None / $XXX per Blood Product Transfusions]
[Blood Product Transfusions] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Blood Product Transfusions] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Blood Product Transfusions] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied [100% thereafter.]]	[0% - 100% [until the [Blood Product Transfusions] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Blood Product Transfusions] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Blood Product Transfusions] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Blood Product Transfusions] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 150.001.001.GE

[**Transplants**:]			
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] Deductible and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefit for Transplants are limited to [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]			
[Donor Expenses are limited to a Maximum Benefit of [$5,000 - $25,000]]			
[Not Covered]			
[The following Covered Transplants are subject to the [Outpatient] [and] [Calendar Year] [and] [Plan Year and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] Maximum Benefit]: • [Kidney] • [Cornea] • [Skin]]			
[The following Covered Transplants subject to the [Maximum Transplant Benefit] [Outpatient] and [Calendar Year] and [Plan Year] [and] [Monthly] [and] [Daily] [Benefit Period] [Per Cause] [and] [Lifetime] [Maximum Benefit]: • Lung(s) • Heart • Simultaneous heart/lung • Liver • Simultaneous kidney/pancreas • Allogeneic and autologous bone marrow transplant/stem cell rescue]			
	[Designated Specialty Service Provider /[Select] Participating Provider /Designated Transplant Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]] [and Non-Participating/Non-Network Provider]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Maximum Transplant Benefit]	[Lifetime Maximum	[$100,000] [Lifetime]	[$100,000] [Lifetime]

	Benefit] [[$100,000] Benefit Period Maximum] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]	[Calendar Year] [Plan Year] [Benefit Period] Maximum [Benefit] [per Covered Person]
[Travel Expenses] will be covered up to a [$5,000 - $20,000] Maximum Benefit when a [Designated Specialty Service Provider][Select Participating Provider][Designated Transplant Provider Benefits] is used as described in the Covered Medical Benefits section]			

BEN: 155.001.001.GE

[**Behavioral Health** [**and Substance Abuse**]:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] [and] [Plan] [and] [Inpatient] [and] [Outpatient] [Coinsurance] [unless otherwise specified].]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$50] for each visit up to [[XX] visits] [$250 - $1,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$2,000 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $25,000] [per] [Covered Person] [Family]]
[Behavioral Health [and Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]
[The [Behavioral Health] [and Substance Abuse] [Deductible] [and] [Coinsurance] does [not] apply to the [Plan Deductible] [or] [Total Out-of-Pocket Limits.]]
[The [Behavioral Health] [and Substance Abuse] Coinsurance] will [not] increase to 100% after the Plan Out of Pocket is satisfied.] [The Behavioral Health Coinsurance, not paid by us, will not apply toward any Out of Pocket Limit.]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Behavioral Health [and Substance Abuse]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Behavioral Health [and Substance Abuse] Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met]], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]][Coinsurance] [Tier [2]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2] [Behavioral Health [and Substance Abuse]] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Behavioral Health [and Substance Abuse]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket	[0% - 100% [until the [Behavioral Health [and Substance Abuse] [Maximum Benefit is Met] [Tier [X]] Out-of-Pocket Limits are

	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Behavioral Health [and Substance Abuse]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Behavioral Health [and Substance Abuse Services]] [Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for Behavioral Health [and Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 160.001.001.GE

[**Substance Abuse**]:]
[Subject to [Plan] [and] [Inpatient] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Inpatient] [and] [Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] are limited to [$1,000 - $5,000] [or] [10-50] [days] [whichever is [less] [greater]] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to [$25 - $100] for each visit up to [[XX] visits] [$250 - $100] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a combined Maximum Benefit of [$1,500 - $6,000] each [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [per] [Covered Person] [Family]]
[Benefits for Inpatient treatment in a state licensed [Acute Behavioral Health Inpatient Facility] [or] [Behavioral Health Rehabilitation and Residential Facility] and Outpatient treatment by a Health Care Practitioner [or a state licensed [Intensive Outpatient Behavioral Health Program] [or] [Partial Hospital and Day Treatment Behavioral Health Facility or Program] are limited to a Lifetime Maximum Benefit of [$5,000 - $20,000] [per] [Covered Person] [Family]]
[Substance Abuse] Benefit Waiting Period is [[12] months] [[365] days]]
[Not Covered]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[[Substance Abuse] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]	[$XXX] [[XX] number of visits] [per Covered Person]
[Substance Abuse Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Substance Abuse Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Substance Abuse] Coinsurance [Tier [1]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]

[Tier [2]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Substance Abuse Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Substance Abuse] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Substance Abuse Services] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Substance Abuse Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 165.001.001.GE

[**Reconstructive Surgery**:]			
[All services, supplies and treatments apply to the [Inpatient] [and] [Outpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Integrated] [Inpatient] [Outpatient] [Per Cause] Deductible] and [Plan] [Inpatient] [Outpatient] Coinsurance [unless otherwise specified]]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**

[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Reconstructive Surgery] [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Maximum Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]

BEN: 170.001.001.GE

[**Dental Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [and] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Dental Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$1,000 - $5,000] [unless due to an Accidental Injury [Injury] [or underlying Sickness] [per Covered Person]]			
[Benefits are limited to conditions present at birth or diagnosed before age [5]]			
[Treatment must begin within [90 days] and be completed within [365 days] of the Dental Injury.]			
[Dental Services Benefit Waiting Period is [12][Months] [[365] days].]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Dental Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for Dental Services are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 175.001.001.GE

[**Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified]]			
[Benefits for [Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating	**[Participating**	**[Non-[Select]**

	Provider [Benefits]]	Provider [Benefits] / Network Provider [Benefits]]	Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]
[[Intravenous Injectable Parenteral Drug Therapy] [and Specialty Pharmaceuticals] Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Intravenous Injectable Parenteral Drug Therapy Service] are payable at [0-100%] [with a [$10-$100] Copayment] when a Designated Specialty Service Provider is used. If a Designated Specialty Service Provider is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a Designated Specialty Service Provider regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 180.001.001.GE

[**Non-Intravenous Injectable Parenteral Drug Therapy**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [and] [Inpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] and [Inpatient] Coinsurance [unless otherwise specified]			
[Benefits for Non-Intravenous Injectable Drug Therapy Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX] [per Covered Person]]			
[Not Covered]			
	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Non-Intravenous Injectable Drug Therapy Services] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Benefits for [Non-Intravenous Injectable Drug Therapy Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 185.001.001.GE

[[**Telemedicine Services**] [**and**] [**Telehealth Services**]:]
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]
[Subject to [Plan] [Outpatient] [Integrated] [Per Cause] Deductible] and Coinsurance [unless otherwise specified].]

[Benefits for [[Telemedicine Services] [and] [Telehealth Services]]are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] [Benefit Period] [Per Cause] Benefit of [$1,000 - $5,000] [per Covered Person]]
[Benefits for [[Telemedicine Services] [and] [Telehealth Services]] are limited to a Maximum Benefit of [[$XX] for each visit] [0-12 visits] [or] [up to [$XXX] each [Calendar] [Plan] [Benefit] Year] [per Covered Person].]
[[Telemedicine Services] [and] [Telehealth Services]] Benefit Waiting Period is [[6] months] [[180] days]]]
[Not Covered]
[[Plan] [Integrated] [Per Cause] Deductible] [and Coinsurance] will be waived for the first [$50 - $500] [0-12 visits] of Covered Services performed [by a [Participating Provider] [Network Provider] [Retail Health Clinic]] [per] [Covered Person] [covered child] [Family] [per [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [after a [12 month] [365 day] Benefit Waiting Period][subject to a [$5 - $75] copayment].]

	[[Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[Telemedicine Services] [and] [Telehealth Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[[Telemedicine Services] [and] [Telehealth Services]]Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
The [[Telemedicine Services] [and] [Telehealth Services]] Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[Copayment]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]	[None / $XXX per [[Telemedicine Services] [and] [Telehealth Services]]
[[Telemedicine Services] [and] [Telehealth Services]][Coinsurance] [Tier [1]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [2]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services]] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and] [Telehealth Services]] [Coinsurance] [Tier [X]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [[Telemedicine Services] [and] [Telehealth Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Telemedicine Services] [and] [Telehealth Services]][Out-of-Pocket Limit][each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Telemedicine Services] [and]			

[Telehealth Services]] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[Benefits for [Telemedicine Services] [and] [Telehealth Services] are payable at [0-100%] [with a [$10-$100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1% - 50%]][limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 190.001.001.GE

[[**Out of Network**][**Travel Benefit**]:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$250 - $1,000] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Out of Network] [Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Out of Network] [Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Out of Network] [Travel Benefit Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Out of Network] Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]

[Out of Network] [Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Out of Network] [Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Out of Network] [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [Out of Network] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not	 [$0 - $25,000 / Not applicable] [$0 - $75,000 / Not	 [$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an

	applicable]	applicable]	additional $0 - $30,000]
[[Out of Network] [Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]

BEN: 195.001.001.GE

[**Choice of Network Service Area Benefit**:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 200.001.GE

[Nationwide Network Benefit:]
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]
[Not Covered]

BEN: 205.001.GE

[**International Coverage**:]			
[All services, supplies and treatments apply to the [Plan] [and][Outpatient] [and] [Inpatient] [and][International Coverage] [Calendar Year] [Plan Year] [Benefit Period] Maximum Benefit]]			
[Subject to [Plan] [and][Outpatient] [and] [Inpatient][and][International Coverage][and] [Integrated] [Per Cause] Deductible] and [Plan] [and][Outpatient] [International Coverage] [and] [Inpatient]Coinsurance [unless otherwise specified].]			
[International Coverage Benefits are limited to a Maximum of [$XXX][for services rendered outside the United States of America]].			
[International Coverage is subject to the International Coverage Deductible [and Coinsurance] then Covered Charges are paid at [100%] up to [$XX], Covered Charges are then subject the [Plan] [and][Outpatient] [and] [Inpatient] [Per Cause] Deductible] and [Plan] [and][Outpatient] [and] [Inpatient]Coinsurance.]]			
[International Coverage Benefit Waiting Period is [90 days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[[International Coverage] Maximum[Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]

Benefit]			
[[International Coverage] Maximum [Lifetime] [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit] [due to an [Accidental Injury] [Injury] [or] [underlying Sickness]]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]	[$XXX] [Per Covered Person]
[International Coverage Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [International Covered Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[Copayment]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]	[None / $XXX per International Coverage Service]
[International Coverage] [Coinsurance] [Tier [1]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [2]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional

[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	$0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[International Coverage] [Coinsurance] [Tier [X]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [International Coverage] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [International Coverage] [Out-of-Pocket Limit] [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000]
[Family]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / Not applicable]	[$0 - $75,000 / an additional $0 - $30,000]
[[International Coverage] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]
[Family]	[$XXX]	[$XXX]	[$XXX]

BEN: 210.001.001.GE

[**Travel Benefit**:]			
[All services, supplies and treatments apply to the [Outpatient] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [Inpatient][and] [and][Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and][Inpatient][and][Outpatient]Coinsurance [unless otherwise specified]]			
[Benefits are limited to [2] [Network][Participating] [Provider] [Office Visits] and [up to] [$500] for [Diagnostic Imaging Services] [and] [Laboratory Services]]			
[Travel Benefit Waiting Period is [[60] days].]			
[Not Covered]			
	[Primary Care Physician / [Select] Participating Provider [Benefits]]	**[Participating Provider [Benefits] / Network Provider [Benefits]]**	**[Non-[Select] Participating Provider [Benefits]/ Non-Participating Provider [Benefits]/ Non-Network Provider [Benefits]]**
[Travel Benefit] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Travel Benefit Deductible]			

[Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The Travel Benefit Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[[Non-Participating] [Non-network] Provider Deductible is in addition to the [Participating] [Network] Provider Deductible.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Access] [Fee]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Copayment]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]	[None / $XXX per Travel Benefit Service]
[Travel Benefit] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]
[Tier [1]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Travel Benefit] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Travel Benefit] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]

[Tier [X]] [Travel Benefit] Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[Travel Benefit] Out-of-Pocket Limits] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

BEN: 215.001.001.GE

[**Repatriation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Repatriation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Repatriation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Repatriation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[]Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Repatriation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Repatriation Services Deductible] [Individual] [Integrated] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]
[The [Repatriation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]	[None / $XXX per Repatriation Service]
[[Repatriation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100%	[0% - 100% [until the [Repatriation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

		thereafter.]]	
[Tier [1]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Repatriation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Repatriation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Repatriation Services] [Out-of-Pocket Limits]] [Individual]	[$XXX]	[$XXX]	[$XXX]

[Family]	[$XXX]	[$XXX]	[$XXX]
[Benefits for [Repatriation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]			

BEN: 275.001.GE

[**Medical Evacuation Services**:]			
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [and] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit]			
[Subject to [Plan] [and] [Outpatient] [Integrated] [Per Cause] Deductible] and [Plan] [and] [Outpatient] Coinsurance [unless otherwise specified]]			
[Benefits for Medical Evacuation Services are limited to a Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit of [$XXX]]			
[Benefits for Medical Evacuation Services are limited to a Maximum Benefit of [[$10,000] [per Covered Person].]			
[Medical Evacuation Services Benefit Waiting Period is [[12] [months].]			
[Not Covered]			
	[[Select] Participating Provider Benefits]	**[Participating Provider Benefits / Network Provider Benefits]**	**[Non-[Select] Participating Provider Benefits/ Non-Participating Provider Benefits/ Non-Network Provider Benefits]**
[Medical Evacuation Services]] Maximum [Lifetime] [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] [Monthly] [Daily] Benefit]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]	[$XXX] [per Covered Person]
[Medical Evacuation Services Deductible] [Individual] [Integrated] [Family]	 [$XXX] [$XXX]	 [$XXX] [$XXX]	 [$XXX] [$XXX]
[The [Medical Evacuation Services Deductible] does [not] apply to the Plan Deductible or Total Out-of-Pocket Limits.]			
[Once [[2] or more Covered Persons have collectively met] the maximum Family Deductible [[has been met], no additional Deductible will be taken during the [Calendar Year] [Plan Year] [Benefit Period] [Time Period].]			
[Copayment]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]	[None / $XXX per Medical Evacuation Service]
[[Medical Evacuation Services] [Coinsurance] [Tier [1]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [1]] Out-of-Pocket Limits are satisfied; [then Tier [2];] [100% thereafter.]]

[Tier [1]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [2]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [2]] Out-of-Pocket Limits are satisfied; [then Tier [X];] [100% thereafter.]]
[Tier [2]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Coinsurance] [Tier [X]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]	[0% - 100% [until the [Medical Evacuation Services] [Tier [X]] Out-of-Pocket Limits are satisfied;] [then Tier [X + [1]];] [100% thereafter.]]
[Tier [X]] [[Medical Evacuation Services]Out-of-Pocket Limit [each [Calendar Year] [Benefit Period] [Time Period] [Plan Year]] [Individual] [Family]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / Not applicable] [$0 - $75,000 / Not applicable]	[$0 - $25,000 / an additional $0 - $10,000] [$0 - $75,000 / an additional $0 - $30,000]
[[Medical Evacuation Services] [Out-of-Pocket Limits]] [Individual] [Family]	[$XXX] [$XXX]	[$XXX] [$XXX]	[$XXX] [$XXX]

[Benefits for [Medical Evacuation Services] are payable at [0%-100%] [with a [$10 - $100] Copayment] when a [Designated Specialty Service Provider] is used. If a [Designated Specialty Service Provider] is not used, [Covered Charges will be [paid at the [Non-][Participating] [or] [applicable] Coinsurance] [reduced by [$1 - $3,000] [1%-50%]] [limited to [$XXX] per [Calendar] [Plan] Year] [per Covered Person] [after the Covered Person has paid any applicable Copayment, Deductible or other fees.] [These limitations will apply to all treatment rendered by a provider that is not designated as a [Designated Specialty Service Provider] regardless of whether the provider is a [Network Provider,] [Participating Provider,] [or] [Select Participating Provider].]

BEN: 280.001.GE

[**Outpatient**] **Prescription Drug Benefits**:]
[All services, supplies and treatments apply to the [Outpatient] [and] [Calendar Year] [Plan Year] Maximum Benefit]
[Subject to [Plan][and][Outpatient][Integrated] [Per Cause] Deductible] and [Plan][and][Outpatient] Coinsurance [unless otherwise specified]]
[Benefits for Prescription Drugs are limited to a Maximum [Calendar Year] [Plan Year] [Monthly] [Daily] Benefit of [$1,000 - $10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]
[Benefits for Prescription Drugs are limited to a Maximum [Lifetime] [Benefit Period] Benefit of [$1,000 -$10,000] [per] [Covered Person] [Covered Child] [$2,000 - $20,000] [per Family]]
[For Prescription Drugs and medicines Covered Charges are limited to [$2,000] per [Calendar Year][Plan Year][Benefit Period] [Time Period] for: • [Legend drugs and medicines that by Federal law can only be obtained with a prescription;] • [Injectable insulin with a prescription;] • [Disposable insulin syringes, and disposable blood/urine, glucose/acetone testing agents or lancets.]]
[[$20] maximum per [Outpatient] Prescription Drug[, limited to $1,000 - $5,000] [limited to [XX] prescriptions] Maximum Benefit per [Calendar Year][Plan Year][Benefit Period] [Time Period] [Month][for] [Anti-Infective Prescription Drugs] [per Covered Person] [Per Covered Child]]
[[Outpatient] Prescription Drugs Benefit Waiting Period is [[12] months] [[365] days].]
[Outpatient] Prescription Drugs Benefits do [not] apply to the [Plan][Inpatient][Outpatient] Out of Pocket Limits]
[Not Covered]
[Participating Pharmacy Plan:] [PBM]
[Prescription Drug [Calendar Year] [Plan Year] [Benefit Period] [Per Cause] Maximum Benefit] [[$XXX] per [Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Lifetime] Maximum Benefit] [[$XXX] [per Covered Person] [Covered Child]]: [[Preferred][Generic] Drug: [$100 - $5,000]] [[Non-preferred][Generic] Drug: [$100 - $5,000]] [[Preferred] Brand Name Drug: [$100 - $5,000]] [[Non-Preferred] Brand Name Drug: [$100 - $5,000]]
[Prescription Drug [Individual] [Integrated] Deductible:] [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-Preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to Plan [Individual] Deductible and Coinsurance.] **[Prescription Drug [Integrated] Family Maximum Deductible:]** [$0 - $9750] [[Preferred][Generic] Drug: [$0 - $9750]] [[Non-preferred] Generic Drug: [$0 - $9750]] [[Preferred] Brand Name Drug: [$0 - $9750]] [[Non-Preferred] Brand Name Drug: [$0 - $9750]] [Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Prescription Drug [Deductible] [per Covered Person] [Covered Child]:] [$0 - $9750]

[**Designated Specialty Pharmacy Provider**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**] **Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Plan] [Integrated] [Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Individual] [Integrated] Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-Preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to Plan [Individual] Deductible and Coinsurance.]

[**Mail Service Prescription Drug [Integrated] Family Maximum Deductible**:] [$0 - $9750]
[[Preferred][Generic] Drug: [$0 - $9750]]
[[Non-preferred] Generic Drug: [$0 - $9750]]
[[Preferred] Brand Name Drug: [$0 - $9750]]
[[Non-Preferred] Brand Name Drug: [$0 - $9750]]
[Subject to [Integrated] [Family] Deductible and Coinsurance.]

[Tier 1] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Participating Pharmacy**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Non-Participating Pharmacy**:] [$0 - $100]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[**Mail Service Prescription Drug Vendor**:] [$0 - $100]
[[Preferred][Generic] Drug: [$0 - $50]]
[[Non-preferred] Generic Drug: [$1 - $50]]
[[Preferred] Brand Name Drug: [$1-100]]
[[Non-Preferred] Brand Name Drug: [$1-100]]

[Tier 1] Coinsurance:

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]

[Tier 1] Out-of-Pocket Limits	[Individual]	[Common][Integrated][Family]
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]

[Tier 2] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan][Integrated][Family] Deductible and Coinsurance.]

[Tier 2] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 2] Out-of-Pocket Limits	**[Individual]**	**[Common][Integrated][Family]**
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[Tier 3] [Copayment:]

[**Designated Specialty Pharmacy Provider**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Participating Pharmacy**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Non-Participating Pharmacy**:] [$0 - $25]
[Reimbursed at the Contracted Rates]
[[Preferred] [Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [$0 - $25]
[[Preferred][Generic] Drug: [$0 - $25]]
[[Non-preferred] Generic Drug: [$1 - $25]]
[[Preferred] Brand Name Drug: [$1-75]]
[[Non-Preferred] Brand Name Drug: [$1-75]]
[Subject to [Plan] Deductible and Coinsurance.]

[Tier 3] Coinsurance

[**Designated Specialty Pharmacy Provider**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Participating Pharmacy**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred Brand Name Drug: [0% - 100%]]
[[Non-Preferred Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Non-Participating Pharmacy**:] [0% - 100%]
[Reimbursed at the Contracted Rates]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[**Mail Service Prescription Drug Vendor**:] [0% - 100%]
[[Preferred][Generic] Drug: [0% - 100%]]
[[Non-preferred] Generic Drug: [0% - 100%]]
[[Preferred] Brand Name Drug: [0% - 100%]]
[[Non-Preferred] Brand Name Drug: 0% - 100%]]
[No Prescription Drug Coinsurance. Subject to [Plan] Coinsurance.]

[Tier 3] Out-of-Pocket Limits	[Individual]	[Common][Integrated][Family]
[**Designated Specialty Pharmacy Provider**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred Brand Name]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Non-Participating Pharmacy**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		
[**Mail Service Prescription Drug Vendor**]	[$0-$25,000]	[$0-$25,000]
[[Preferred][Generic] Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-preferred] Generic Drug:]	[$0-$25,000]	[$0-$25,000]
[[Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[[Non-Preferred] Brand Name Drug:]	[$0-$25,000]	[$0-$25,000]
[Subject to [Plan] Out-of-Pocket Limits]		

[[$0-500] [Calendar Year] [Benefit Period] [Per Cause] [Time Period] [Plan Year] [Brand Name Drug] Deductible. [The Deductible applies to [level] [group][1][A][,] [level] [group] [2] [B] [,] [level] [group [3] [C] [and] [level] [group] [4] [D] [and] [level] [group] [5] [E]] [Brand Name] Drugs.]	
[[Therapeutic l] [Class] [1] [a] drugs] [Deductible] [Drugs appearing on the drug list]	[$0 - $9750]
[[Therapeutic l] [Class] [1] [a] drugs] [Drugs appearing on the drug list]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill.][for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [2] [B] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [2] [B] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [3] [C] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [3] [C] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]
[[Therapeutic l] [Class] [4] [D] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [4] [D] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

[[Therapeutic l] [Class] [5] [E] drugs] [Deductible]	[$0 - $9750]
[[Therapeutic l] [Class] [5] [E] drugs]	[Not Covered] [$0-$100] [10-100%] [Copayment] [with a minimum Copayment of [$5-50]] [Amounts exceeding [$5-100]]]allowance] [up to a maximum Copayment of [$0-$1000]] [per Prescription or refill].[for the first XX of Prescriptions][then $XX for the next XX of Prescription] [then $XX for subsequent Prescriptions]]

BEN: 220.001.001.GE

[**Life Insurance**:]

[Certificate Holder	$[0-250,000]]
[Covered Dependent Spouse	$[0-250,000]]
[Covered Dependent Child(ren)	$[0-50,000]]

[This Amount of Life Insurance will be subject to the Age Reduction Percentages listed below:]

[Age Reduction Percentages:]

[Reduction Age:]	[Reduction Percentage:]
[[55]	Reduces to [70]% of the amount in force immediately prior to age [55]]
[[65]	Reduces to [60]% of the amount in force immediately prior to age [65]]
[[70]	Reduces to [60]% of the amount in force immediately prior to age [70]]

BEN: 225.001.GE

[**Accelerated Benefit**:]

[[Up to] [50%] of the Life Insurance Benefit.]

BEN: 230.001.GE

[**Accidental Death & Dismemberment Insurance**[**for Employee**]:]

[The Accidental Death Benefit will be] [[an amount equal to] [and in addition to]] the amount of Life Insurance [(including any applicable adjustment or reduction)] in effect on the date of loss.]

[Certificate Holder	$[10,000] [2X's] [3X's]]
[Dependent Covered Spouse	$[5,000] [2X's] [3X's]]
[Dependent Covered Child(ren)	$[2,000] [2X's] [3X's]]

BEN: 235.001.GE

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]
SIG: 005.002.GE

[[**CERTIFICATE OF MEDICAL INSURANCE**]
SIG: 015.003.GE

The insurance described in this certificate is effective on the date shown in the Benefit Summary only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan.
SIG: 020.003.GE

This certificate is evidence of Your coverage under the Policy of medical insurance issued to an trust~~association~~.
SIG: 025.001~~3~~.GE

This certificate describes the benefits and major provisions which affect Covered Persons. The final interpretation of any specific provision is based on the terms of the Policy. ~~[~~The Policy is issued in the State of [Illinois~~_____~~] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this certificate or the Policy.~~]~~ The certificate is subject to applicable laws of the state in which it is issued.
SIG: 030.002.001.GE

The Policy may be examined at Our Home Office or the main office of the Policyholder.
SIG: 040.001.GE

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

Please read Your certificate carefully and become familiar with its terms, limits and conditions.
SIG: 045.002.GE

[**RIGHT TO EXAMINE CERTIFICATE FOR 10 DAYS**
If You are not satisfied, return the certificate to Us or Our agent within 10 days after You have received it. All premiums will be refunded and Your coverage will be void.]

[**IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR ENROLLMENT FORM FOR INSURANCE**
Please read the copy of the enrollment form included with this certificate. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the enrollment form. If a material omission or misstatement is made in the enrollment form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount. Carefully check the enrollment form and, if any information shown in the enrollment form is not correct and complete, write to Us at the address above, within 10 days.]

Secretary

President

SIG: 050.001.GE

[**THIS CERTIFICATE CONTAINS AN UTILIZATION REVIEW PROVISIONS SECTION**]]
SIG: 060.002.GE

[[II.] [GUIDE TO YOUR CERTIFICATE]

The sections of the certificate appear in the following order:

I. [Signature Page]

II. [Guide To Your Certificate]

III. [Definitions] [for Medical and Outpatient Prescription Drug Coverage]

IV. [Effective Date and Termination Date]

V. [Utilization Review Provisions]

VI. [[Provider Charges] [and] [Maximum Allowable Amount] Provisions]

VII. [Medical Benefits]

VIII. [Outpatient Prescription Drug Benefits]

IX. [Life Insurance Benefits]

X. [Exclusions]

XI. [Pre-Existing Conditions Limitation]

XII. [Coordination of Benefits (COB)]

XIII. [Claim Provisions]

XIV. [Premium Provisions]

XV. [Recovery Provisions]

XVI. [Conversion]

XVII. [Other Provisions]]

TOC: 005.001.GE

[[III.] [DEFINITIONS] [FOR MEDICAL AND OUTPATIENT PRESCRIPTION DRUG COVERAGE]

When reading this certificate, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the certificate carefully.
DEF: 005.002.GE

[**Access Fee**
An Access Fee is the dollar amount that a Covered Person must pay each time certain [services are received] [or] [visits are made]. The Access Fee is subtracted from Covered Charges before applying any Deductible, Coinsurance or other Out-of-Pocket Limit. [An Access Fee will not be reimbursed by Us nor does it count toward satisfying any Deductible, Coinsurance or other Out-of-Pocket Limit.]

An Access Fee only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Access Fees are along with the Covered Charges to which they apply.

The following Access Fees may apply to Covered Charges:

[1.] [**Facility** [**Access**] **Fee:** The dollar amount that must be paid directly to the facility for each surgical procedure and each Inpatient stay. [A single Inpatient stay includes readmissions within [30 days] for the same condition.]]

[2.] [**Emergency Room** [**Access**] **Fee:** The dollar amount that must be paid directly to the facility for an Emergency Room visit. [We will waive an Emergency Room Access Fee if the Covered Person is admitted for an Inpatient stay immediately following the Emergency Room visit.]]
DEF: 010.001.GE

[**Accident or Accidental**
Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.

2. It results from an external agent or trauma.

3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.

4. It is definite as to time and place.

5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness.]
DEF: 015.001.GE

[**Administrator**
An organization or entity designated by Us to manage the benefits provided in this plan. [The designated Administrator will have the discretionary authority to act on Our behalf in the

administration of this plan.] [The Administrator may enter into agreements with various providers to provide services covered under this plan.]]
DEF: 020.001.GE

[**Assistant Surgeon**
A Health Care Practitioner who is qualified by licensure, training and credentialing to perform the procedure in an assistant role to the primary surgeon in the state and facility where the procedure is performed.]
DEF: 025.001.GE

[**Average Sales Price**
A published cost of a Prescription Drug as listed by Our national drug data bank or by a federal or other national source on the date the Prescription Drug is purchased.]
DEF: 030.001.GE

[**Average Wholesale Price**
A published cost of a Prescription Drug that is paid by a Pharmacy to a wholesaler as listed by Our national drug data bank on the date the Prescription Drug is purchased.]
DEF: 035.001.GE

[**Aversion Therapy**
A series of procedures, medications or treatments that are designed to reduce or eliminate unwanted or dangerous behavior through the use of negative experience, such as pairing the behavior with unpleasant sensations or punishment.]
DEF: 040.001.GE

[**Behavioral Health**
Any condition classified as a mental disorder in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. [Behavioral Health also includes family and marriage counseling.] [For the purpose of this plan, Behavioral Health does not include Substance Abuse.]]
DEF: 045.001.GE

[**Behavioral Health Facilities and Programs**
The following Behavioral Health Facilities and Programs are defined in this plan:
DEF: 050.001.GE

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

a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care or Subacute Medical Care for Behavioral Health or Substance Abuse.
b. Be staffed by an on duty licensed physician 24 hours per day.
c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
d. Maintain daily medical records that document all services provided for each patient.
e. Provide a restrictive environment for patients who present a danger to self or others.
f. Provide alcohol and chemical dependency detoxification services.

g. Handle medical complications that may result from a Behavioral Health or Substance Abuse diagnosis.
h. Not primarily provide Rehabilitation Services, residential, partial hospitalization or intensive Outpatient services although these services may be provided in a distinct section of the same physical facility.]

DEF: 050.002.GE

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

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

DEF: 050.003.GE

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

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

DEF: 050.004.GE

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

a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide care for Behavioral Health or Substance Abuse.

b. Provide at least 3 hours of individual or group psychotherapy by an appropriately licensed Health Care Practitioner 1 to 5 days per week. Recreational therapy, educational therapy, music and dance therapy and similar services may be provided but are not included in the 3 hour minimum requirement of psychotherapy.]]

DEF: 050.005.GE

[**Beneficiary**
A person to whom a life insurance benefit is payable in the event of a Covered Person's death. The Beneficiary is named by the Covered Person.]
DEF: 055.001.GE

[**Benefit Period**
The length of time [this plan is in force,] as shown in the Benefit Summary. [The Benefit Summary shows the maximum Benefit Period for which You [and any Covered Dependents] are covered under this plan.]
DEF: 060.001.GE

[**Benefit Waiting Period**
The period of consecutive days [or months] that must pass after the Effective Date of coverage before a Covered Person is eligible to be covered for [a Sickness,] [and] [specific benefits as shown in the Benefit Summary] [and] [or] [preventive medicine services] under the terms of this plan. Each Covered Person is responsible for payment of all services that are received during the Benefit Waiting Period. [The Benefit Waiting Period applies separately to each Covered Person.] [Benefits are available from the first day Covered Charges are Incurred for an Injury that is sustained on or after the Covered Person's Effective Date.]

[A Sickness that occurs within the first [150-180 days] after the Covered Person's Effective Date of coverage will not be covered for a period of [12 months] after the Effective Date.]

A Benefit Waiting Period only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Benefit Waiting Periods are along with the Covered Charges to which they apply.]
DEF: 065.001..001.GE

[**Calendar Year**
The period beginning on January 1 of any year and ending on December 31 of the same year.]
DEF: 070.001.GE

[**Calendar Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person in any one Calendar Year while this coverage is in force.]
DEF: 075.001.GE

[**Cardiac Rehabilitation Program**
An Outpatient program that is supervised by a Health Care Practitioner and directed at improving the physiological well-being of a Covered Person with heart disease.]
DEF: 080.001.GE

[**Certificate Holder**
The person listed on the Benefit Summary as the Certificate Holder.]
DEF: 085.001.GE

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

Coinsurance only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Coinsurance percentage or amount is along with the Covered Charges to which it applies.]
DEF: 090.001.GE

[**Contracted Rate**
The amount a Health Care Practitioner, facility[, Participating Pharmacy,] [Specialty Pharmacy Provider] or supplier that has a contract with [Us or] Our Network Manager, as identified for this plan, has agreed to accept as total payment for the treatment, services [,or] supplies [or Prescription Drugs] provided.]
DEF: 095.001.GE

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

A Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Copayments are along with the Covered Charges to which they apply.]
DEF: 100.001.GE

[**Cosmetic Services**
A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.]
DEF: 105.001.GE

[**Covered Charge**
An expense that We determine meets all of the following requirements:

[1.] [It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.]

[2.] [It is Incurred by a Covered Person while coverage is in force under this plan as the result of:

- [a.] [A Sickness [that first manifests itself on or after the Covered Person's Effective Date]; or]
- [b.] [An Injury [that is sustained on or after the Covered Person's Effective Date]; or]
- [c.] [For preventive medicine services [or family planning services] as outlined in the Medical Benefits section.]]

[3.] [It is Incurred for services or supplies listed in the Medical Benefits section [or Outpatient Prescription Drug Benefits section][, unless the charges are Incurred during a Benefit Waiting Period].]

[4.] [It is Incurred for treatment, services or supplies which are Medically Necessary.]

[5.] [It is not in excess of the Maximum Allowable Amount.]

Charges from the Covered Person's [Non-Network] [Non-Participating] Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by Us.]
DEF: 110.001.GE

[**Covered Charge**
An expense that We determine meets all of the following requirements:

[1.] [It is Incurred for treatment, services or supplies provided by a Health Care Practitioner, facility or supplier.]

[2.] [It is Incurred by a Covered Person while coverage is in force under this plan as the result of a Sickness or an Injury [or for preventive medicine services] [or family planning services] as outlined in the Medical Benefits section].]

[3.] [It is Incurred for services or supplies listed in the Medical Benefits section [or Outpatient Prescription Drug Benefits section][, unless the charges are Incurred during a Benefit Waiting Period].]

[4.] [It is Incurred for treatment, services or supplies which are Medically Necessary.]

[5.] [It is not in excess of the Maximum Allowable Amount.]

Charges from the Covered Person's [Non-Network] [Non-Participating] Provider may exceed the Maximum Allowable Amount. The Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount, as determined by Us.]
DEF: 110.002.GE

[**Covered Dependent**
A person who meets the definition of a Dependent and is eligible to receive benefits under this plan.]
DEF: 115.001.GE

[**Covered Person**
A person who is eligible to receive benefits under this plan.]
DEF: 120.001.GE

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

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or

2. Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or

3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.]

DEF: 135.001.GE

[**Deductible**
A Deductible is the dollar amount of Covered Charges that must be paid [during a Benefit Period] before benefits are paid by Us.

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

[One or more of the following Deductibles may apply to Covered Charges as shown in the Benefit Summary:]
DEF: 140.001.GE

[1.] [**Annual**] [**Carryover Deductible:** Covered Charges Incurred by a Covered Person [due to an Accident] [for Inpatient services] [for Inpatient services received on December 31st of a Calendar Year] [during the last [3] months of a [Plan Year] [Calendar Year] [Benefit Period]] that count toward satisfying a Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [[Non-Network] [Non-Participating] Provider Deductible,] [but do not satisfy the [Network] [Participating] Provider Deductible] [Individual Out-of-Pocket Limit]] [for that [Plan Year,] [Calendar Year,] [Benefit Period,]] will also count toward satisfying the Covered Person's [Individual Deductible,] [Integrated Deductible] [or] [[Non-Network] [Non-Participating] Provider Deductible] for the next [Plan Year] [Calendar Year] [Benefit Period]. [This [Annual] Carryover Deductible [does not count toward satisfying the [maximum] Family Deductible] [and] [only applies in the first [Plan Year] [Calendar Year] [Benefit Period].]] [For the purpose of determining whether a[n Annual] Carryover Deductible applies, Covered Charges will be considered to apply toward the [Individual Deductible] [or] [[Non-Network] [Non-Participating] Provider Deductible] in the order the Covered Charges are processed.]]
DEF: 140.003.GE

[2.] [**Common Accident Deductible:** If more than one Covered Person is injured in the same Accident, only one Individual Deductible must be satisfied for all Covered Charges for that Accident. The Covered Charges must be Incurred within [the first 90 days] [a specified period of time] after the date the Accident occurs. [Covered Charges Incurred [more than [90 days]] after the [date the Accident occurs] [time period shown in the Benefit Summary] will be paid subject to all the terms, limits and conditions in this plan without regard to the Common Accident Deductible provision.]]
DEF: 140.004.GE

[3.] [**Condition Specific Deductible:** The dollar amount of Covered Charges that must be satisfied by a Covered Person because of a named condition, shown on [the Benefit Summary] [a Condition Specific Deductible endorsement that is included with this plan], and for any complications related to that named condition. When Covered Charges equal to the Condition Specific Deductible for the named condition have been Incurred and processed by Us, the Condition Specific Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the [Benefit Summary] [Condition Specific Deductible endorsement]]. After the Condition Specific Deductible is satisfied, additional Covered Charges for the named

condition will be paid subject to all the terms, limits and conditions in this plan, including satisfaction of any other applicable Coinsurance, Deductible or other fees.]

DEF: 140.005.GE

[4.] [**Family Deductible:** [The dollar amount that must be satisfied by all Covered Persons before benefits are payable by Us.] [The [Individual] Deductibles that all Covered Persons may have to pay are limited to the Family Deductible amount.] When the Family Deductible amount is reached, We will consider the Deductible requirements for all Covered Persons in Your family to be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary][, except for any Condition Specific Deductible that a Covered Person may have].]

DEF: 140.014.GE

[5.] [**Individual Deductible:** The dollar amount of Covered Charges each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the Individual Deductible have been Incurred and processed by Us, the Individual Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.015.GE

[6.] [**Integrated Deductible:** Covered Charges Incurred by all Covered Persons[, including Covered Charges for Prescription Drugs,] count toward satisfying a single Deductible. When Covered Charges equal to the Integrated Deductible have been Incurred and processed by Us, the Integrated Deductible for all Covered Persons will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.016.GE

[7.] [**Network**] [**Participating**] **Provider Deductible:** The dollar amount of Covered Charges received from providers in the [Health Care Provider Network] [Participating Provider Network] that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Network] [Participating] Provider Deductible have been Incurred and processed by Us, the [Network] [Participating] Provider Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.017.GE

[8.] [**Non-Network**] [**Non-Participating**] **Provider Deductible:** The dollar amount of Covered Charges received from [Non-Network] [Non-Participating] Providers that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Non-Network] [Non-Participating] Provider Deductible have been Incurred and processed by Us, the [Non-Network] [Non-Participating] Provider Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.018.GE

[9.] [**Per Cause Deductible:** The dollar amount of Covered Charges that must be satisfied by a Covered Person for each Sickness or Injury and for any complications related to that Sickness or Injury before benefits are payable by Us. When Covered Charges equal to the

Per Cause Deductible have been Incurred and processed by Us, the Per Cause Deductible for that particular Sickness or Injury and for any complications related to that Sickness or Injury will be satisfied for the Covered Person for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.019.GE

[10.] [[**Select**] **Network Deductible:** The dollar amount of Covered Charges received from [Select] Participating Providers that each Covered Person must satisfy before benefits are payable by Us. When Covered Charges equal to the [Select] Network Deductible have been Incurred and processed by Us, the [Select] Network Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].]

DEF: 140.020.GE

[**Dental Injury**
Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.]
DEF: 145.001.GE

[**Dental Treatment Plan**
A dentist's report of recommended treatment on a form satisfactory to Us that:

1. Itemizes the dental procedures and charges required for care of the mouth; and

2. Lists the charges for each procedure; and

3. Is accompanied by supporting preoperative imaging tests and any other appropriate diagnostic materials required by Us.]

DEF: 150.001.GE

[**Dependent**
A Dependent is:

[1.] The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried; and]
[b.] [Who is age [18] or younger; and]
[c.] [Who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student; and]
[d.] [Whose legal address is the same as the Certificate Holder's legal address].]

[If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that:

[a.] [You are required by a qualified medical child support order to provide medical insurance; or]
[b.] [The child was claimed as an exemption on Your most recent federal income tax return].]

[If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

[a.] [The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
[b.] [The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Certificate Holder for financial support [and be claimed as an exemption on Your most recent federal income tax return]. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan or after the child reaches the normal age for termination. Additional proof may be requested periodically [but not more often than annually after the [2-year] period following the date the child reaches the normal age for termination].]

[A child will no longer be a Dependent on the earliest of the date that he or she:

[a.] [Is no longer a full-time student; or]
[b.] [Graduates; or]
[c.] [Ceases to be claimed as an exemption on the Certificate Holder's federal income tax return, except for a Dependent child who is a full-time student; or]
[d.] [Attains age [24]; or]
[e.] [Marries; or]
[f.] [Is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped[.][; or]]
[g.] [Or You request their coverage be terminated.]

[This plan terminates in accordance with the Termination Date of Coverage provision.]
[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]

DEF: 155.003.001.AR

[**Dependent**
A Dependent is:

[1.] [The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner] [if recognized under applicable law]; or]

[2.] [The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for which the Certificate Holder is the legal guardian:

[a.] [Who is unmarried][; and]
[b.] [Who is chiefly dependent on the Certificate Holder for financial support].]

[A child will no longer be a Dependent on the earliest of the date that:

[a.] [He or she marries][;]

[b.] [He or she is no longer chiefly dependent on the Certificate Holder for financial support][; or]
[c.] [He or she or the Certificate Holder request their coverage be terminated.]]
[This plan terminates in accordance with the Termination Date of Coverage provision.]
[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]
DEF: 155.007.001.GE

[**Designated Specialty Provider**
Any Health Care Practitioner, facility or supplier, identified for this plan by [Us or] the Network Manager, who has agreed to accept a Contracted Rate as payment for designated covered specialty treatment, services or supplies through Our Designated Specialty Provider Network.]
DEF: 160.001.GE

[**Designated Specialty Provider Network**
The group of Designated Specialty Providers, within the Health Care Provider Network as identified for this plan by [Us or] the Network Manager, who have agreed to accept a Contracted Rate as payment in full for designated covered specialty treatment, services or supplies. This list is subject to change at any time without notice.]
DEF: 165.001.GE

[**Designated Transplant Provider**
A Health Care Practitioner, facility or supplier, as determined by Us, that a Covered Person must use to obtain the maximum benefits available under the Transplant Services provision in the Medical Benefits section.]
DEF: 170.001.GE

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

1. A 12 month delay in one functional area; or

2. A 33% delay in one functional area or a 25% delay in each of two areas (when expressed as a quotient of developmental age over chronological age); or

3. A score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas if appropriate standardized instruments are individually administered in the evaluation.]

DEF: 175.001.GE

[**Diagnostic Imaging**

Procedures and tests including, but not limited to, x-rays, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition or determine the nature of a condition.]
DEF: 180.001.GE

[**Domestic Partner**
A person [of the same] [or] [opposite gender] who resides with the Certificate Holder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

1. Be at least [18] years of age.

2. Be competent to enter into a contract.

3. Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

A Domestic Partner must provide Us with an affidavit attesting that the domestic partnership has existed for a minimum period of [24 months] at the time of enrollment under this plan. Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.]
DEF: 185.002.GE

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

[1.] [It is designed for and able to withstand repeated use.]

[2.] [It is primarily and customarily used to serve a medical purpose.]

[3.] [It is used by successive patients.]

[4.] [It is suitable for use at home.]

[5.] [It is normally rented.]]
DEF: 190.001.GE

[**Effective Date**
The date coverage under this plan begins for a Covered Person. [The Covered Person's coverage begins at 12:01 a.m. local time at the Certificate Holder's state of residence.]]
DEF: 195.003.GE

[**Emergency Confinement**
An Inpatient stay for a Sickness or an Injury that develops suddenly and unexpectedly and if not treated immediately on an Inpatient basis would:

1. Endanger the Covered Person's life; or

2. Cause serious bodily impairment to the Covered Person.]
DEF: 205.001.GE

[**Emergency Room**

A place affiliated with and physically connected to an Acute Medical Facility and used primarily for short term Emergency Treatment.]
DEF: 210.001.GE

[**Emergency Treatment**
Treatment, services or supplies for a Sickness or an Injury that develops suddenly and unexpectedly and if not treated immediately would:

1. Endanger the Covered Person's life; or

2. Cause serious bodily impairment to the Covered Person.]

DEF: 215.001.GE

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

1. Not proven to be of benefit for diagnosis or treatment of a Sickness or an Injury; or

2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or

3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or

4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

5. Medications used for non-FDA approved indications and/or dosage regimens.

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

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

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:

    a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
    b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.

2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:

    a. The American Medical Association Drug Evaluations; or
    b. The American Hospital Formulary Service Drug Information; or
    c. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.

3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that:

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

DEF: 235.001.001.GE

[**Family Plan**
A plan of insurance covering the Certificate Holder and one or more of the Certificate Holder's Dependents.]
DEF: 240.002.GE

[**Health Care Practitioner**
A person licensed by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.]
DEF: 250.001.GE

[**Health Care Provider Network**
The group of Health Care Practitioners, facilities and suppliers, identified by [Us or] the Network Manager for this plan, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. This list is subject to change at any time without notice. [The Health Care Provider Network may be made up of various levels of provider networks.]]
DEF: 255.001.GE

[**Home Health Care**
Services provided by a state licensed Home Health Care Agency as part of a program for care and treatment in a Covered Person's home.]
DEF: 260.001.GE

[**Home Health Care Agency**
An organization:

1. Whose primary purpose is to provide Home Health Care; and

2. Which is certified by Medicare; and

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

DEF: 265.001.GE

[**Home Office**
Our office in [Milwaukee, Wisconsin] [or other administrative offices as indicated by Us].
DEF: 270.001.GE

[**Hospice**

An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of [6 months] or less as certified by a physician. A Hospice must meet all of the following requirements:

1. Comply with all state licensing requirements.

2. Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

3. Provide a treatment plan and services under the direction of a physician.]

An Inpatient Hospice facility must meet all of the following requirements in addition to the requirements above:

1. Be a dedicated unit within an Acute Medical Facility or a Subacute Rehabilitation Facility or a separate facility that provides Hospice services on an Inpatient basis.

2. Be licensed by the state in which the services are rendered to provide Inpatient Hospice services.

3. Be staffed by an on call physician 24 hours per day.

4. Provide nursing services supervised by an on duty registered nurse 24 hours per day.

5. Maintain daily clinical records.

6. Admit patients who have a terminal illness.

7. Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided.]

DEF: 275.001.GE

[**Immediate Family Member**
An Immediate Family Member is:

1. You or Your spouse [or Domestic Partner]; or

2. The children, brothers, sisters and parents of either You or Your spouse [or Domestic Partner]; or

3. The spouses of the children, brothers and sisters of You and Your spouse [or Domestic Partner]; or

4. Anyone with whom a Covered Person has a relationship based on a legal guardianship.]

DEF: 280.001.GE

[**Incur or Incurred**
The date services are provided or supplies are received.]
DEF: 285.001.GE

[**Injury**
Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.]
DEF: 290.001.GE

[**Inpatient**
Admitted to [an Acute Behavioral Health Inpatient Facility,] an Acute Medical Facility or other licensed facility for a stay of at least [24 hours] for which a charge is Incurred for room and board or observation.]
DEF: 295.001.GE

[**Malocclusion**
Teeth that do not fit together properly which creates a bite problem.]
DEF: 305.001.GE

[**Mandibular Protrusion or Recession**
A large chin which causes an underbite or a small chin which causes an overbite.]
DEF: 310.001.GE

[**Maxillary or Mandibular Hyperplasia**
Excess growth of the upper or lower jaw.]
DEF: 315.001.GE

[**Maxillary or Mandibular Hypoplasia**
Undergrowth of the upper or lower jaw.]
DEF: 320.001.GE

[**Maximum Allowable Amount**
The maximum amount of a billed charge We will consider when determining Covered Charges, as determined by Us. Benefit payments of Covered Charges are not based on the amount billed but, rather, they are based on what We determine to be the Maximum Allowable Amount. Amounts billed in excess of the Maximum Allowable Amount by or on behalf of a Health Care Practitioner, facility or supplier are not payable by Us under this contract. [Please see the [Provider Charges] [and] [Maximum Allowable Amount] Provisions section for the method(s) We use to determine the Maximum Allowable Amount.]]
DEF: 325.001.GE

[**Maximum Lifetime Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person under this plan. [This maximum will apply even if coverage under this plan is interrupted.] When the Maximum Lifetime Benefit has been received, no other benefits are payable for that Covered Person.]
DEF: 330.001.GE

[**Medical Facilities**
The following Medical Facilities are defined in this plan:
DEF: 335.001.GE

[1.] [**Acute Medical Facility [(Hospital)]:** A facility that provides acute care or Subacute Medical Care for a Sickness or an Injury on an Inpatient basis. This type of facility may also be referred to as a subacute medical facility or a long term acute care facility and must meet all of the following requirements:

a. Be licensed by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care or Subacute Medical Care.
b. Be staffed by an on duty physician 24 hours per day.

c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
d. Maintain daily medical records that document all services provided for each patient.
e. Provide immediate access to appropriate in-house laboratory and imaging services.
[f.] [Not primarily provide care for [Behavioral Health,] [Substance Abuse] [or] Rehabilitation Services although these services may be provided in a distinct section of the same physical facility.]
[g.] [Provide care in [an intensive care unit (ICU),] [a neonatal intensive care unit (NCU),] [a coronary intensive care unit (CCU)] [and] [step-down units].]]

DEF: 335.002.GE

[2.] [**Acute Medical Rehabilitation Facility:** A facility that provides acute care for Rehabilitation Services for a Sickness or an Injury on an Inpatient basis. A distinct section of an Acute Medical Facility solely devoted to providing acute care for Rehabilitation Services would also qualify as an Acute Medical Rehabilitation Facility. These types of facilities must meet all of the following requirements:

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

DEF: 335.003.GE

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

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

DEF: 335.004.GE

[4.] [**Skilled Nursing Facility:** A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility must meet all of the following requirements:

a. Be licensed by the state to provide skilled nursing services.
b. Be staffed by an on call physician 24 hours per day.
c. Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day.
d. Maintain daily clinical records.
e. Not primarily [be a place for rest, for the aged or for Custodial Care] [or] [provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility]. [The facility may also provide extended care or Custodial Care which would not be covered under this plan.]]

DEF: 335.005.GE

[5.] [**Subacute Rehabilitation Facility:** A facility that provides Subacute Medical Care for Rehabilitation Services for a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of the following requirements:

a. Be licensed by the state in which the services are rendered to provide Subacute Medical Care for Rehabilitation Services.
b. Be staffed by an on call physician 24 hours per day.
c. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
d. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this plan.]

DEF: 335.006.GE

[6.] [**Retail Health Clinic:** A facility that meets all of the following requirements:

[a.] [[Be licensed by] [or] [operate pursuant to] the state in accordance with the laws for the specific services being provided in that facility;]
[b.] [Be staffed by a Health Care Practitioner in accordance with the laws of that state;]
[c.] [Is [attached to] [or] [part of] a store or retail facility;]
[d.] [Is separate from a[n] [Acute Medical Facility [(Hospital)]][, Emergency Room][, Acute Medical Rehabilitation Facility][, Free-Standing Facility][, Skilled Nursing Facility][, Subacute Rehabilitation Facility,] [or] [Urgent Care Facility] [and any Health Care Practitioner's office located therein,] [even when services are performed after normal business hours;]]
[e.] [Provides general medical treatment or services for a Sickness or Injury[, or provides preventive medicine services,] [on a non-seasonal basis;] [and]
[f.] [Does not provide room and board or overnight services.]]

DEF: 335.008.GE

[7.] [**Urgent Care Facility:** A facility that is attached to an Acute Medical Facility but separate from the Emergency Room or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility even if services are provided after normal business hours. Room and board and overnight services are not covered. This type of facility must meet all of the following requirements:

a. Be licensed by the state in accordance with the laws for the specific services being provided in that facility.
b. Be staffed by an on duty physician during operating hours.
c. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.
d. Provide immediate access to appropriate in-house laboratory and imaging services.]]

DEF: 335.007. GE

[**Medical Review Manager**
Our Company or an organization or entity, designated by Us, which may:

[1.] [Review services as required by the Utilization Review Provisions section][; or]

[2.] [Perform discharge planning and case management services][; or]

[3.] [Evaluate the Medical Necessity of treatment, services or supplies][; or]

[4.] [Administer treatment for [Behavioral Health] [or] [Substance Abuse] through Health Care Practitioners, facilities or suppliers][; or]

[5.] [Review a Covered Person's [Behavioral Health] [or] [Substance Abuse] condition and evaluate the Medical Necessity of referral treatment].]

[The Medical Review Manager's name is shown on the insurance coverage identification (ID) card.]
DEF: 340.001.GE

[**Medical Supplies**
Disposable medical products or Personal Medical Equipment that are used alone or with Durable Medical Equipment.]
DEF: 345.001.GE

[**Medical Supply Provider**
Agencies, facilities or wholesale or retail outlets that make medical supplies available for use.]
DEF: 350.001.GE

[**Medically Necessary or Medical Necessity**
Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and

2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and

3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and

4. Is provided [in the most conservative manner or] in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.]
DEF: 355.001.GE

[**Medicare**
Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.]
DEF: 360.001.GE

[**Mid-Level Practitioner**
An individual with advanced education and experience in the direct care of patients with an emphasis on primary care. A Mid-Level Practitioner includes physician assistants, nurse midwives and nurse practitioners. A Mid-Level Practitioner must be licensed or certified by the state or other geographic area in which the Covered Charges are rendered to treat the kind of Sickness or Injury for which a claim is made. The Mid-Level Practitioner must be practicing within the limits of his or her license or certification and in the geographic area in which he or she is licensed or certified.]
DEF: 365.001.GE

[**Negotiated Rate**
The amount negotiated between Us, or on behalf of Us, and the Health Care Practitioner, facility or supplier as total payment for the services or supplies provided. [The Negotiated Rate may include any discount arrangement We may have with the Health Care Practitioner, facility or supplier.]]
DEF: 370.001.GE

[**Network Manager**
An organization or entity, designated by Us, which may administer the [Health Care Provider Network,] [and] [or] [Participating Provider Network,] [and] [or] [[Select] Participating Provider Network,] [and] [or] [Designated Specialty Provider Network,] [and] [or] [Participating Pharmacy Network] [and] [or] [Specialty Pharmacy Network].]

[The Network Manager's name is shown on the insurance coverage identification (ID) card.]
DEF: 375.001.GE

[**Network Provider**
Any Health Care Practitioner, facility or supplier belonging to the Health Care Provider Network including, but not limited to, the following:

[1.] [Participating Providers.]

[2.] [[Select] Participating Providers.]

[3.] [Designated Specialty Providers.]]
DEF: 380.001.GE

[**Non-Network Provider**
Any Health Care Practitioner, facility or supplier, not identified for this plan by [Us or] the Network Manager, as participating.]
DEF: 385.001.GE

[**Non-Participating Provider**
Any Health Care Practitioner, facility or supplier, not identified for this plan by [Us or] the Network Manager, as participating.]
DEF: 390.001.GE

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

1. Developing daily living skills.

2. Strengthening and enhancing function.

3. Coordination of fine motor skills.

4. Muscle and sensory stimulation.]

DEF: 395.001.GE

[**Office Visit**
A[n in-person] meeting between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office[, an Acute Medical Facility's Outpatient department,] [a Free-Standing Facility][,] [a Retail Health Clinic] [or] [an Urgent Care Facility]. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury as defined in the most recent edition of Current Procedural Terminology [or provides preventive medicine services].]
DEF: 400.001.001.GE

[**Orthognathic Treatment**
Malocclusion, Mandibular Protrusion or Recession, Maxillary or Mandibular Hyperplasia or Maxillary or Mandibular Hypoplasia. Refer to the Definitions of these conditions in this section of the plan.]
DEF: 405.001.GE

Orthotic Device
An external device that is; 1) Intended to restore physiological function or cosmesis to a patient; and 2) Custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient. Orthotic device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: 1) Is carried in stock and sold with out therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and 2) Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.
DEF: 408.001.AR

[**Out-of-Pocket Limit**
The Out-of-Pocket Limit is the sum of the Covered Charges for which We do not pay benefits [during a Benefit Period] [because of the [Coinsurance,] [or] [Deductible].] [When Covered Charges equal to the Out-of-Pocket Limit have been Incurred and processed by Us, the Out-of-Pocket Limit will be satisfied] [for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary].] [The Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this plan.]

The following do not count toward satisfying any Out-of-Pocket Limit:

[1.] [All [Access Fees] [and] [Copayments] [and] [Deductibles].]

[2.] [All penalties applied under the Utilization Review Provisions section.]

[3.] [Amounts not paid by Us due to the difference between the [Non-Network] [Non-Participating] Provider benefit and the benefit that would have been paid had a [Network] [Participating] Provider been used.]

[4.] [Amounts in excess of the Maximum Allowable Amount.]

[5.] [Charges Incurred after the maximum amount has been paid for a benefit under this plan.]

[6.] [All [Ancillary Charges,] [Ancillary Pharmacy Network Charges,] [Prescription Drug Coinsurance amounts,] [Prescription Drug Copayments,] [and] [Prescription Drug Deductibles].]

DEF: 410.001.GE

An Out-of-Pocket Limit only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Out-of-Pocket Limits are along with the Covered Charges [[and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply].

[1.] [**Family Out-of-Pocket Limit:** [The total dollar amount of Covered Charges that must be paid by You and Your Covered Dependents before We will consider the Out-of-Pocket Limit for all Covered Persons under the same Family Plan to be satisfied.]

[2.] [**Individual Out-of-Pocket Limit:** The dollar amount of Covered Charges that must be paid by each Covered Person before the Out-of-Pocket Limit is satisfied for that Covered Person.]

[3.] [**Network**] [**Participating**] **Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from providers in the [Health Care Provider Network] [Participating Provider Network] that must be paid by each Covered Person before the [Network] [Participating] Provider Out-of-Pocket Limit is satisfied for that Covered Person.]

[4.] [[**Non-Network**] [**Non-Participating**] **Provider Out-of-Pocket Limit:** The dollar amount of Covered Charges for services received from [Non-Network] [Non-Participating] Providers that must be paid by each Covered Person before the [Non-Network] [Non-Participating] Provider Out-of-Pocket Limit is satisfied for that Covered Person.]]

DEF: 415.001.GE

[**Outpatient**
Treatment, services or supplies received at a licensed medical facility, Health Care Practitioner's office or dispensary on other than an Inpatient basis for a stay of less than 24 hours.]
DEF: 420.001.GE

[**Outpatient Calendar Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for Outpatient treatment, services or

supplies. When the Outpatient Calendar Year Maximum Benefit has been received, no other benefits are payable for Outpatient treatment, services or supplies that the Covered Person receives for the remainder of that Calendar Year.]
DEF: 425.001.GE

[**Participating Provider**
Any Health Care Practitioner, facility or supplier, identified for this plan by [Us or] the Network Manager, as participating.]
DEF: 435.001.GE

[**Participating Provider Network**
The group of Participating Providers within the Health Care Provider Network, identified for this plan by [Us or] the Network Manager, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. This list is subject to change at any time without notice.]
DEF: 440.001.GE

[**Per Cause Limit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person for each Sickness or Injury and for any complications related to that Sickness or Injury. When the Per Cause Limit has been paid, no other benefits are payable under this plan for that particular Sickness or Injury and for any complications related to that Sickness or Injury for the Covered Person [over the lifetime of that Covered Person] [for the [time period] [Plan Year] [Calendar Year] [Benefit Period] shown in the Benefit Summary].]
DEF: 445.001.GE

[**Period of Confinement**
The initial and subsequent Inpatient stays resulting from the same or a related Sickness or Injury and/or any complications unless the current Inpatient stay begins more than [30 days] after the date of discharge from the most recent Inpatient stay.]
DEF: 450.001.GE

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

1. Is designed for and able to withstand repeated use; and

2. Is primarily and customarily provided to serve a medical purpose; and

3. Is not intended for use by successive patients.]

DEF: 455.001.GE

[**Physical Medicine**
Treatment of physical conditions relating to bone, muscle or neuromuscular pathology. This treatment focuses on restoring function using mechanical or other physical methods.]
DEF: 460.001.GE

[**Physical Therapy**
The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and alleviating pain.]
DEF: 465.001.GE

[**Plan Year**
The period beginning on the month and day of the Effective Date in any year and ending on the same month and day as the Effective Date in the following year.]
DEF: 475.001.GE

[**Plan Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred by each Covered Person in any one Plan Year while this coverage is in force.]
DEF: 480.001.GE

[**Policy**
The group master contract issued by Us to the Policyholder providing benefits for Covered Persons.]
DEF: 485.001.GE

[**Policyholder**
The [person,] [organization] [or] [entity] to [which] [whom] the Policy is issued as shown in the Benefit Summary.]
DEF: 490.001.GE

[**Policy Owner**
The parent or legal guardian who signs the enrollment form for coverage under this plan when only minor children are Covered Persons.]
DEF: 495.001.GE

[**Pre-Existing Condition**
A Sickness or an Injury and related complications[, not fully disclosed on the [enrollment form]]:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] during the [24-month] period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or

2. That produced signs or symptoms during the [24-month] period immediately prior to the Covered Person's Effective Date.

   The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

   a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
   b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

   [A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.]]

DEF: 500.002.001.GE

[**Prescription Drug**
Any medication that:

[1.] [Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States][; and]

[2.] [Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws][; and]

[3.] [Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or "Rx Only" on the manufacturer's label, or similar wording as designated by the FDA].]

DEF: 505.001.GE

Prosthetic Device

An external device that is; 1) Intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and 2) Custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient. Prosthetic device does not include an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

DEF: 510.001.AR

[**Rehabilitation Services**

Specialized treatment for a Sickness or an Injury which meets all of the following requirements:

1. Is a program of services provided by one or more members of a multi-disciplinary team.

2. Is designed to improve the patient's function and independence.

3. Is under the direction of a qualified Health Care Practitioner.

4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.

5. May be provided in either an Inpatient or Outpatient setting.]

DEF: 515.001.GE

[[**Select**] **Participating Provider**

Any Health Care Practitioner, facility or supplier as identified for this plan by [Us or] the Network Manager who has agreed to accept a Contracted Rate as payment for specific treatment, services or supplies through Our [Select] Participating Provider Network.]

DEF: 520.001.GE

[[**Select**] **Participating Provider Network**

The group of [Select] Participating Providers, within the Health Care Provider Network as identified for this plan by [Us or] the Network Manager, who have agreed to accept a Contracted Rate as payment in full for specific treatment, services or supplies. The list is subject to change at any time without notice.]

DEF: 525.001.GE

[**Service Area**

The geographic area, as defined by Us, served by [Participating Providers,] [and] [or] [[Select] Participating Providers,] [and] [or] [Specialty Care Providers] [and] [or] [Designated Specialty Providers]. Contact [the Network Manager] [or] [Us] to determine the precise geographic area serviced by [Participating Providers,] [and] [or] [[Select] Participating Providers,] [and] [or] [Specialty Care Providers] [and] [or] [Designated Specialty Providers]. The Service Area is subject to change at any time without notice.]
DEF: 530.001.GE

[**Sickness**
A disease or illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.]
DEF: 535.001.GE

[**Single Plan**
A plan of insurance covering only the Certificate Holder.]
DEF: 540.003.GE

[**Special Exception Rider**
A form that is included with this plan which identifies a body part, system, disease, Sickness, Injury or other condition for a Covered Person in which all charges related to that body part, system, disease, Sickness, Injury or other condition are excluded from coverage [for a specified period of time as shown in the Special Exception Rider].]
DEF: 555.001.GE

[**Specialty Care Provider**
A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties [or who is designated by the Network Manager as a Specialty Care Provider]. [A Specialty Care Provider cannot be a Primary Care Provider.]
DEF: 560.001.GE

[**Speech Therapy**
The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.]
DEF: 565.001.GE

[**Subacute Medical Care**
A short-term comprehensive Inpatient program of care for a Covered Person who has a Sickness or an Injury that:

1. Does not require the Covered Person to have a prior admission as an Inpatient in a licensed medical facility; and

2. Does not require intensive diagnostic and/or invasive procedures; and

3. Requires Health Care Practitioner direction, intensive nursing care, significant use of ancillaries, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.]

DEF: 570.001.GE

[**Substance Abuse**

Abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) that is published at the time a claim is received by Us. [For the purpose of this plan, Substance Abuse does not include Behavioral Health.]]
DEF: 570.002.GE

[**Surgical Assistant**
A Health Care Practitioner who is licensed to assist at surgery in the state and credentialed at the facility where the procedure is performed but who is not qualified by licensure, training and credentialing to perform the procedure as a primary surgeon at that facility.]
DEF: 575.001.GE

[**Telehealth Services**
The use of modern telecommunication and information technologies by a Health Care Practitioner in the treatment of his or her established patient.]
DEF: 580.001.GE

[**Telemedicine Services**
A medical inquiry initiated by a Health Care Practitioner for the purpose of assistance with a patient's assessment, diagnosis, consultation, treatment or the transfer of medical data that requires the use of modern telecommunications technology.]
DEF: 585.001.GE

[**Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction**
TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing:

1. Clicking and/or difficulties in opening and closing the mouth.

2. Pain or swelling.

3. Complications including arthritis, dislocation and bite problems of the jaw.]

DEF: 590.001.GE

[**Total Disability/Totally Disabled**
You or Your spouse [or Domestic Partner] are unable to perform the essential duties of any occupation for which reasonably fitted by education, training or experience, whether performed for financial gain or not. Retired individuals and homemakers shall not be considered unable to perform an occupation solely because they are unemployed. [A Covered Dependent child is Totally Disabled only if confined as a patient in an Acute Medical Facility [or Behavioral Health Facility].]]
DEF: 595.001.GE

[**Urgent Care**
Treatment or services provided for a Sickness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours; and

2. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.]

DEF: 600.001.GE

[**We, Us, Our, Our Company**
Time Insurance Company [or its Administrator].]
DEF: 605.002.GE

[**You, Your, Yours**
The person listed on the Benefit Summary as the Certificate Holder.]
DEF: 610.002.GE

[**In addition to the definitions listed above, the following definitions apply to the Outpatient Prescription Drug Benefits section**:]
DEF: 615.001.GE

[**Allowance**
The initial amount to be paid by Us toward the cost of a covered Prescription Drug, dispensed by a [Participating Pharmacy,] [Specialty Pharmacy Provider] [or a] [Non-Participating Pharmacy]. [The Allowance is shown on [a Drug List] [the Benefit Summary].] [The difference in cost between the Allowance and the actual charge for the Prescription Drug must be paid by the Covered Person.]

[The Allowance does not count toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or any other section in this plan].]]
DEF: 620.001.GE

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

[The Ancillary Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or any other section in this plan].]]
DEF: 625.001.GE

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

The Ancillary Pharmacy Network Charge does not count toward satisfying any Coinsurance, Copayment, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]
DEF: 630.001.GE

[**Average Sales Price**

A published cost of a Prescription Drug as listed by Our national drug data bank or by a federal or other national source on the date the Prescription Drug is purchased.]
DEF: 635.001.GE

[**Average Wholesale Price**
A published cost of a Prescription Drug that is paid by a Pharmacy to a wholesaler as listed by Our national drug data bank on the date the Prescription Drug is purchased.]
DEF: 640.001.GE

[**Brand Name Drug**
A Prescription Drug for which a pharmaceutical company has received a patent or trade name.]
DEF: 645.001.GE

[**Compounded Medication**
A drug product made up of two or more active parts or ingredients which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order. If covered, Compounded Medications will be considered to be Non-Preferred Brand Name Drugs.]
DEF: 650.001.GE

[**Drug List**
A list of Prescription Drugs that We designate as eligible [for reimbursement]. A Drug List is subject to change at any time without notice.]
DEF: 655.001.GE

[**Generic Drug**
A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug [within the same or a similar Therapeutic Class]; and

2. Does not carry any drug manufacturer's brand name on the label; and

3. Is not protected by a patent.

It must be listed as a Generic Drug by Our national drug data bank on the date it is purchased [and it must be approved by Us]. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by Our national drug data bank on the date it is purchased [and it must be approved by Us].]
DEF: 660.001.GE

[**Mail Service Prescription Drug Vendor**
A Participating Pharmacy that is under contract with Us or Our Network Manager through Our Participating Pharmacy Network. The Mail Service Prescription Drug Vendor dispenses selected Prescription Maintenance Drugs to Covered Persons through the mail.]
DEF: 665.001.GE

[**Maximum Allowable Cost (MAC) List**
A list of Prescription Drugs that are considered for reimbursement at a Generic Drug product level [or a Prescription Drug Class level] [based on the Prescription Drug Class Reference Price] that is established by Us. This list is subject to change at any time without notice.]

DEF: 670.001.GE

[**New-to-Market Prescription Drugs:** Prescription Drugs fully approved by the United States Food and Drug Administration (FDA) [as new drugs] [or] [as drugs used to treat a different indication than that for which they were originally approved] [within the past [12 months]], which will be subject to an evaluation process [not to exceed [12 months]]. The evaluation process will review additional information on the safety, cost-effectiveness and efficacy of those drug products. This evaluation process will take place to determine appropriate clinical standards of practice.]
DEF: 675.001.GE

[**Non-Participating Pharmacy**
A Pharmacy that is not under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network [or Specialty Pharmacy Network].]
DEF: 680.001.GE

[**Non-Preferred Brand Name Drug**
A Brand Name Drug that is not listed as preferred in a Drug List.]
DEF: 685.001.GE

[**Non-Preferred Generic Drug**
A Generic Drug that is not listed as preferred in a Drug List.]
DEF: 690.001.GE

[**Participating Pharmacy**
A Pharmacy that is under contract with Us or Our Network Manager to provide Prescription Drugs to the Covered Person through Our Participating Pharmacy Network [or Specialty Pharmacy Network].]
DEF: 695.001.GE

[**Participating Pharmacy Network**
A Prescription Drug delivery system established by Us or the Network Manager in which Participating Pharmacies are under contract with Us or Our Network Manager. The list of Participating Pharmacies is subject to change at any time without notice.]
DEF: 700.001.GE

[**Pharmacy**
A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.]
DEF: 705.001.GE

[**Preferred Brand Name Drug**
A Brand Name Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.]
DEF: 710.001.GE

[**Preferred Generic Drug**
A Generic Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.]
DEF: 715.001.GE

[**Prescription Card Service Administrator (PCSA)**

An organization or entity that administers the processing of claims under the Outpatient Prescription Drug Benefits section. This organization or entity may be changed at any time without notice.]
DEF: 720.001.GE

[**Prescription Drug Calendar Year Maximum Benefit**
The maximum amount, as shown in the Benefit Summary, that We will pay for Covered Charges Incurred during each Calendar Year by a Covered Person for Prescription Drugs. When the Prescription Drug Calendar Year Maximum Benefit has been received, no other benefits are payable for Prescription Drugs that the Covered Person receives for the remainder of that Calendar Year.]
DEF: 725.001.GE

[**Prescription Drug Class**
Prescription Drugs that are grouped by Us according to a specific category, such as [Therapeutic Class,] Brand Name Drug or Generic Drug designation, diagnosis or cost effectiveness. The actual Prescription Drugs that are included in each category are shown on a Drug List that is broken down by tiers or levels based on the way Covered Charges for the drugs are reimbursed by Us. We may periodically change the placement of a Prescription Drug from one tier or level to another at any time without notice. As a result of these changes, a Covered Person may be required to pay more or less for a Prescription Drug.

The Benefit Summary will identify what any applicable Prescription Drug Coinsurance, Prescription Drug Copayment, Prescription Drug Deductible and other Prescription Drug Out-of-Pocket Limits and any maximum limits are for each tier or level of coverage in each category [along with the [time period] [Plan Year] [Calendar Year] [Benefit Period] that applies to each coverage tier or level].]
DEF: 730.001.GE

[**Prescription Drug Coinsurance**
The Prescription Drug Coinsurance is the [dollar amount or] percentage of Covered Charges for Prescription Drugs that must be paid by a Covered Person after any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug Copayment] [and] [or] [Prescription Drug Deductible] are satisfied. The Covered Person must pay any applicable Prescription Drug Coinsurance directly to the Participating Pharmacy [or Specialty Pharmacy Provider].

The Prescription Drug Coinsurance only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Prescription Drug Coinsurance percentage [or amount] is [along with the [Prescription Drug Class] [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which it applies]. [The Prescription Drug Coinsurance does not count toward satisfying any Out-of-Pocket Limit under the Medical Benefits section.]]
DEF: 735.001.GE

[**Prescription Drug Condition Specific Deductible**
The dollar amount of Covered Charges for Prescription Drugs that must be satisfied by a Covered Person because of a named condition, shown in [the Benefit Summary] [a Condition Specific Deductible endorsement that is included with this plan], and for any complications related to that named condition. When Covered Charges for Prescription Drugs equal to the Prescription Drug Condition Specific Deductible for the named condition have been Incurred and processed by Us, the Prescription Drug Condition Specific Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary] [shown in the Condition Specific Deductible endorsement]. [After the Prescription Drug Condition Specific Deductible is satisfied, additional Covered Charges for

Prescription Drugs for the named condition will be paid subject to all the terms, limits and conditions in this plan[, including satisfaction of any other applicable [Prescription Drug Coinsurance,] [Prescription Drug Deductible,] [Deductible under any other section of this plan,] [or] [other fees].]]
DEF: 740.001.GE

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

A Prescription Drug Copayment only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Copayments are [along with the Prescription Drug Class to which they apply]. [A Prescription Drug Copayment does not count toward satisfying any Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]]
DEF: 745.001.GE

[**Prescription Drug Deductible**
A Prescription Drug Deductible is the dollar amount of Covered Charges for Prescription Drugs that each Covered Person pays [during a Benefit Period] before benefits are paid by Us. The Covered Person must pay any applicable Prescription Drug Deductible directly to the Participating Pharmacy [or Specialty Pharmacy Provider]. When Covered Charges equal to the Prescription Drug Deductible have been Incurred and processed by Us, the Prescription Drug Deductible for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary]. [Charges applied to the Prescription Drug Deductible do not count toward satisfying any Prescription Drug Condition Specific Deductible that would apply.]

A Prescription Drug Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what any applicable Prescription Drug Deductibles are [along with the [Prescription Drug Class] [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply]. [Charges applied to the Prescription Drug Deductible do not count toward satisfying any Out-of-Pocket Limit under the Medical Benefits section.]]
DEF: 750.001.GE

[**Prescription Drug Family Deductible**
[The dollar amount that must be satisfied by all Covered Persons before benefits are payable by Us.] [The Prescription Drug Deductibles that all Covered Persons may have to pay are limited to the Prescription Drug Family Deductible amount.] When the Prescription Drug Family Deductible amount is reached, We will consider the Prescription Drug Deductible requirements for all Covered Persons in the family to be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary][, except for any Prescription Drug Condition Specific Deductible that a Covered Person may have].

The Prescription Drug Family Deductible only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Family Deductible amount is [and the [time period] [Plan Year] [Calendar Year] [Benefit Period] to which it applies]. [Charges applied to the Prescription Drug Family Deductible do not count toward satisfying any Out-of-Pocket Limit under the Medical Benefits section.]]
DEF: 755.001.GE

[**Prescription Drug Family Out-of-Pocket Limit**
[We will consider the Prescription Drug Out-of-Pocket Limit for all Covered Persons to be satisfied, for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary], when the total amount of Covered Charges applied to the Prescription Drug Out-of-Pocket Limit under the same Family Plan equals the Prescription Drug Family Out-of-Pocket Limit.]

A Prescription Drug Family Out-of-Pocket Limit only applies if it is shown in the Benefit Summary. The Benefit Summary will identify what the applicable Prescription Drug Family Out-of-Pocket Limit is along with the Covered Charges [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which it applies.]
DEF: 760.001.GE

[**Prescription Drug Out-of Pocket Limit**
The Prescription Drug Out-of-Pocket Limit is the sum of Covered Charges for Prescription Drugs for which We do not pay benefits [during a Benefit Period] [because of the [Prescription Drug Deductible] [and] [Prescription Drug Coinsurance]]. When Covered Charges equal to the Prescription Drug Out-of-Pocket Limit have been Incurred and processed by Us, the Prescription Drug Out-of-Pocket Limit for that Covered Person will be satisfied for the remainder of the [time period] [Plan Year] [Calendar Year] [Benefit Period] [shown in the Benefit Summary]. The Prescription Drug Out-of-Pocket Limit applies separately to each Covered Person, except as otherwise provided by this plan.]

[The following do not count toward satisfying any Prescription Drug Out-of-Pocket Limit:

[1.] [All [Ancillary Charges,] [Ancillary Pharmacy Network Charges,] [or] [Prescription Drug Copayments].]

[2.] [Amounts in excess of the Allowance.]

[3.] [All penalties applied under the Utilization Review Provisions section.]

[4.] [Amounts in excess of the Maximum Allowable Amount.]

[5.] [Charges Incurred after the maximum amount has been paid for a benefit under this plan.]

[6.] [All [Access Fees,] [Coinsurance,] [Copayments,] [Deductibles] [or] any other fees that apply under the Medical Benefits section.]

[A Prescription Drug Out-of-Pocket Limit only applies if it is shown in the Benefit Summary.] The Benefit Summary will identify what the applicable Prescription Drug Out-of-Pocket Limits are [along with the Covered Charges [and the] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply].]
DEF: 765.001.GE

[**Prescription Maintenance Drugs**
Prescription Drugs that are:

1. [Oral contraceptives or] [D][d]rugs that are taken regularly to treat a chronic health condition; and

2. Covered under this Outpatient Prescription Drug Benefits section; and

3. Approved by Us for coverage under the Mail Service Prescription Drug Vendor provision in this section.

[Prescription Maintenance Drugs must be dispensed through a Mail Service Prescription Drug Vendor for benefits to be considered under this plan.]]
DEF: 770.001.GE

[**Prescription Order**
The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill; or

2. Insulin [or insulin derivatives] only by prescription; or

3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:

   a. Disposable insulin syringes and needles; or
   b. Disposable blood/urine/glucose/acetone testing agents or lancets.]

DEF: 775.001.GE

[**Reference Price**
The maximum amount that We will pay for covered Prescription Drugs within a Prescription Drug Class or within similar Prescription Drug Classes as established by Us.]
DEF: 780.001.GE

[**Specialty Pharmaceuticals**
These types of Prescription Drugs include:

[1.] [Drugs used to treat rare or certain chronic diseases.]

[2.] [Drugs that have a highly targeted, cellular mechanism of action.]

[3.] [Drugs that may require [self-]injection or other parenteral or unique method of administration.]

[4.] [Drugs that may require special administration and monitoring.]

[5.] [Drugs that are regularly supplied by Specialty Pharmacy Providers.]

[6.] [Drugs that are otherwise defined by Us in the Benefit Summary or in a Drug List.]

[If a Specialty Pharmaceutical Prescription Drug is covered under this Outpatient Prescription Drug Benefits section, is dispensed or administered at a Health Care Practitioner's office setting, and is not obtained through a Specialty Pharmacy Provider, the Covered Person may be billed for any applicable Ancillary Charge, Prescription Drug Coinsurance, Prescription Drug Copayment and Prescription Drug Deductible in addition to a Copayment under the Medical Benefits section for an Office Visit.]]
DEF: 785.001.GE

[**Specialty Pharmacy Provider**
A Pharmacy that may be under contract with Us or Our Network Manager to distribute Specialty Pharmaceuticals to the Covered Person through Our Specialty Pharmacy Network. [A Specialty Pharmacy Provider may also act as Our preferred distributor of Specialty Pharmaceuticals even though they are not part of Our Specialty Pharmacy Network.]
DEF: 790.001.GE

[**Specialty Pharmacy Network**
A Prescription Drug delivery system for Specialty Pharmaceuticals that is established by Us or the Network Manager in which Specialty Pharmacy Providers are under contract with Us or Our Network Manager. The list of Specialty Pharmacy Providers is subject to change at any time without notice.]
DEF: 795.001.GE

[**Therapeutic Class**
A classification into which Prescription Drugs are grouped based on the drugs' mechanisms of action and/or the symptoms or diseases they are used to treat. [The actual Prescription Drugs that are included in a Therapeutic Class are shown on a Drug List.]]
DEF: 800.001.GE

[[**IV.**] [**EFFECTIVE DATE AND TERMINATION DATE**]
EFF: 005.002.GE

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

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

The rates may change if the Certificate Holder moves to another zip code, there is a change in benefits [or Dependents are added or deleted].]
EFF: 010.0058~~8~~.GE

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

[1.] [**Adding a Newborn Child:** [A newborn child can be added on the date the child was born.] You must [call Our office or] send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the date the child is born. If this is a Single Plan and these requirements are not met, the child will not be covered from birth. However, if this is a Family Plan and if these requirements are not met, Your newborn child will be covered [for Sickness or Injury] only for the first 90 days from birth.]

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

[3.] [**Adding Any Other Dependent:** [To add any other Dependent, an enrollment form must be completed and sent to Us along with any required premium.] [Evidence of insurability must also be provided.] [The Effective Date of coverage will be 12:01 a.m. local time at the

Certificate Holder's state of residence on the date We approve coverage under Our coverage criteria.] [Coverage will take effect at 12:01 a.m. local time at the Certificate Holder's state of residence in accordance with the definition of Effective Date in this plan.]
EFF: 015.001.AR

[**Termination Date of Coverage**
The Certificate Holder may cancel this coverage at any time by sending Us written notice or calling Our office. [Upon cancellation, [We will return the unearned portion of any premium paid] [any premium paid for a time not covered will be returned [on a [short rate] [pro-rata] basis] [in accordance with the laws in the Certificate Holder's state of residence] [minus any claims that were Incurred after the termination date and paid by Us].]]

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

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

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

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

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

[5.] [The date all certificates with the same form number are non-renewed in the state in which this certificate was issued or the state in which the Certificate Holder presently resides.]

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

[7.] [The date the Certificate Holder moves to a state where We do not provide individual medical insurance coverage.]

[8.] [The date a Covered Person moves outside of the Service Area if he or she has a PPO plan.]

[9.] [The date a Covered Person becomes eligible for Medicare, if allowed by federal law.]

[10.] [The date a Covered Dependent no longer meets the Dependent definition in this plan.]

[We will pay benefits to the end of the time for which We have accepted premiums.]]]
EFF: 020.004.GE

[[V.] [UTILIZATION REVIEW PROVISIONS]

[Utilization Review Process
THE COVERED PERSON MUST CALL THE TOLL FREE NUMBER GIVEN ON THE IDENTIFICATION (ID) CARD TO OBTAIN OUR AUTHORIZATION FOR THE SERVICES LISTED UNDER THE WHEN TO CALL PROVISION IN THIS SECTION. [BENEFITS WILL BE REDUCED AS DESCRIBED IN THE REDUCTION OF PAYMENT PROVISION IN THIS SECTION, IF A COVERED PERSON DOES NOT COMPLY WITH THIS UTILIZATION REVIEW PROCESS AND DOES NOT OBTAIN AUTHORIZATION.]

A REVIEW BY THE MEDICAL REVIEW MANAGER DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. PAYMENT OF BENEFITS WILL BE SUBJECT TO ALL THE TERMS, LIMITS AND CONDITIONS IN THIS CERTIFICATE.

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

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

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

1. The certificate number for this plan.

2. The Health Care Practitioner's name and telephone number.

3. The service, procedure and diagnosis.

4. The proposed date of admission or date the service or procedure will be performed.

5. The facility's name and phone number.

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

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

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

[a.] [Non-Emergency Confinements: Call at least [7 business days] prior to an Inpatient admission for a non-emergency confinement that will exceed 24 hours in length.]
[b.] [Emergency Confinements: Call within [24 hours], or as soon as reasonably possible, after admission for an Emergency Confinement that will exceed 24 hours in length. The

Covered Person must provide or make available to the Medical Review Manager the full details of the Emergency Confinement.]

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

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

[a.] [Any surgical procedures.]

[b.] [Invasive cardiology services for diagnostic or therapeutic cardiac procedures, except cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).]

[c.] [Invasive radiology services for diagnostic or interventional purposes.]

[d.] [Dialysis.]

[e.] [Radiation therapy.]

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

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

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

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

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

[6.] [**Physical Medicine:** Call at least [7 business days] prior to beginning a course of treatment if the anticipated course of treatment will exceed [12 visits] or will last longer than [30 days].]

[7.] [**Infertility:** Call at least [7 business days] prior to beginning treatment.]

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

[9.] [**Home Health Care:** Call at least [7 business days] prior to beginning Home Health Care.]

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

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

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

[1.] No benefits will be paid under this plan for any transplant services that are not authorized by the Medical Review Manager prior to transplant evaluation, testing, preparative treatment or donor search [when services are provided by a [non-Designated Transplant Provider] [Non-Network][Non-Participating] Provider]]..

[2.] [If authorization is not obtained for the Covered Person's course of treatment for the other services listed in the When to Call provision above, benefits will be reduced for otherwise Covered Charges by [XX%] but by no more than [$XXXXX] per course of treatment [when services are provided by a [[Network][Participating provider] [or] [[Non-Network][Non-Participating] Provider]], if any of the following occur:

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

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Access Fee, Coinsurance, Copayment, Deductible or Out-of-Pocket Limit.]]
URP: 005.002.001.GE

[[VI.] [[PROVIDER CHARGES] [AND] [MAXIMUM ALLOWABLE AMOUNT] PROVISIONS]

[YOU [AND YOUR COVERED DEPENDENTS] ARE FREE TO USE ANY PROVIDER YOU [AND YOUR COVERED DEPENDENTS] CHOOSE. IT IS THE COVERED PERSON'S RESPONSIBILITY TO DETERMINE IF A PROVIDER IS A [NETWORK PROVIDER,] [PARTICIPATING PROVIDER,] [[SELECT] PARTICIPATING PROVIDER,] [OR] [DESIGNATED SPECIALTY PROVIDER] OR A [NON-NETWORK] [NON-PARTICIPATING] PROVIDER BEFORE ANY SERVICES ARE RENDERED. PLEASE SEE THE BENEFIT SUMMARY FOR SPECIFIC BENEFIT LEVELS [THAT APPLY TO EACH TYPE OF PROVIDER].]

[[NON-NETWORK] [NON-PARTICIPATING] PROVIDERS MAY BILL MORE THAN WE DETERMINE TO BE A MAXIMUM ALLOWABLE AMOUNT AND THE COVERED PERSON IS RESPONSIBLE FOR PAYMENT OF ANY AMOUNT BILLED ABOVE THE MAXIMUM ALLOWABLE AMOUNT. [THE COVERED PERSON IS NOT RESPONSIBLE FOR PAYMENT OF AMOUNTS BILLED BY A [NETWORK PROVIDER] [PARTICIPATING PROVIDER] [PROVIDER] IN EXCESS OF THE MAXIMUM ALLOWABLE AMOUNT FOR COVERED CHARGES RECEIVED WITHIN THE COVERED PERSON'S NETWORK.]]

[Payment of [Network] [Participating] Provider Benefits
[A Covered Person may receive a higher benefit level for Covered Charges received from a Participating Provider. The [Network] [Participating] Provider benefit levels are shown in the Benefit Summary.] [A higher benefit level may also be obtained by using a [[Select] Participating Provider] [or Designated Specialty Provider]. [Network services and supplies for which We have a Contracted Rate are not subject to Maximum Allowable Amount reductions.]

Using a [Network] [Participating] Provider is not a guarantee of coverage. All other requirements of this plan must be met for Covered Charges to be considered for payment. [Deductibles may vary based on whether the provider is a [Participating Provider,] [[Select] Participating Provider,] [or] [Designated Specialty Provider].] [Covered Charges can accrue only to one Deductible at a time, based on the provider's benefit level.]

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

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

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

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

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

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

[**Maximum Allowable Amounts for** [**Network**] [**Participating**] **Providers**
For goods and services provided by a [Network] [Participating] Provider, facility or supplier, the Maximum Allowable Amount is the lesser of billed charges or the Contracted Rate. A Covered Person is not responsible for payment of amounts billed by a [Network] [Participating] Provider in excess of the Maximum Allowable Amount for Covered Charges received within the Covered Person's network.]

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

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

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

[1.] Billed charges; or

[2.] The Negotiated Rate; or

[3.] If a Negotiated Rate is not available, in accordance with [the] [lesser of] [greater of] [average of] [weighted average of] [median of] [one or more of] the following methodologies:

PAR: 005.013.GE

[a.] [The amount a Health Care Practitioner, facility or supplier of a similar type [and] [or] [and/or] in the same geographic area bills for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted charge data and relative values.]

PAR: 005.014.GE

[b.] [The amount derived by applying comparable markups from facilities of a similar type [and] [or] [and/or] in the same geographic area, to the estimated costs of the facility providing the goods and services reported on the claim, established utilizing the facility's most recently available cost reports submitted to The Centers for Medicare and Medicaid Services (CMS).]

PAR: 005.015.GE

[c.] [The expected or estimated charges of facilities of a similar type [and] [or] [and/or] in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through CPT or HCPCS codes, or grouping of services as determined through standard DRG, refined DRG, APC or other standard industry methodologies, depending upon the services and setting reported on the claim.]

PAR: 005.016.GE

[d.] [The [lowest] [average] [mode] [median] Contracted Rate [and] [or] [and/or] [non-Medicare or non-Medicaid] Negotiated Rate amount a Health Care Practitioner, facility or supplier of a similar type [and] [or] in the same geographic area has accepted for the same or similar goods and services as reported on the claim, based on a combined profile of derived and actual submitted claims data.]

PAR: 005.017.GE

[e.] [[XX] times the amount, as would be allowed to the facility by Medicare, for the goods and services reported on the claim, established utilizing the most currently available Medicare, facility-specific, reimbursement schedules [and methodologies].]

PAR: 005.018.GE

[f.] [[XX] times the amount, as would be allowed to the provider of a similar type [and] [or] [and/or] in the same geographic area, when providing the same or similar goods and services reported on the claim, defined as the same service as reported through Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes by Medicare.]

PAR: 005.019.GE

[g.] [The amount as defined in another schedule or method of deriving Maximum Allowable Amounts, as identified [and] [or] [and/or] shown in the Benefit Summary, for the goods and services reported on the claim.]

PAR: 005.020.GE

[h.] [The [lowest] [average] [mode] [median] amount a Health Care Practitioner, facility or supplier of a similar type [and] [or] [and/or] in the same geographic area, for the goods

and services reported on the claim, has accepted for the same or similar goods and services, derived from Our or another payers' Maximum Allowable Fees or actual amounts paid.]

PAR: 005.021.GE

[i.] [The expected or estimated charges of facilities of a similar type [and] [or] [and/or] in the same geographic area, for the goods and services reported on the claim, using the facility's overall charge structures as a benchmark, determined by utilizing overall charges per discharge or encounter, adjusted by a valid, facility-specific, case or service mix index available.]

PAR: 005.022.GE

[j.] [The amount as defined in a fee schedule that We develop, for the goods and services reported on the claim.]

PAR: 005.023.GE

[k.] [For [infusion] [injectable] therapy and services [not processed through the pharmacy benefit manager] [not filled by prescription through a Participating Pharmacy] [submitted on a standard medical claim form], the amount most commonly paid [by Us or another payer] [to a nationally contracted Specialty Pharmacy Provider] [to a contracted provider], not to exceed the [Contracted Rate discounts off of Average Wholesale Price (AWP),] [or] [Maximum Allowable Cost (MAC),] [or] [Average Sales Price (ASP),] other nationally recognized drug cost basis used by nationally contracted vendors, or any other methodology described under this plan.]]

PAR: 005.024.GE

[**Methodology Is Subject to Change**

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

[**Using the** [**Health Care Provider Network**] [**Participating Provider Network**]

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

[**Using Designated Specialty Providers**

If the Covered Person elects to receive designated covered specialty services from a Designated Specialty Provider, benefits may be paid at a higher benefit level than when a [Participating Provider] [or] [[Select] Participating Provider] is used. The benefit level payable when designated specialty treatment, services or supplies are received from a Designated Specialty Provider is shown in the Benefit Summary. For the Designated Specialty Provider benefit level to be payable, both the service and the provider must be designated by Us at the specialty services benefit level. IT IS YOUR RESPONSIBILITY to verify that a provider is a Designated Specialty Provider at the

time of service and that the services to be received are designated as specialty services from that provider.]

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

[**Receiving Care for Emergency Conditions**
Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement will be paid at the Participating Provider benefit level until the Covered Person's condition has stabilized. After the condition has stabilized, benefits will be paid at the [Non-Network] [Non-Participating] Provider benefit level. We will, if possible, assist in the Covered Person's transfer to a [Network] [Participating] Provider if requested by the Covered Person. [Covered Charges for [Non-Network] [Non-Participating] Provider Emergency Treatment[, Urgent Care] and Emergency Confinement may be subject to Maximum Allowable Amount reductions.]]

[**Receiving Ancillary Services**
Please note that certain ancillary services, such as lab tests or services performed by anesthesiologists, radiologists, pathologists or Emergency Room physicians, that are ordered by a [Network] [Participating] Provider are sometimes out-sourced to a [Non-Network] [Non-Participating] Provider. [Covered Charges for such services will be processed as [Non-Network] [Non-Participating] Provider benefits.] [To obtain [Network] [Participating] Provider benefits, it is important that such services be referred to another [Network] [Participating] Provider when possible.] [[Covered Charges for such services rendered in association with direct treatment from a [Network] [Participating] Provider will be paid at the corresponding benefit level].] [and may be subject to the Maximum Allowable Amounts for [Network] [Participating] Providers and Maximum Allowable Amounts for [[Non-Network] [Non-Participating]] Providers provisions.]] [A higher benefit level may be available if the Covered Person uses a Designated Specialty Provider for ancillary services that are designated by Us to be specialty services from that provider.]]]
PAR: 010.001.001.GE

[[VII.] [MEDICAL BENEFITS]

[WE WILL PAY COVERED CHARGES ONLY FOR THE SERVICES AND SUPPLIES LISTED AS MEDICAL BENEFITS IN THIS SECTION OF THE PLAN. HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED SERVICES AND SUPPLIES LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY.

REFER TO THE EXCLUSIONS SECTION OF THE PLAN FOR SERVICES AND SUPPLIES THAT ARE NOT COVERED UNDER THIS CERTIFICATE.

THE COVERED PERSON MUST FOLLOW THE UTILIZATION REVIEW PROVISIONS SECTION [AND THE PROVIDER CHARGES] [AND] [MAXIMUM ALLOWABLE AMOUNT] PROVISIONS SECTION] TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER THIS CERTIFICATE.]

[After the Covered Person has paid any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for medical benefits listed in this section of the certificate for each Covered Person [during a Benefit Period]. Any applicable [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] or other fees and the Covered Charges [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] to which they apply are shown in the Benefit Summary. Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[We will not pay benefits for charges that are Incurred for [a Sickness,] [specific benefits as shown in the Benefit Summary] [and] [or] [preventive medicine services] during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Benefit Summary. Benefits are available from the first day Covered Charges are Incurred for an Injury that is sustained on or after the Covered Person's Effective Date.]

[Prescription Drugs that are received on an Outpatient basis are considered for benefits under the Outpatient Prescription Drug Benefits section unless they are specifically listed as Covered Charges in the Medical Benefits section.] [Expenses Incurred under this section do not apply toward any Out-of-Pocket Limits under any other section of this plan.]]

We pay only for the following Covered Charges:
MED: 005.002.GE

[**Inpatient Medical Facility Services**
Services that are provided in an Acute Medical Facility:

[1.] [Daily room and board [in the most appropriate setting in the Acute Medical Facility].]

[2.] [Daily room and board in an intensive care setting, such as an intensive care unit (ICU), a neonatal intensive care unit (NCU), a coronary intensive care unit (CCU) and a step-down unit.]

[3.] [Routine nursing services and pediatric charges, including charges for testing for hypothyroidism, phenylketonuria, galactosemia and sickle-cell anemia, or a well newborn child for up to [5] full days in an Acute Medical Facility nursery or until the mother is discharged from the Acute Medical Facility following the birth of the child, whichever is later.]

[4.] [Other Medically Necessary services.]

[For Rehabilitation Services benefits, see the Inpatient Rehabilitation Services provision even when these services are received in an Acute Medical Facility. For interpretation of Diagnostic Imaging

and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section. For benefits for all other professional services, see the Health Care Practitioner Services provision in this section.]]
MED: 010.001.AR

[**Outpatient Medical Facility Services**
Services performed in an Acute Medical Facility's Outpatient department, a Free-Standing Facility or an Urgent Care Facility. [However, Physical Medicine is covered under the Outpatient Physical Medicine Services provision in this section.]

[We will pay benefits for Covered Charges Incurred for Emergency Treatment at a [Non-Network] [Non-Participating] Provider at the benefit level of a [Network] [Participating] Provider. [However, services received by a [Non-Network] [Non-Participating] Provider may be subject to Maximum Allowable Amount reductions.] Follow-up visits after the initial Emergency Treatment will be subject to all the terms, limits and conditions in this plan [including, but not limited to, the [Non-Network] [Non-Participating] Provider Deductible, Coinsurance and other [Non-Network] [Non-Participating] Provider Out-of-Pocket Limits and may be subject to Maximum Allowable Amount reductions when services are received from a [Non-Network] [Non-Participating] Provider].]

[Covered Charges for services received in an Emergency Room that are not for Emergency Treatment will be paid subject to all the terms, limits and conditions in this plan as if the same services had been received in the least intensive setting.]
MED: 015.001.GE

[**Doctor**] [**Physician**] **Office Visit**
Office Visit charges Incurred during an Office Visit for a [Covered Person] [Covered Dependent child] are payable as shown in the Benefit Summary. [For the purpose of this provision, Office Visits include evaluation and management services as defined in the most recent edition of Current Procedural Terminology [and preventive medicine services].] [An Office Visit will also include [allergy testing,] [allergy shots,] [immunotherapy injections of inhaled allergens,] [and] [laboratory and radiology services [which are covered preventive medicine services]].

[Covered Charges will not include [laboratory and radiology services [which are not a covered preventive medicine service,]] [magnetic resonance imaging (MRI),] [computerized axial tomography (CAT scan),] [preventive medicine services,] [surgical procedures,] [chemotherapy,] [allergy testing,] [diagnosis or treatment of [Behavioral Health] [and] [Substance Abuse]] [or] [any other service not specifically listed as a Covered Charge in the Benefit Summary for this [Doctor] [Physician] Office Visit provision].]
MED: 020.001.GE

[**Preventive Medicine Services**
[1.] [Preventive medicine services for well child care and adult care, including immunizations as recommended by the United States Preventative Services Task Force on the date the service is Incurred.] [This does not include routine well newborn care at birth [unless the Maternity Care Services coverage is included in this plan as shown in the Benefit Summary].]

[2.] [The following diagnostic services:]

[a.] [Pap smears with chlamydia screening.]

[b.] [Mammography screening.]
[c.] [Stool for occult blood testing.]
[d.] [Prostate specific antigen screening.]
[e.] [Fasting glucose testing.]
[f.] [Lipid profile testing.]
[g.] [Complete blood count (or component parts) testing.]
[h.] [Urinalysis testing.]
[i.] [Tuberculin skin testing with purified protein derivative.]
[j.] [Other diagnostic services as recommended by the United States Preventative Services Task Force on the date the service is Incurred.]]

Preventive medicine services also include an annual prostate cancer specific antigen screening for covered males who are 40 years of age or older.

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.] [The Benefit Waiting Period will be waived if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan.] [The maximum benefit for preventive medicine services is shown in the Benefit Summary.]
MED: 025.001.GE

Colorectal Cancer Examination Coverage
Coverage includes colorectal cancer examination and laboratory tests for a Covered Person:

1. age fifty (50) years of age or older;

2. less than fifty (50) year of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and

3. experiencing the following symptoms of colorectal cancer as determined by a Health Care Practitioner licensed under the Arkansas Medical Practices Act:

   a. bleeding from the rectum or blood in the stool; or
   b. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

Colorectal screening shall involve an examination of the entire colon, including the following examinations and/or laboratory tests:

1. annual fecal occult blood test utilizing take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

2. double-contrast barium enema every five (5) years; or

3. colonoscopy every ten (10) years; and

4. any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

Screenings for the management or subsequent need for follow-up colonoscopies shall be limited to:

1. if the initial colonoscopy is normal, follow-up is recommended in ten (10) years;

2. for individuals with one (1) or more neoplastic polyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;

3. if single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and

4. for patients with large sessile adenomas greater than three centimeters (> 3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

MED: 026.002.AR

Loss or Impairment of Speech or Hearing
Coverage shall be provided for Medically Necessary audiology and speech pathology services for the treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech – Language Pathology and Audiology. Coverage does not include hearing instruments or devices.
MED: 027.002.AR

[**Accident Medical Expense Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] accident medical expense benefit is included in this plan.]

Covered Charges Incurred by a [Covered Person] [Covered Dependent child] for the treatment of an Accidental Injury are covered at [100%] up to the amount shown in the Benefit Summary if:

1. The Injury occurs and Covered Charges are received while this Accident Medical Expense Benefit provision is in force; and

2. Covered Charges for treatment of the Injury are Incurred within [the first [90 days]] [a specified period of time] after the date the Accident occurs [as shown in the Benefit Summary].

[Covered Charges in excess of the accident medical expense benefit shown in the Benefit Summary or Incurred [more than [90 days]] after the [date the Accident occurs] [time period shown in the Benefit Summary] will be paid subject to all the terms, limits and conditions in this plan without regard to this Accident Medical Expense Benefit provision.]]
MED: 030.001.GE

[**Accident Medical Expense Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] accident medical expense benefit is included in this plan.]

Covered Charges that are received as a result of an Accidental Injury that occurs while this accident medical expense benefit coverage is in force will be subject to the following requirements [provided that the charges are Incurred within the [first [90 days] after the date the Accident occurs] [time period shown in the Benefit Summary]]:

1. The [Covered Person] [Covered Dependent child] who is injured in an Accident must satisfy a [$XXX] Deductible [and Coinsurance [of [XX%]] up to [$XXXX] [the amount shown in the Benefit Summary]] for Covered Charges Incurred as a result of the Injury; and

2. Once the Deductible [and Coinsurance] [is] [are] satisfied, Covered Charges related to the Injury are paid at [100%] [up to [$XXXX] [the amount shown in the Benefit Summary]] [then] [Covered Charges are subject to the [plan] [Individual] [Inpatient] [Outpatient] [or] [Integrated] Deductible [and] [or] [plan] [Inpatient] [Outpatient] Coinsurance]; and

3. The Deductible [and Coinsurance] that [is] [are] met under this accident medical expense benefit [does] [do] not count toward satisfying any other Deductible[, Coinsurance] or Out-of-Pocket Limit under any section of this plan.

Additional Covered Charges resulting from the Accident [that exceed [$XXXX] [the amount shown in the Benefit Summary]] [or] [that are Incurred [more than [90 days]] after the [date the Accident occurs] [time period shown in the Benefit Summary]], will be paid subject to all the terms, limits and conditions in this plan without regard to this Accident Medical Expense Benefit provision.]
MED: 040.001.GE

[**Accident Medical Expense Reduced Plan Deductible**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] accident medical expense reduced plan deductible is included in this plan.]

For a [Covered Person] [Covered Dependent child] who is injured in an Accident, We will reduce the [Individual,] [Outpatient,] [Inpatient,] [or] [Integrated] [Deductible] [and] [or] [Coinsurance] amount that must be satisfied for Covered Charges resulting from the Accident. The reduced amount that will be applied is shown in the Benefit Summary. [Coinsurance will apply.] When Covered Charges related to the Accident exceed the reduced [Individual,] [Outpatient,] [Inpatient,] [or] [Integrated] [Deductible] [and] [or] [Coinsurance] amount specified in the Benefit Summary, benefits will be paid by Us provided that:

1. The Injury occurs and Covered Charges are received while this Accident Medical Expense Reduced Plan Deductible provision is in force; and

2. Covered Charges for treatment of the Injury are Incurred within [the first [90 days]] after the date the Accident occurs; and

3. We receive proof that the services were received as a result of an Accident.

When additional Covered Charges resulting from the Accident are Incurred more than [90 days] after the date the Accident occurs, the [Covered Person] [Covered Dependent child] will have to satisfy the regular [Individual] [Outpatient] [Inpatient] [Deductible] [and] [or] [Coinsurance] under this plan minus any amount that was previously satisfied. Benefits for those additional services

that are related to the Accident and for Covered Charges that are unrelated to the Accident will be paid subject to all the terms, limits and conditions in this plan without regard to this Accident Medical Expense Reduced Plan Deductible provision.]

No credit will be provided under this provision if the [Covered Person's] [Covered Dependent child's] [Individual] [Outpatient] [Inpatient] [Deductible] [and] [or] [Coinsurance] [was] [were] satisfied prior to receiving Covered Charges resulting from the Accident.]
MED: 045.001.GE

[**Diagnostic Imaging Services** [**and Laboratory Services**]

1. Diagnostic Imaging services [and laboratory services].

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

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary[, unless Emergency Treatment is required].]]
MED: 050.001.GE

[**Laboratory Services**

1. Laboratory services.

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

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary[, unless Emergency Treatment is required].]]
MED: 055.001.GE

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

[1.] [Physical Therapy, Occupational Therapy and Speech Therapy.]

[2.] [Pulmonary rehabilitation programs.]

[3.] [Adjustments[, and] manipulations [and] [massage therapy].]

[4.] [Cardiac Rehabilitation Programs.]

[5.] [Services for treatment of Developmental Delay.]

Coverage for Outpatient Physical Medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.

For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]
MED: 065.001.001.GE

[**Outpatient Alternative Medicine Services**
[The following services, as each is defined by the Office of Alternative Medicine of the National Institutes of Health, when provided by a Health Care Practitioner on an Outpatient basis:]

[1.] [Acupuncture.]

[2.] [Massage therapy.]

[3.] [Nutritional counseling.]

[4.] [Meditation or relaxation therapy.]

[5.] [Naturopathic medicine.]

Coverage for Outpatient alternative medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.]

For laboratory services and Diagnostic Imaging services benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]
MED: 070.001.GE

[**Durable Medical Equipment and Personal Medical Equipment**
[1.] [Rental or purchase, whichever is most cost effective as determined by Us, of the following items when prescribed by a Health Care Practitioner:]

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

[2.] [Casts, splints, trusses and orthopedic braces, excluding foot orthotics.]

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

[4.] Prosthetic Devices and Orthotic Devices, including repairs or replacements one time every three years, that are prescribed and provided by a licensed doctor and are determined by US to be Medically Necessary.

[~~4~~5.] [External breast prostheses needed because of surgical removal of all or part of the breast.]

~~[~~~~5~~6.] [Oxygen and the equipment needed for the administration of oxygen.]

[~~6~~7.] [Other Durable Medical Equipment and supplies that are approved in advance by Us.]

[Charges for replacement of or maintenance, repair, modification or [enhancement to the whole or parts of wheelchairs will be covered when authorized by Us before any equipment is purchased] [Charges for replacement of or maintenance, repair, modification or [enhancement to the whole or parts of] any of the items listed above are not covered, regardless of when the item was originally purchased.] [Replacements due to outgrowing [wheelchairs] Durable [or Personal] Medical Equipment] as a result of the normal skeletal growth of a child will be covered when authorized by Us before any equipment is purchased.] [Charges for duplicate Durable Medical Equipment, Personal Medical Equipment and supplies are not covered.]]
MED: 075.001.001.AR~~GE~~

[**Maternity Care Services**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] maternity care services coverage is included in this plan.]

1. Prenatal care.

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

3. Postpartum care.

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary [provided that a Health Care Practitioner determines the pregnancy began after the Benefit Waiting Period and the pregnancy terminates while this coverage is in force].]

[Benefits will only be considered for Covered Charges Incurred while the maternity care services coverage is in effect.]
MED: 080.001.GE

[**Complications of Pregnancy**
Any Sickness associated with a pregnancy [that begins after the Effective Date of coverage], except for hyperemesis gravidarum or a non-emergency caesarean section delivery.]
MED: 085.001.GE

[**Infertility Services**
[This coverage is optional.] The Benefit Summary will indicate if the [optional] infertility services coverage is included in this plan.]

[1.] [Infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications, related tests, services or procedures for treatment to promote conception.]

[2.] [Artificial insemination.]

[3.] [In vitro fertilization.]

[4.] [Reversal of reproductive sterilization.]

[5.] [Cryopreservation of sperm or eggs.]

[6.] [Surrogate pregnancy.]

[Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.]]
MED: 090.001.GE

[**Health Care Practitioner Services**

1. Services of a primary surgeon, an Assistant Surgeon or a Surgical Assistant during the surgery. Benefits will be reduced for additional surgical procedures performed in the same operative session.

2. Other Health Care Practitioner services.

[For interpretation of Diagnostic Imaging and laboratory tests benefits, see the Diagnostic Imaging Services and Laboratory Services provision in this section.]]
MED: 095.001.GE

[**Professional Ground [or Air] Ambulance Services**
Professional ground [or air] transportation in an ambulance for a Covered Person who needs Emergency Treatment for a Sickness or an Injury to the nearest Acute Medical Facility that can treat the Sickness or Injury. [The ambulance service must meet all applicable state licensing requirements.]]
MED: 100.001.GE

[**Home Health Care Services**
[1.] [Home Health Care visits by a licensed nurse.]

[2.] [Respiratory therapy.]

[3.] [Intravenous injectable parenteral drug therapy [when authorized by Us to be paid under the Medical Benefits section].]

[4.] [Non-intravenous injectable drug therapy [when authorized by Us to be paid under the Medical Benefits section.]]

Home Health Care must be provided by a Home Health Care Agency. [One visit consists of up to [2 hours] of care within [a 24-hour period] by anyone providing services or evaluating the need for Home Health Care]. Services must be included in a plan of treatment established by a Health Care Practitioner.

[For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.]
[[For intravenous injectable parenteral drug therapy] [and] [non-intravenous injectable drug therapy] benefits, see the Outpatient Prescription Drug Benefits section.]]
MED: 105.001.GE

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

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

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

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

[The covered counseling services listed above are not subject to the limitations for treatment of [Behavioral Health] [or] [Substance Abuse].]]
MED: 110.001.GE

[**Inpatient Rehabilitation Services**
Services provided as an Inpatient in an Acute Medical Rehabilitation Facility that include, but are not limited to:

1. Rehabilitation Services provided for the same or a related Sickness or Injury that required an Inpatient Acute Medical Facility stay.

2. Treatment of complications of the condition that required an Inpatient Acute Medical Facility stay.

3. Physical Therapy, Occupational Therapy and Speech Therapy.

4. Pulmonary rehabilitation programs.

5. The evaluation of the need for the services listed above.

[Coverage for Inpatient Rehabilitation Services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.]
MED: 115.001.GE

[**Subacute Rehabilitation Facility and Skilled Nursing Facility Care**
Services in a Subacute Rehabilitation Facility or Skilled Nursing Facility that are:

[1.] [Provided in lieu of care in an Acute Medical Facility][; or]

[2.] [For the same condition that required confinement in an Acute Medical Facility and the Covered Person must enter the Subacute Rehabilitation Facility or Skilled Nursing Facility within [14 days] after discharge from the Acute Medical Facility after a confinement of at least [3 days].]

[Coverage for Subacute Rehabilitation Facility or Skilled Nursing Facility care will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by Us.]]
MED: 120.001.GE

[**Family Planning Services**
The following services [when provided by a Participating Provider]:

[1.] [Health Care Practitioner Office Visits for contraception management.]

[2.] [Services ordered by a Health Care Practitioner in relation to administration and dispensing of FDA-approved contraceptive Prescription Drugs or injections or the fitting or dispensing of an IUD or diaphragm.]

[3.] [The insertion or removal of Norplant or other similar device by a Health Care Practitioner.]

[For oral contraceptive benefits, see the Outpatient Prescription Drug Benefits section.]]
MED: 125.001.GE

[**Sterilization**

Services for permanent sterilization for each Covered Person. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.]]
MED: 130.001.GE

[**Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction**
Surgical treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction are only those services that are included in a treatment plan authorized by Us prior to the surgery.

The following services for non-surgical treatment of TMJ and CMJ:

[1.] [Diagnostic examination.]

[2.] [Diagnostic Imaging services.]

[3.] [Injection of muscle relaxants.]

[4.] [Therapeutic drug injections.]

[5.] [Physical Therapy.]

[6.] [Diathermy therapy.]

[7.] [Ultrasound therapy.]

[For Physical Therapy benefits, see the Outpatient Physical Medicine Services provision in this section.]]
MED: 135.001.GE

[**Diabetic Services**
The following services are for a Covered Person with diabetes:

1. Routine eye exams.

2. Nutritional counseling.

3. Diabetic training.

4. Routine foot care.

5. Home glucose monitoring [and diabetic supplies].

[6.] [Insulin, syringes, needles, lancets and testing agents.]]

[For insulin, syringes, needles, lancets and testing agents benefits, see the Outpatient Prescription Drug Benefits section.] [For other diabetic equipment and supplies benefits, see the Durable Medical Equipment and Personal Medical Equipment provision in this section.]
MED: 140.001.GE

[**Growth Hormone Therapy Services**
Treatment, diagnosis or supplies, including drugs and hormones, only when such treatment is clinically proven to be effective for any of the following conditions:

1. Growth hormone deficiency as confirmed by documented laboratory evidence.

2. Growth retardation secondary to chronic renal failure before or during dialysis.

3. AIDS wasting syndrome.

Growth hormone treatment must be likely to result in a significant improvement in the Covered Person's condition.]
MED: 145.001.GE

[**Tonsils and Adenoids**
[Services for removal of tonsils and adenoids. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary, unless Emergency Treatment is required.] [The Benefit Waiting Period will be waived if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan.]]
MED: 150.001.GE

[[**Bunions,**] [**Hemorrhoids**] [**and**] [**Varicose Veins**]
[Services for surgical treatment of [bunions,] [hemorrhoids] [and] [varicose veins]. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary.] [The Benefit Waiting Period will be waived if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan.]]
MED: 155.001.GE

[**Inguinal Hernia**
[Services for surgical treatment of an inguinal hernia. [Covered Charges will be considered for the Covered Person after the Benefit Waiting Period shown in the Benefit Summary]. [The Benefit Waiting Period will be waived [if surgical treatment is required for incarcerated or strangulated inguinal hernia] [or] [if other medical insurance with reasonably similar benefits was shown on the enrollment form and was in force on the day before the Effective Date of the Covered Person's coverage under this plan].]]
MED: 160.001.GE

[**Blood Product Transfusions**
Whole blood, blood plasma and blood products if not replaced.]
MED: 165.001.GE

[**Transplants**
All transplants must be authorized in advance by Us. [No benefits will be paid for any organ, tissue or cellular transplants that are not reviewed by Us prior to transplant evaluation, testing, preparative treatment or donor search.]

[Benefits for the following transplants will be considered on the same basis as benefits for any other Sickness:] [Benefits for the following transplants will be paid as shown in the Benefit Summary:]

1. Kidney.

2. Cornea.

3. Skin.

[Transplants with Designated Transplant Provider:] [We have contracted with Designated Transplant Providers to provide transplantation services for specified types of transplants to Covered Persons at a Negotiated Rate. [When the Covered Person uses a Designated Transplant Provider at the time the first service is Incurred for transplant evaluation, testing, preparative treatment and/or donor search, the maximum transplant benefit [is] [may be] increased.] [When a Designated Transplant Provider is used, travel expenses for the Covered Person and one travel companion are paid, subject to Our guidelines.] [If the Covered Person later decides to use a

Health Care Practitioner for transplant related services instead of a Designated Transplant Provider, benefits will be paid as outlined below.]

[When the Covered Person does not use a Designated Transplant Provider at the time the first service is Incurred for transplant evaluation, testing, preparative treatment and/or donor search, the maximum transplant benefit applies. The maximum transplant benefit will not be increased for any reason even if the Covered Person chooses to use a Designated Transplant Provider at a later date [unless approved by Us]. The maximum transplant benefit that is available when a Covered Person does not use a Designated Transplant Provider applies to all transplant related services that are provided by a non-Designated Transplant Provider, regardless of whether the Health Care Practitioner is a Participating Provider or [Non-Network] [Non-Participating] Provider.]

[Benefits for the following transplants will be paid as shown in the Benefit Summary.] [The following transplants are eligible for the increased maximum transplant benefit:]

1. Lung(s).

2. Heart.

3. Simultaneous heart/lung.

4. Liver.

5. Simultaneous kidney/pancreas.

6. Allogeneic and autologous bone marrow transplant/stem cell rescue. All marrow ablative chemotherapy, harvesting of the bone marrow, harvesting of the stem cell, the reinfusion of the marrow or blood precursor cells and any other treatment protocols connected with a bone marrow transplant/stem cell rescue apply toward meeting the maximum transplant benefit limit as shown in the Benefit Summary.

7. Any other transplants that are shown in the Benefit Summary.

The maximum transplant benefit applies to all Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ. All Covered Charges associated with transplants are applied toward the maximum transplant benefit including, but not limited to:

1. All Inpatient and Outpatient care, facility fees, professional fees and follow-up care.

2. Prescription Drug benefits even though they may be paid under the Outpatient Prescription Drug Benefits section.

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

Covered Charges for transplants authorized by Us include all related medical services Incurred [14 days] before the transplant surgery until [365 days] after the transplant surgery[, or a lesser period not to exceed the termination date of this plan]. All payments for these services are applied toward the maximum transplant benefit.

[All Covered Charges for transplant related benefits will also be applied [and are subject] to the [Calendar Year] [Plan Year] maximum [and] [Maximum Lifetime Benefit] as shown in the Benefit Summary.]]
MED: 170.001.GE

[**Transplants**

All transplants must be authorized in advance by Us. [No benefits will be paid for any organ, tissue or cellular transplants that are not reviewed by Us prior to transplant evaluation, testing, preparative treatment or donor search.]

We pay Covered Charges for the following transplants:

1. Kidney.

2. Cornea.

3. Skin.

4. Lung(s).

5. Heart.

6. Simultaneous heart/lung.

7. Liver.

8. Simultaneous kidney/pancreas.

9. Allogeneic and autologous bone marrow transplant/stem cell rescue. All marrow ablative chemotherapy, harvesting of the bone marrow, harvesting of the stem cell, the reinfusion of the marrow or blood precursor cells and any other treatment protocols connected with a bone marrow transplant/stem cell rescue apply toward satisfying the maximum transplant benefit limit as shown in the Benefit Summary.

10. Any other transplants that are shown in the Benefit Summary.

[Covered Charges for transplants, combined transplants, and sequential transplants, including replacement or subsequent transplants of the same organ are applied toward the [Calendar Year] [Plan Year] [and] [Outpatient Calendar Year Maximum Benefit] [and] [Maximum Lifetime Benefit] including, but not limited to:

1. All Inpatient and Outpatient care, facility fees, professional fees and follow-up care.

2. Prescription Drug benefits even though they may be paid under the Outpatient Prescription Drug Benefits section.

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

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

All Covered Charges for transplant related benefits will be applied[, and are subject] to the [Calendar Year] [Calendar Year Maximum Benefit] [Plan Year] [and] [transplant limit] [and] [Outpatient Calendar Year Maximum Benefit] [and] [Maximum Lifetime Benefit] as shown in the Benefit Summary.]
MED: 175.001.GE

[**Behavioral Health** [**and Substance Abuse**]
The following services for treatment of Behavioral Health [and Substance Abuse]:

1. Inpatient services when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

2. Outpatient services when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Behavioral Health [or Substance Abuse] in an office setting.

[Drugs prescribed for the treatment of Behavioral Health [and Substance Abuse] are covered under this provision in the plan.] [For benefits for drugs prescribed for the treatment of Behavioral Health [and Substance Abuse], see the Outpatient Prescription Drug Benefits section.]]
MED: 180.002.GE

[**Substance Abuse**
The following services for treatment of Substance Abuse:

1. Inpatient services when confined in an Acute Behavioral Health Inpatient Facility or a Behavioral Health Rehabilitation and Residential Facility.

2. Outpatient services when care is received in an Intensive Outpatient Behavioral Health Program, a Partial Hospital and Day Treatment Behavioral Health Facility or Program or by a Health Care Practitioner who is licensed to treat Substance Abuse in an office setting.

[Drugs prescribed for the treatment of Substance Abuse are covered under this provision in the plan.] [For benefits for drugs prescribed for the treatment of Substance Abuse, see the Outpatient Prescription Drug Benefits section.]]
MED: 185.002.GE

[**Reconstructive Surgery**
Reconstructive surgery:

[1.] [To restore function for conditions resulting from an Injury [provided the Injury occurred while the Covered Person is covered under this plan].

[2.] [That is incidental to or follows a covered surgery resulting from a Sickness or an Injury of the involved part [if the trauma, infection or other diseases occurred or had their onset while the Covered Person is covered under this plan].

[3.] [Following a Medically Necessary mastectomy. Reconstructive surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, and physical complications in all stages of mastectomy, including lymphedemas.]

[4.] [Because of a congenital Sickness or anomaly of a Covered Dependent child[, who was covered under this plan since birth,] that resulted in a functional defect].]

[Cosmetic Services and services for complications from Cosmetic Services are not covered regardless of whether the initial surgery occurred while the Covered Person was covered under this plan or under any previous coverage.]]
MED: 190.001.GE

[**Dental Services**

[1.] [Services related to the dental extraction of teeth as a prerequisite of scheduled radiation therapy.]

[2.] [The treatment of a Dental Injury from an Accidental blow to the face causing trauma to teeth, the gums or supporting structures of the teeth. The treatment must begin within [90 days] and be completed within [365 days] of the Dental Injury.]

[3.] Anesthesia and Acute Medical Facility or Free-Standing Facility performed in connection with Medically Necessary dental procedures if the Health Care Practitioner treating the patient certifies that:

a. a child under seven (7) years of age has been determined by two (2) dentists licensed under the Arkansas Dental Practice Act, to require, without delay, Medically Necessary dental treatment for a significantly complex dental condition;
b. a person has been diagnosed with a serious mental or physical condition; or
c. a person has a significant behavioral problem as determined by the Covered Person's Heath Care Practitioner licensed under the Arkansas Medical Practices Act.

[The Covered Person may submit a Dental Treatment Plan to Us before treatment starts for an estimate of any benefits that would be payable.] [We reserve the right to limit benefits to the least expensive procedure that will produce a professionally adequate result.]]
MED: 195.001.AR

[**Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]
Services for total parenteral nutrition and other fluids, blood and blood products, and medications requiring a written prescription that would be administered intravenously.]
MED: 200.001.GE

[**Non-Intravenous Injectable Parenteral Drug Therapy** [**and Specialty Pharmaceuticals**]
Services for Prescription Drugs that can be administered by means of intramuscular or subcutaneous injection. [If the injectable drug is covered under the Medical Benefits section, any administration fees are covered under the Health Care Practitioner Services provision in this section when the injectable drug is received on an Outpatient basis through a method other than self-administration.] [For insulin injection benefits, see the Outpatient Prescription Drug Benefits section.]]
MED: 205.001.GE

[**Telehealth Services**
Telehealth Services that may include the use of:

[1.] [Telephone.]

[2.] [Facsimile.]

[3.] [E-mail.]

[4.] [Internet.]

[5.] [Compressed digital interactive video, audio or data transmission.]

[6.] [Clinical data transmission using computer imaging by way of still-image capture and store forward.]

[7.] [Other technology that facilitates access to the Health Care Practitioner.]]
MED: 215.001.GE

[**Telemedicine Services**
Telemedicine Services that may include the use of:

[1.] [Telephone.]

[2.] [Facsimile.]

[3.] [E-mail.]

[4.] [Internet.]

[5.] [Compressed digital interactive video, audio or data transmission.]

[6.] [Clinical data transmission using computer imaging by way of still-image capture and store forward.]

[7.] [Other technology that facilitates access to the Health Care Practitioner.]]
MED: 220.001.GE

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

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

[Benefits are not payable for any services Incurred in a country where travel warnings, issued by the U.S. State Department, exist for visitors from the United States at the time the services are received.]]
MED: 225.001.GE

[**Out-of-Network Travel Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] out-of-network travel benefit is included in this plan.]

If an unforeseen Sickness or Injury occurs while a Covered Person is traveling in the United States but outside of his or her network Service Area, benefits will be payable on the same basis as if they were provided by a [Network] [Participating] Provider provided that the services could not have been reasonably delayed until the Covered Person was able to return to his or her network Service

Area. The maximum benefit available is shown in the Benefit Summary. Covered Charges are for the following services [at the Network Provider] [Participating Provider] level and may be subject to the Maximum Allowable Amount] that are required as a result of a Sickness or an Injury:

1. Health Care Practitioner Office Visits.

2. Diagnostic Imaging services and laboratory services, as outlined in the Diagnostic Imaging Services and Laboratory Services provision in the Medical Benefits section.

3. Other Urgent Care services.

Benefits are subject to all the other terms, limits and conditions in this plan. Benefits are available under this provision only for Covered Charges Incurred while this out-of-network travel benefit is in effect. Treatment, services or supplies that are received for conditions, other than those which created the immediate need for medical care, while traveling outside of the Service Area will be paid at the [Non-Network] [Non-Participating] Provider level.]
MED: 230.001.GE

[**Choice of Network Service Area Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] choice of network service area benefit is included in this plan.]

Each Covered Person may choose a different [Health Care Provider Network] [Participating Provider Network] if a Covered Person is located outside the Service Area of the primary [Health Care Provider Network] [Participating Provider Network]. The Covered Person may use any [Network] [Participating] Provider in the Service Area that he or she selects. However, benefits will be reduced if Covered Charges are received from a [Non-Network] [Non-Participating] Provider or in a Service Area that is different from the one selected, except for Emergency Treatment.

A Covered Person may request a transfer from one network Service Area to another by providing Us with a written request. This request must include the reason for the transfer. No change is effective until the transfer request is received by Us and approved by Us.

Covered Charges Incurred by a Covered Person in his or her network Service Area will be applied toward satisfying any [Family Deductible] [or] [Integrated Deductible] and [integrated] Family Out-of-Pocket Limit. Benefits are subject to all the terms, limits and conditions in this plan. Benefits are available under this provision only for Covered Charges Incurred while this choice of network service area benefit is in effect.]
MED: 235.001.GE

[**Nationwide Network Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] nationwide network benefit is included in this plan.]

We have a nationwide network of providers[, through Private Healthcare Systems (PHCS),] who provide services at discounted rates. If You have this coverage, a Covered Person may receive services from one of these providers anywhere in the United States. The Out-of-Pocket Limit will

be lower than if a [Non-Network] [Non-Participating] Provider is selected. Although services are billed by the provider at a discounted rate, benefits may be subject to Maximum Allowable Amount reductions. The [Copayment,] [Deductible] [and] [Coinsurance] amounts that must be satisfied are shown in the Benefit Summary.

You [and Your Covered Dependents] are responsible for verifying that the provider is a member of the nationwide network prior to receiving treatment. Our customer service department may be contacted at the telephone number listed on the ID card to determine if a provider belongs to the nationwide network. The list of network providers is subject to change at any time. We cannot guarantee that the provider is still participating in the nationwide program at the time treatment is received. Covered Charges Incurred after a provider's participation in the nationwide network has terminated will be paid at the [Non-Network] [Non-Participating] Provider level.

Benefits are subject to all the other terms, limits and conditions in this plan. Benefits are available under this provision only for Covered Charges Incurred while this nationwide network benefit is in effect.]
MED: 240.001.GE

[**International Coverage**
[The Benefit Summary will indicate if the international coverage is included in this plan.]

Covered Charges for international coverage are:

[1.] [Health Care Practitioner visits for a Sickness or an Injury.]

[2.] [Preventive medicine services that are administered and delivered by a Health Care Practitioner as:

[a.] [Outlined in the Preventive Medicine Services provision in the Medical Benefits section.]
[b.] [Recommended by the United States Centers for Disease Control and Prevention.]
[c.] [Recommended for residents by the public health care authorities in the country in which the Covered Person works or resides.]]

[3.] [Diagnostic Imaging services and laboratory services, as outlined in the Diagnostic Imaging Services and Laboratory Services provision in the Medical Benefits section.]

[4.] [Drugs, prescribed during a Health Care Practitioner visit, that have a biological equivalent to Prescription Drugs as outlined in the Outpatient Prescription Drug Benefits section.]

[5.] [Emergency Treatment.]

If You have this coverage and a Covered Person Incurs Covered Charges while residing or working outside of the United States [or the possessions of the United States], benefits may be payable [at the Network Provider] [Participating Provider] level and may be subject to the Maximum Allowable Amount] for such foreign medical expenses provided that:

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

[2.] The foreign medical expenses are determined by Us to be Covered Charges under this plan.

Expenses will be based on the exchange rate in effect on the date the services are Incurred. Covered Charges will be based on the location of the Participating Employer.

Benefits are not payable for any services Incurred in a country where travel warnings, issued by the U.S. State Department, exist for visitors from the United States at the time the services are received. Benefits will only be considered for Covered Charges Incurred while the international coverage is in effect.]
MED: 245.001.GE

[**Travel Benefit**
[This coverage is optional.] [The Benefit Summary will indicate if the [optional] travel benefit coverage is included in this plan.]

If You have this coverage and a Covered Person Incurs Covered Charges while traveling outside of the United States, possessions of the United States or outside of Canada, benefits may be payable [at the Network Provider] [Participating Provider] level and may be subject to the Maximum Allowable Amount] for such foreign medical expenses provided that:

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

2. The foreign medical expenses are determined by Us to be Covered Charges under this plan.

Benefits are not payable for any services Incurred in a country where travel warnings, issued by the U.S. State Department, exist for visitors from the United States at the time of the Covered Person's visit. Benefits will only be paid while the travel benefit coverage is in effect.]
MED: 250.001.GE

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

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

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

2. Be approved in writing by Us.

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

Providing benefits for alternate medical care in a particular case does not commit Us to do so in another case, nor does it waive or modify the terms and conditions of this plan, render them unenforceable or prevent Us from strictly applying the benefits, limitations and exclusions of this plan at any other time or for any other insured person, whether or not the circumstances are similar or the same.]]
MED: 265.001.GE

[**Repatriation Services**
Covered Charges are for the preparation and transportation of a Covered Person's remains to his or her home country or [country] [state] of regular domicile should the Covered Person die while covered under this plan[, provided treatment of the Illness or Injury that caused the Covered Person's death would have been covered under this plan had the person not died]. If applicable, such action will be in accordance with any international transportation requirements.

[Repatriation must be authorized by Us in advanced before the remains are prepared for transportation.] [No benefits will be paid for transportation expenses of anyone accompanying the body.]]
MED: 275.001.GE
[**Medical Evacuation Services**:
Covered Charges are for the Covered Person's Medically Necessary evacuation to his or her home country or to a facility operated pursuant to the laws of his or her home country for the treatment of a Sickness or Injury, should the Covered Person be admitted on an Inpatient basis to [an Acute Behavioral Health Inpatient Facility,] an Acute Medical Facility or other licensed facility as a result of a Sickness or Injury.

[Medical Evacuation must be [authorized by Us in advance before the Covered Person is evacuated] [and] [approved by the attending Health Care Practitioner]. [Except as specifically provided herein, no benefits will be provided for charges Incurred outside of the United States or its possessions [or Canada].]]
MED: 280.001.GE

Medical Foods
Benefits are payable for Covered Charges incurred for Medically Necessary Health Care Practitioner prescribed amino acid modified preparations, low protein modified food products and any other special dietary products and formulas for the treatment of phenylketonuria, when the expense exceeds [$2,400] per Covered Person per calendar year.
MED: 291.002.AR

[[VIII.] [OUTPATIENT PRESCRIPTION DRUG BENEFITS]

[ONLY THE PRESCRIPTION DRUGS LISTED AS OUTPATIENT PRESCRIPTION DRUG BENEFITS IN THIS SECTION OF THE PLAN WILL BE CONSIDERED COVERED CHARGES. HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED PRESCRIPTION DRUGS LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY. REFER TO THE EXCLUSIONS SECTION OF THE PLAN FOR DRUGS, MEDICATIONS AND SUPPLIES THAT ARE NOT COVERED UNDER THIS PLAN.

[THE COVERED PERSON MUST FOLLOW THE UTILIZATION REVIEW PROVISIONS SECTION [AND USE THE PARTICIPATING PHARMACY NETWORK] [OR SPECIALTY PHARMACY NETWORK] TO RECEIVE THE MAXIMUM BENEFITS AVAILABLE UNDER THIS PLAN.]

[PRIOR AUTHORIZATION MAY BE REQUIRED FOR CERTAIN PRESCRIPTION DRUGS BEFORE THEY ARE CONSIDERED FOR COVERAGE UNDER THE OUTPATIENT PRESCRIPTION DRUG BENEFITS SECTION. PLEASE ACCESS THE WEBSITE LISTED ON THE BACK OF THE IDENTIFICATION (ID) CARD TO RECEIVE INFORMATION ON WHICH PRESCRIPTION DRUGS REQUIRE PRIOR AUTHORIZATION, TO CHECK PRESCRIPTION DRUG COVERAGE AND PRICING OR TO LOCATE A PARTICIPATING PHARMACY.]]

[After the Covered Person has paid any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Coinsurance,] [Copayment,] [Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan. Any applicable [Coinsurance,] [Copayment,] [Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary. Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[Any [Ancillary Charge] [or] [any Ancillary Pharmacy Network Charge] under this section will not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

[After the Covered Person has paid any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or any other applicable fees, benefits will be paid by Us for Covered Charges for Outpatient Prescription Drugs listed in this section of the plan.] [Any applicable [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible] or other fees [and the Prescription Drug Class] [and] [time period] [Plan Year] [Calendar Year] [Benefit Period] [to which they apply] are shown in the Benefit Summary.] [Benefits paid under this section will be applied to the Maximum Lifetime Benefit and are also subject to any other maximum benefit for Prescription Drugs provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]]

[Any [Ancillary Charge,] [and] [or] [Ancillary Pharmacy Network Charge,] [and] [or] [Prescription Drug Coinsurance,] [and] [or] [Prescription Drug Copayment,] [and] [or] [Prescription Drug Deductible,] under this section will not count toward satisfying any [Access Fee,] [and] [or] [Coinsurance,] [and] [or] [Copayment,] [and] [or] [Deductible] [and] [or] [Out-of-Pocket Limit] under the medical section or any other section in this plan.]

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

under the Outpatient Prescription Drug Benefits section.] [Any amount in excess of the maximum amount provided under this section is not covered under any other section of this plan.] [Expenses Incurred under this section do [not] apply toward any Out-of-Pocket Limits under any other section of this plan.]

[A Prescription Drug must be dispensed through a [Participating Pharmacy] [or Specialty Pharmacy Provider] to receive benefits.] Certain Prescription Drugs may be covered under this plan only if they are dispensed through a Specialty Pharmacy Provider.] [These limitations will be shown in the Benefit Summary.]

[This plan provides benefits only for the following Covered Charges for [Prescription] [Generic] Drugs that are received on an Outpatient basis [and dispensed through a] [Participating Pharmacy] [or Specialty Pharmacy Provider] [as shown in the Benefit Summary]:

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

[2.] [[Prescription] [Generic] Drugs that are listed in Our Drug List.]

[3.] [[Up to a] [15 consecutive day] supply for each Prescription Order, unless restricted to a lesser amount by the Prescription Order, the manufacturers' packaging or any limitations in this plan. [We will pay [up to a] [90 consecutive day] supply for each Prescription Order for Prescription Maintenance Drugs, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

[4.] [[Up to] [3 vials] [or] [up to a] [15 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]]

[5.] [[Up to] [100] disposable insulin syringes and needles[, up to] [100] disposable blood/urine/glucose/acetone testing agents[, or] [up to] [100] lancets[, or] [up to a] [15 consecutive day] supply for each Prescription Order[, whichever is less]. [If a Mail Service Prescription Drug Vendor is used, We will pay [up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]]

[6.] [Prescription Maintenance Drugs that are dispensed through a Mail Service Prescription Drug Vendor. We will pay for the following:

[a.] [Up to] [9 vials] [or] [up to a] [90 consecutive day] supply of one type of self-injectable insulin for each Prescription Order[, whichever is less].]

[b.] [Up to] [300] disposable insulin syringes and needles [or] [up to] [300] disposable blood/urine/glucose/acetone testing agents [or] [up to] [300] lancets[, or] [up to a] [90 consecutive day] supply for each Prescription Order[, whichever is less].]

[c.] [Up to a] [90 consecutive day] supply for each Prescription Order for Prescription Maintenance Drugs, unless restricted to a lesser amount by the Prescription Order, the manufacturer's packaging, additional dispensing limitations or other limitations in this plan.]]

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

[8.] [[Prescription] [Generic] Drugs that are within the quantity, supply, cost-sharing or other limits that We determine are appropriate for a [Prescription] [Generic] Drug [or within a Therapeutic Class based on the Prescription Drug Class].]

[9.] [[Prescription] [Generic] Drugs and [Prescription] [Generic] Drug products if all active ingredients are covered under this plan.]

[10.] [[Prescription] [Generic] Drugs used for Outpatient treatment of [Behavioral Health] [or] [Substance Abuse].]

[11.] [Prescription] [Generic] Drugs used for contraception that are oral contraceptives, contraceptive patches, contraceptive vaginal rings, injectable contraceptives, contraceptive implants or diaphragms.

[12.] [Specialty Pharmaceuticals that are authorized by Us to be paid under the Outpatient Prescription Drug Benefits section [and are obtained through a [Participating Pharmacy] [or] [Specialty Pharmacy Provider].]

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

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

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

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

[Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA may be subject to similar terms, limits and conditions of coverage or will not be covered by this plan if the original drug would not be covered.]]

PAYMENT OF BENEFITS

[**Participating Pharmacy**
Present the identification (ID) card to the Participating Pharmacy to obtain benefits. The Covered Person must pay any applicable [Coinsurance] [and] [Deductibles] [under the Medical Benefits section,] -[and][Ancillary Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment] [and] [or] [Prescription Drug] [Deductible] to the Participating Pharmacy. The following additional cost sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

[1.] [When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the [Prescription Drug] [-Copayment][,][and] [or] [Prescription Drug] [Deductible][,][and] [or] [Prescription Drug] [Coinsurance][,] [and] [or] [Contracted Rate] for that Generic Drug as shown in the [Benefit Summary] [Drug List].]

[2.] [When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the [Prescription Drug] [-Copayment][,] [and] [or] [Prescription Drug] [Deductible][,] -[and] [or] [Prescription Drug[[Coinsurance][,] [and] [or] [Contracted Rate] for that Brand Name Drug as shown in the [Benefit Summary] [Drug List].]

[3.] [If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the [Prescription Drug] [Copayment][,] [and] [or] [Prescription Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurance][,] [and] [or] [Contracted Rate] for that Brand Name Drug, as shown in the [Benefit Summary] [Drug List], plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]

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

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug minus any applicable [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug] [Coinsurance] amount,] [Prescription Drug] [Copayment,][and/or] [Prescription Drug] [Deductible].]] [The Covered Person will be reimbursed up to the Allowance for the cost of the covered Prescription Drug.] [Any [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug] [Coinsurance] amount,] [Prescription Drug] [Copayment,] [Prescription Drug] [Deductible] [and/or] any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,]

[Deductible] [or] [Out-of-Pocket Limit] under the medical portion [or the Outpatient Prescription Drug Benefits section] of this plan.]]

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

[**Non-Participating Pharmacy**
When the Covered Person has prescriptions 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 Charges, the Covered Person must file a claim with Us as explained in the How To File A Claim provision in this section. [The Covered Person will be reimbursed at the Contracted Rate that would have been paid to a Participating Pharmacy [or Specialty Pharmacy Provider] for the cost of the covered Prescription Drug minus any applicable [Ancillary Charge,] [Ancillary Pharmacy Network Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment] [and/or] [Prescription Drug] [Deductible.]] [The Covered Person will be reimbursed up to the Allowance amount for the cost of the covered Prescription Drug.] [Any [Ancillary Charge,] [Prescription Drug] [Coinsurance,] [Prescription Drug] [Copayment,] [Prescription Drug] [Deductible] [and/or] any amounts not paid by Us due to the difference between the billed amount for the Prescription Drug and Our benefit payment do not count toward satisfying any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] [or] [Out-of-Pocket Limit] under the medical portion of this plan.]]
RXP: 005.002.002~~1~~.AR

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

[The following [Prescription Drug] [Copayment] cost sharing provisions apply to covered Outpatient Prescription Maintenance Drugs that are obtained through a Mail Service Prescription Drug Vendor for home delivery:

[1.] [When a covered Generic Drug is available and that Generic Drug is received, the Covered Person pays the mail service [Prescription Drug] [Copayment,][,] [and] [or] [Prescription Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurnace] [,] [and] [or] [Contracted Rate] for that Generic Drug as shown in the [Benefit Summary] [Drug List].

[2.] [When a Generic Drug is not available and a Brand Name Drug is received, the Covered Person pays the mail service [Prescription Drug] [Copayment][,] [and] [or] [Prescription

Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurnace][,] [and] [or] [Contracted Rate] for that Brand Name Drug as shown in the [Benefit Summary] [Drug List].]

[3.] [If a Brand Name Drug is received when a Generic Drug is available, the Covered Person pays the mail service [Prescription Drug] [Copayment] [,] [and] [or] [Prescription Drug] [Deductible][,] [and] [or] [Prescription Drug] [Coinsurnace][,] [and] [or] [Contracted Rate]for that Brand Name Drug, as shown in the [Benefit Summary] [Drug List], plus the difference in the Contracted Rate between the cost of the Brand Name Drug and the Generic Drug. The difference in the Contracted Rate between the two drugs will not be reimbursed by Us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Limit under the Outpatient Prescription Drug Benefits section [or the Medical Benefits section].]

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

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

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

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

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

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

[We reserve the right to limit Covered Charges under this Outpatient Prescription Drug Benefits section to a single Participating Pharmacy to help ensure that quality services are provided to You [and Your Covered Dependents].]]
RXP: 010.001.001.GE

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

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

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

[For the purpose of the Coordination of Benefits section, the Outpatient Prescription Drug Benefits section will be considered a separate Plan and will be coordinated only with other Prescription Drug coverage. We will not provide any benefits for Prescription Drug charges that are paid by another Plan as the primary payor.]

[The Covered Person is responsible for any Prescription Drug] [Coinsurance,][,] [and] [or] [-Prescription Drug] [Copayment][,] [and] [or] [Prescription Drug] [Deductible] that is paid for a Prescription Order that is filled, regardless of whether the Prescription Order is revoked or changed due to adverse reaction or changes in dosage, dosage regimen or Prescription Order. These charges will not be reimbursed by Us.]]]
RXP: 015.001.001.GE

[[IX.] [LIFE INSURANCE BENEFITS]

[The life insurance benefit[s] listed in this section [is] [are] optional.] The Benefit Summary will indicate if [any of] the [optional] coverage[s] listed in this section [is] [are] included in this plan for any Covered Persons. We will pay benefits for the [optional] life insurance benefit[s] that [is] [are] covered under this plan up to the maximum amount shown in the Benefit Summary. Benefits are not subject to any [Access Fee,] [Coinsurance,] [Copayment,] [Deductible] or any other fees under this plan. Benefits paid under this section will not be applied to the Maximum Lifetime Benefit. However, benefits are subject to all the other applicable terms, limits and conditions in this plan.

This plan provides coverage only for the following life insurance benefit[s] that [is] [are] purchased by You [and any Covered Dependents]:

[**Term Life Insurance**
[We will pay the term life insurance benefit to the Beneficiary if We receive proof of the Covered Person's death.] [We reserve the right to have an autopsy done where it is not prohibited by law before benefits are considered.]

[At age 65, the term life insurance coverage [terminates] [is reduced to [65%] of the original amount of term life insurance coverage that the Covered Person had on the Effective Date].] [On the date [term life insurance coverage] [any of the [optional] coverage[s] listed in this section] end[s] for the Certificate Holder, that coverage will also end for any Covered Dependents.]]

[Payment will be made to the designated Beneficiary.] If there is no surviving Beneficiary, payment will be made to the Covered Person's estate. The Beneficiary designation should be kept up-to-date so that benefits will be paid as the Covered Person wants them to be paid. The Beneficiary may be changed by sending Us written notice. No change is effective until We receive written notice. If the Covered Person would like a payment option other than lump sum, please contact Us.]

[Once an amount equal to the term life insurance benefit has been paid for a Covered Person, no other benefits are available for that Covered Person under this provision.]]

[**Accelerated Benefit**
We will pay an accelerated benefit for a Covered Person who has a terminal illness if all of the following requirements are met:

1. A claim for the accelerated benefit is sent to Us.

2. The Covered Person has a condition which will cause his or her life expectancy to be [12 months] or less.

3. We receive proof and a certification from a Health Care Practitioner that objectively documents the presence of a terminal illness and provides a prognosis that the Covered Person has [12 months] or less to live. The Health Care Practitioner cannot be a Covered Person, an Immediate Family Member[, employer of a Covered Person] or a person who ordinarily resides with a Covered Person.]

Payment of the accelerated benefit will be subject to any irrevocable Beneficiary designation or prior assignment of the term life insurance benefit under this plan. We will make only one accelerated benefit payment during each Covered Person's lifetime. [We reserve the right to obtain a second opinion from a Health Care Practitioner at Our expense before benefits are considered.]

Following payment of the accelerated benefit, the maximum amount for the term life insurance coverage will be reduced by an amount equal to the amount that is paid for the accelerated benefit. A new Benefit Summary will be sent to You reflecting the new benefit amount for the term life insurance coverage. Premium payments must be continued for the full amount of the term life insurance coverage that the Covered Person had prior to receiving the accelerated benefit payment.

Receipt of an accelerated benefit may be a taxable event. You may want to consult a tax advisor about any potential income tax consequences.]

[**Accidental Death Benefit**
We will pay an Accidental death benefit to the Beneficiary if all of the following requirements are met:

1. We receive proof of the Covered Person's death.

2. The proof shows that death resulted directly from bodily Injury caused solely as a result of an Accident and independent of disease, physical condition, bodily infirmity or any other cause.

3. Death occurred within the first [180 days] after the Covered Person's Effective Date.

The maximum accidental death benefit amount is in addition to the term life insurance coverage amount. [We reserve the right to have an autopsy done where it is not prohibited by law before benefits are considered.]]

[**Termination of Coverage**
The Certificate Holder's life insurance coverage terminates on the earliest of the date as determined in accordance with the termination date of this plan or the date of renewal occurring on or after his or her [65th] birthday. Dependent life insurance coverage terminates on the earliest of the date as determined in accordance with the termination date of this plan, or the date the Certificate Holder's life insurance coverage ceases, or, if a Covered Dependent spouse [or Domestic Partner], the date of renewal occurring on or after his or her [65th] birthday or the date on which the Certificate Holder and Covered Dependent spouse [or Domestic Partner] become legally divorced.]

[**General Provisions**
With the exception of the Extension of Benefits provision and the provisions stated below, this coverage is subject to applicable provisions in this plan, including the Eligibility and Effective Date of Certificate Holder, Eligibility and Effective Date of Dependents, termination date of this plan and Misstatements provisions. Nothing will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations in this plan, other than as stated in this Life Insurance Benefits section.

For purposes of this Life Insurance Benefits section only, the Assignment, Incontestability and Entire Plan provisions below are added.]

[**Assignment**
A Covered Person's right to benefits under this Life Insurance Benefits section is assignable. A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment. We are not responsible for the validity or effect of any assignment of life insurance benefits.]

[**Incontestability**
In the absence of fraud, all statements made on the enrollment form will be deemed representations and not warranties. Except for nonpayment of premium, no statement made in any enrollment form shall be used to void coverage after coverage has been in force for 2 years. In the event of the Covered Person's death or incapacity, no statement made in any enrollment form shall be used to void the coverage unless a copy of the enrollment form is furnished to the Covered Person's beneficiary or personal representative. This provision does not preclude defenses based upon provisions relating to eligibility.]

[**Entire Plan**
The entire agreement is made up of the group master Policy, a Covered Person's enrollment form, the certificate of insurance and any riders and endorsements. A copy of the enrollment form shall be included when the certificate is issued. All statements made by the group master Policyholder are considered to be representations, not warranties. This means that the statements are considered to have been made in good faith. No statement will void this certificate unless it is contained in a written enrollment form and a copy is furnished to the person making such statement.

For purposes of this Life Insurance Benefits section only, the Reinstatement provision is revised as follows:

Death occurring between the date the coverage lapses and coverage is reinstated will not be covered.]]
LIF: 005.001.GE

[**Life Insurance Conversion Privilege**
You have the right to convert Your life benefit to a life benefit conversion plan if Your life insurance coverage under the group Policy ceases due to termination of membership in the group or the group level eligible for this plan of coverage provided You have been covered under this plan for at least [5] years, or if You are a Covered Dependent and coverage ceases due to death of the Certificate Holder or termination of Your Covered Dependent status when You no longer meet the definition of Dependent in the certificate. Cancellation of this coverage due to non-payment of required premium does not result in a conversion right.

If Your loss of life benefit coverage is due to Your ceasing to be a Covered Dependent, benefits under a converted plan will not be in excess of the benefits under this certificate, without disability or other supplementary benefits. If Your loss of coverage is due to termination of the master group Policy, the maximum amount which can be converted is the lesser of 1) the face amount of Your death benefit under this certificate, or 2) [$2,000]. The amount of conversion coverage available will be reduced by all amounts of group life insurance coverage for which You are eligible within [31] days after termination of this coverage.

You must submit a written enrollment form and the required premium to Us within [31] days after coverage under this plan terminates to elect the life benefit conversion coverage. Evidence of insurability will not be required, however, rates may be affected.

If written enrollment is not made within [31] days following the termination of insurance under this plan, conversion coverage may not be available. If You have not received notice of the conversion privilege at least [15] days prior to the expiration of the [31] day conversion period, then You have an additional period within which to exercise the privilege. This additional period shall expire [15] days after You receive the conversion rights notice, but in no event shall the period extend beyond [60] days after the expiration of the initial [31] day conversion election period.

If written enrollment is not made within the timeframes specified above following the termination of life insurance under this plan, life conversion coverage will not be available.

If the life conversion election requirements are met, the conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates.

Type of Conversion Policy Available
The converted plan may be on any plan of life insurance then customarily offered by Us to individuals respective to the applicant's age and for the amount applied for, except plans of term life insurance. We will not include any supplementary benefits with the converted plan.

Death Benefit during Conversion Election Period
A death benefit will be paid to the Covered Person's Beneficiary if the Covered Person is entitled to a conversion right under this Rider, and dies within the conversion election period.

The death benefit will be the maximum amount of Life Insurance that the Covered Person could have converted. This amount will be paid whether or not the person applied for conversion life coverage or paid the first premium.]
LIF: 010.001.001.GE

[[X.] [EXCLUSIONS]

We will not pay benefits for any of the following:
EXC: 005.002.GE

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

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

EXC: 010.001.GE

[2.] [Charges for treatment of [Behavioral Health] [or] [Substance Abuse][, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement][, except as otherwise covered in the [Behavioral Health provision] [or] [Substance Abuse provision] [Behavioral Health and Substance Abuse provision] in the Medical Benefits section].]
EXC: 015.001.GE

[3.] [Charges that are related to or a complication of a Pre-Existing Condition.]
EXC: 020.001.GE

[4.] [Charges that:

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

EXC: 025.001.GE

[5.] [Charges that are:

[a.] [Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law.] [If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, the benefits under this plan will be reduced by any amount that would have been reimbursed by Medicare.]
[b.] [Payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California).]

[c.] [For free treatment provided in a federal, veteran's, state or municipal medical facility.]
[d.] [For free services provided in a student health center.]
[e.] [For services that a Covered Person has no legal obligation to pay or for which no charge would be made if the Covered Person did not have a health plan or insurance coverage.]]

EXC: 030.001.GE

[6.] [Charges for work-related Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits.] [Sickness or Injury that arises out of, or is the result of, any work for wage or profit.] [This exclusion will not apply to any of the following:

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

EXC: 035.001.GE

[7.] [Charges for which a Covered Person is entitled to payment under any motor vehicle medical payment or premises medical expense coverage. Coverage under this plan is secondary to medical payment or medical expense coverage available to the Covered Person, regardless of whether such other coverage is described as secondary, excess or contingent.]

EXC: 040.001.GE

[8.] [Charges caused by or contributed to by:

[a.] [War or any act of war, whether declared or undeclared.]
[b.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces].]
[c.] [Foreign [or domestic] acts of terrorism that result in a nationwide epidemic.]]

EXC: 045.001.GE

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

EXC: 050.001.GE

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

EXC: 055.001.GE

[11.] [Charges for foot conditions including, but not limited to, expenses for:

[a.] [Flat foot conditions.]
[b.] [Foot supportive devices, including orthotics and corrective shoes.]
[c.] [Foot subluxation treatment.]

[d.] [Care of corns; [bunions, except capsular or bone surgery;] calluses; toenails, except for ingrown toenails; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.]
[e.] [Hygienic foot care that is routine[, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section].]]

EXC: 060.001.GE

[12.] [Charges for: [dental care that is routine;] [dental charges;] [bridges, crowns, caps, dentures, dental implants or other dental prostheses;] [dental braces or dental appliances;] [extraction of teeth;] [orthodontic charges;] [odontogenic cysts;] [any other expenses for treatment or complications of the teeth and gum tissue[, except as otherwise covered in the Dental Services provision in the Medical Benefits section].]]

EXC: 065.001.GE

[13.] [Charges for treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction[, except as otherwise covered in the Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction provision in the Medical Benefits section, that include, but are not limited to:

[a.] [Any electronic diagnostic modalities.]
[b.] [Occlusal analysis.]
[c.] [Muscle testing].]]

EXC: 070.001.GE

[14.] [Charges for any appliance, medical or surgical expenses for:]

[a.] [Malocclusion or protrusion or recession of the mandible.]
[b.] [Maxillary or mandibular hyperplasia.]
[c.] [Maxillary or mandibular hypoplasia.]]

EXC: 075.001.GE

[15.] [Charges for: [any diagnosis, supplies, treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity [or morbid obesity], whether or not weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions;] [weight reduction] [or] [weight control surgery, treatment or programs;] [any type of gastric bypass surgery;] [suction lipectomy;] [physical fitness programs,] [exercise equipment] [or] [exercise therapy][, including health club membership fees or services;] [nutritional counseling][, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section].]

EXC: 080.001.GE

[16.] [Charges for Transplant services that are:

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

EXC: 085.001.GE

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

EXC: 090.001.GE

[18.] [Charges for:

[a.] [Hemorrhoids,] [hernia[, except as otherwise covered in the Medical Benefits section],] [varicose veins] [or] [spider veins].]

[b.] [Tonsils or adenoids[, except on an Emergency basis].]

EXC: 095.001.GE

[19.] [Charges for revision of breast surgery for capsular contraction, removal or replacement of a prosthesis or augmentation [or reduction] mammoplasty, except as otherwise covered in the Reconstructive Surgery provision in the Medical Benefits section.]

EXC: 100.001.GE

[20.] [Charges for prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.]

EXC: 105.001.GE

[21.] [Charges for:

[a.] [A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse or massage therapist; a rolfer; a home health aide or personnel with similar training and experience; a stand-by Health Care Practitioner] [, except as otherwise covered in the Outpatient Physical Medicine Services provision in the Medical Benefits section].]

[b.] [Home Health Care.]

[c.] [Treatment or services provided by a chiropractor.]

[d.] [Custodial Care; [respite care; rest care; supportive care;] homemaker services.]

[e.] [A Health Care Practitioner who is not properly licensed or authorized in the state where services are rendered.]

[f.] [[Phone consultations;] [internet consultations;] [e-mail consultations;] [Telemedicine Services;] [Telehealth Services].]

[g.] [Health Care Practitioner administrative expenses including, but not limited to, expenses for claim filing, contacting utilization review organizations or case management fees.]

[h.] [Missed appointments.]

[i.] [Sales tax; gross receipt tax.]

[j.] [Living expenses; travel; transportation[, except as otherwise covered in the [Professional Ground [or Air] Ambulance Services provision,] [Medical Evacuation Services provision,] [Repatriation Services provision] [or] [Transplants provision] in the Medical Benefits section].]

[k.] [Treatment or services that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.]]

EXC: 110.001.001.GE

[22.] [Charges for:

[a.] [Adjustments and manipulations.]

[b.] [Massage therapy.]

[c.] [Subluxation treatment and/or services.]

EXC: 115.001.GE

[23.] [Charges for growth hormone therapy[, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth][, except as otherwise covered in the Growth Hormone Therapy Services provision in the Medical Benefits section].]

EXC: 120.001.GE

[24.] [Charges related to [maternity or pregnancy,] [or] [routine well newborn care including nursery charges at birth,] [or] [non-spontaneous abortion][, except as otherwise covered in the Maternity Care Services provision] [or] [Complications of Pregnancy provision in the Medical Benefits section] [or a maternity rider to this plan].]

EXC: 125.001.AR

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

EXC: 130.001.GE

[26.] [Charges for:

[a.] [Genetic testing or counseling, genetic services and related procedures for screening purposes [including, but not limited to, amniocentesis and chorionic villi testing].]

[b.] [Infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any treatment to promote conception.]

[c.] [Sterilization.]

[d.] [Family planning.]

[e.] [Cryopreservation of sperm or eggs.]

[f.] [Surrogate pregnancy.]

[g.] [Fetal surgery, treatment or services.]

[h.] [Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury.]

[i.] [Circumcision.]]

EXC: 135.001.GE

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

EXC: 140.001.GE

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

EXC: 150.001.GE

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

EXC: 155.001.GE

[30.] [Charges for: [behavior modification or behavioral (conduct) problems;] [learning disabilities;] [developmental delays;] [attention deficit disorders;] [educational testing, training or materials;] [cognitive enhancement or training;] [vocational or work hardening programs;] [transitional living].]
EXC: 160.001.GE

[32.] [Charges for services provided by or through a school system.]
EXC: 165.001.GE

[33.] [Charges for preventive care[, except as otherwise covered in the Preventive Medicine Services provision in the Medical Benefits section.]]
EXC: 170.001.GE

[34.] [Charges for:

[a.] [Non-medical items, self-care or self-help programs.]
[b.] [Aroma therapy.]
[c.] [Meditation or relaxation therapy.]
[d.] [Naturopathic medicine.]
[e.] [Treatment of hyperhidrosis (excessive sweating).]
[f.] [Acupuncture; biofeedback; [neurotherapy;] electrical stimulation; or Aversion Therapy.]
[g.] [Inpatient treatment of chronic pain disorders.]
[h.] [Family or marriage counseling.]
[i.] [Applied behavior therapy treatment for autistic spectrum disorders.]
[j.] [Smoking cessation.]
[k.] [Snoring.]
[l.] [The treatment or prevention of hair loss.]
[m.] [Change in skin pigmentation.]
[n.] [Stress management.]]
EXC: 175.001.001.GE

[35.] [Charges for treatment or services required due to an Injury sustained [in operating a motor vehicle] while the Covered Person's blood alcohol level, as defined by law, [was [.08] or higher][, exceeded the blood alcohol level otherwise permitted by law or violated legal standards] [for a person operating a motor vehicle in the state where the Injury occurred]. [This exclusion applies whether or not [the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not] the Covered Person is [charged with] any violation in connection with the Accident.]]
EXC: 180.001.GE

[36.] [Charges for: [drugs that have not been fully approved by the FDA for marketing in the United States;] [drugs limited by federal law to investigational use;] [drugs that are used for Experimental or Investigational Services, even when a charge is made;] [drugs with no FDA-approved indications for use;] [FDA approved drugs used for indications, dosage or dosage regimens or administration outside of FDA approval; except for drugs recognized for the treatment of the specific type of cancer for which the drug has been prescribed in the American Medical Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network Drugs and Biologics Compendium, the Elsevier Gold Standard's Clinical Pharmacology, or the drug has been recognized as safe and effective for

treatment of that specific type of cancer in 2 articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature;] [drugs that are undergoing a review period, not to exceed [12 months], following FDA approval of the drug for use and release into the market;] [drugs determined by the FDA as lacking in substantial evidence of effectiveness for a particular condition, disease or for symptom control.]]

EXC: 185.001.AR~~GE~~

[37.] [Charges for a Sickness or an Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

EXC: 190.001.GE

[38.] [Charges for treatment or services Incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged[, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.]]

EXC: 195.001.GE

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

EXC: 200.001.GE

[40.] [Charges for treatment or services required due to Injury received while engaging in any hazardous activity [that would not be the Covered Person's primary occupation], including[, but not limited to,] the following: [Participating,] [or] [instructing,] [or] [demonstrating,] [or] [guiding] [or] [accompanying others] in [parachute jumping,] [or] [hang-gliding,] [or] [bungee jumping,] [or] [flight in an aircraft other than a regularly scheduled flight by an airline,] [or] [racing any [motorized] [or non-motorized vehicle,] [or] [operating a motorcycle,] [or] [operating an all-terrain vehicle,] [or] [rock or mountain climbing,] [or] [hunting,] [or] [[professional] [or semi-professional] [contact] sports of any kind]. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity[, unless otherwise noted as a Covered Charge in this plan].]

EXC: 205.001.GE

[41.] [Drugs administered or dispensed by a Health Care Practitioner, who is not a Participating Pharmacy [or Specialty Pharmacy Provider][, unless authorized by Us under the Medical

Benefits section before they are dispensed];] [drugs consumed, injected or otherwise administered at the prescribing Health Care Practitioner's office[,unless otherwise noted as a Covered Charge in the Medical Benefits section].]]

EXC: 210.001.GE

[42.] [Charges for services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is [a Covered Person,] an Immediate Family Member, [employer of a Covered Person] or a person who ordinarily resides with a Covered Person.] [Services provided by the Covered Person's Immediate Family Member, an employer, or anyone residing with the Covered Person.]

EXC: 215.001.GE

[43.] [Charges for any amount in excess of the Maximum Lifetime Benefit or any other maximum benefit for covered services.]

EXC: 220.001.GE

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

[a.] [Charges in excess of the Maximum Allowable Amount, [as determined by Us under this plan] [except as otherwise shown in the Benefit Summary].]

[b.] [Charges that are not Medically Necessary.]]

EXC: 225.001.GE

[45.] [Charges Incurred for Experimental or Investigational Services.]

EXC: 230.001.GE

[46.] [Charges Incurred outside of the United States, unless traveling for pleasure or business and the services would have been covered under this plan if the services had been received in the United States.] [Charges Incurred outside of the United States, unless the services would have been covered under this plan if the services had been received in the United States.] [Charges Incurred outside of the United States, except for services that are received for Emergency Treatment.] [Charges Incurred outside of the United States or its possessions or Canada[, unless the optional Travel Benefit is in effect as shown in the Benefit Summary] [except as otherwise covered in the [Medical Evacuation Services provision] [or] [Repatriation Services provision] in the Medical Benefits section]. [Charges Incurred outside of the United States.]]

EXC: 235.001.GE

[47.] [Charges for drugs obtained from pharmacy provider sources outside the United States, except as otherwise covered in the [International Coverage,] [Travel Benefit,] [or] [World Wide Coverage] provision[s] in the Medical Benefits section.]

EXC: 240.001.001.GE

[48.] [Charges for Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury[, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury].]

EXC: 245.001.GE

[49.] [Charges related to Health Care Practitioner assisted suicide.]

EXC: 250.001.GE

[50.] [Charges for vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner] [except for:] [a) Legend prenatal vitamin Prescription Drugs if the Covered Person has the [optional] Maternity Care Services provision in the Medical Benefits section coverage in effect, as shown in the Benefit Summary, and the prenatal vitamins are prescribed during pregnancy][; or] [b) Clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake].]
EXC: 255.001.GE

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

[a.] [Herbal or homeopathic medicines or products.]
[b.] [Minerals.]
[c.] [Health and beauty aids.]
[d.] [Batteries.]
[e.] [Appetite suppressants.]
[f.] [Dietary or nutritional substances or dietary supplements.]
[g.] [Nutraceuticals.]
[h.] [Tube feeding formulas and infant formulas.]
[i.] [Medical foods.]]
EXC: 260.001.GE

[52.] [Charges for cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry, except following cranial surgery.]
EXC: 265.001.GE

[53.] [Charges for: [home traction units;] [home defibrillators;] [or other medical devices designed to be used at home[, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section]].]
EXC: 270.001.GE

[54.] [Charges for: [Durable Medical Equipment;] [Personal Medical Equipment].]
EXC: 275.001.GE

[55.] [Charges for: [Diagnostic Imaging services;] [laboratory services].]
EXC: 280.001.GE

[56.] [Charges for a temporary interim prosthesis.]
EXC: 285.001.GE

[57.] [Charges for: [[any injectable medications] [or] [Specialty Pharmaceuticals] that are not specifically authorized by Us under the [Medical Benefits section] [or] [Outpatient Prescription Drug Benefits section];] [any administrative charge for drug injections].]
EXC: 290.001.GE

[58.] [Charges for: [drugs administered or dispensed by a Health Care Practitioner, who is not a Participating Pharmacy [or Specialty Pharmacy Provider], unless authorized by Us before they are dispensed;] [drugs consumed, injected or otherwise administered at the prescribing Health Care Practitioner's office;] [drugs dispensed at or by a Health Care Practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the Covered Person;]

[drugs dispensed at a Pharmacy that is not a [Mail Service Prescription Drug Vendor,] [Participating Pharmacy,] [or] [Specialty Pharmacy Provider;] [Specialty Pharmaceuticals that are dispensed and/or distributed through a provider that is not a [Participating Pharmacy] [or] [Specialty Pharmacy Provider];] [amounts above the Contracted Rate for Participating Pharmacy [or Specialty Pharmacy Provider] reimbursement;] [the difference between the cost of the Prescription Order at a Non-Participating Pharmacy and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy [or Specialty Pharmacy Provider] been used;] [Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by Us before they are dispensed;] [injectable Prescription Drugs [or Specialty Pharmaceuticals], unless authorized by Us before they are dispensed;] [any administrative charge for drug injections or administrative charges for any other drugs;] [drugs dispensed by a Non-Participating Pharmacy, except when needed for Emergency Treatment].]

EXC: 295.001.GE

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

EXC: 300.001.001.GE

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

EXC: 325.001.GE

[1.] [Charges for that part of any Prescription Order exceeding a [15 consecutive day] supply per Prescription Order.] [Charges for that part of any Prescription Order exceeding a [90 consecutive day] supply if the Prescription Drug is dispensed through a Mail Service Prescription Drug Vendor.]

EXC: 330.001.GE

[2.] [Charges for that part of any Prescription Order exceeding [3 vials] or a [15 consecutive day] supply of one type of insulin.] [Charges for that part of any Prescription Order exceeding [9 vials] or a [90 consecutive day] supply if it is dispensed through a Mail Service Prescription Drug Vendor.]

EXC: 335.001.GE

[3.] [Charges for that part of any Prescription Order exceeding [100] disposable insulin syringes or needles, [100] disposable blood/urine/glucose/acetone testing agents or [100] lancets or a [15 consecutive day] supply.] [Charges for that part of any Prescription Order exceeding [300] disposable blood/urine/glucose/acetone testing agents or [300] lancets or a [90 consecutive day] supply if the supplies are dispensed through a Mail Service Prescription Drug Vendor.]

EXC: 340.001.GE

[4.] [Charges for drugs that are paid under another Plan sponsor or payor as primary payor.]
EXC: 345.001.GE

[5.] [Charges for drugs that are not listed in a Drug List.] [Charges for any Ancillary Charge or any difference between the cost of the Prescription Order at a Non-Participating Pharmacy and the Contracted Rate that would have been paid for the same Prescription Order had a Participating Pharmacy [or Specialty Pharmacy Provider] been used.]
EXC: 350.001.GE

[6.] [Charges for [contraceptive drugs] [or devices] [oral contraceptives] [,except as [otherwise covered in the Family Planning Services provision in the Medical Benefits section] [or as] [required by law]].]
EXC: 355.001.GE

[7.] [Charges for Prescription Drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed.] [Charges for any injectable Prescription Drugs [or Specialty Pharmaceuticals], unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed.] [Any administrative charge for drug injections or administrative charges for any other drugs.]
EXC: 360.001.GE

[8.] [Charges for devices or supplies including, but not limited to, blood/urine/glucose/acetone testing devices, needles and syringes, support garments, bandages and other non-medical items regardless of intended use, except as described under a Prescription Order.]
EXC: 365.001.GE

[9.] [Charges for over-the-counter (OTC) medications that can be obtained without a Health Care Practitioner's Prescription Order, except for injectable insulin;] [or] [drugs that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us[, unless specifically authorized for coverage] [by Us] [on Our Drug List].]
EXC: 370.001.GE

[10.] [Charges for drugs that are not considered Generic Drugs including, but not limited to, [Brand Name Drugs,] [Compounded Medication] [or] [Specialty Pharmaceuticals].]
EXC: 375.001.GE

[11.] [Charges for: [Compounded Medications that contain one or more active ingredients that are not covered under this plan;] [combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this plan;] [combination drugs or drug products that are manufactured and/or packaged together, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed.]]
EXC: 380.001.GE

[12.] [Charges for: [Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order;] [prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order;] [amounts in excess of the Generic Drug prescription cost;] [amounts in excess of the Reference Price for a Prescription Drug or Prescription Drug Class;] [amounts above the Contracted Rate for Participating Pharmacy [or Specialty Pharmacy Provider] reimbursement].]
EXC: 385.001.GE

[13.] [Charges for: [drugs administered or dispensed by an Acute Medical Facility, rest home, sanitarium, extended care facility, convalescent care facility, Subacute Rehabilitation Facility or similar institution;] [drugs administered or dispensed by a Health Care Practitioner, who is not a Participating Pharmacy [or Specialty Pharmacy Provider], unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed;] [drugs consumed, injected or otherwise administered at the prescribing Health Care Practitioner's office;] [drugs that are dispensed at or by a Health Care Practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the Covered Person;] [drugs dispensed by a Non-Participating Pharmacy, except when needed for Emergency Treatment].]
EXC: 390.001.GE

[14.] [Charges for: [any drug used for Cosmetic Services as determined by Us;] [drugs used to treat onychomycosis (nail fungus);] [botulinum toxin and its derivatives].]
EXC: 395.001.GE

[15.] [Charges for: [drugs prescribed for dental services, or unit-dose drugs;] [drugs used in the treatment of chronic fatigue or related syndromes or conditions;] [drugs containing nicotine or its derivatives].]
EXC: 400.001.GE

[16.] [Charges for DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a Covered Person under the age of [8].]
EXC: 405.001.GE

[17.] [Charges for Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne, rosacea or related conditions for a Covered Person age [30 or older].]
EXC: 410.001.GE

[18.] [Charges for: [duplicate prescriptions;] [replacement of lost, stolen, destroyed, spilled or damaged prescriptions;] [prescriptions refilled more frequently than the prescribed dosage indicates.]]
EXC: 415.001.GE

[19.] [Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: [smoking deterrence or cessation;] [athletic performance;] [body conditioning, strengthening, or energy;] [prevention or treatment of hair loss;] [prevention or treatment of excessive hair growth or abnormal hair patterns].]
EXC: 420.001.GE

[20.] [Charges for drugs used to treat, impact or influence: [obesity;] [morbid obesity;] [weight management;] [sex transformation;] [gender dysphoric disorder;] [gender reassignment;] [sexual function, dysfunction or inadequacy;] [sexual energy, performance or desire;] [skin coloring or pigmentation;] [social phobias;] [slowing the normal processes of aging;] [memory improvement or cognitive enhancement;] [daytime drowsiness;] [overactive bladder;] [dry mouth;] [excessive salivation;] [or] [hyperhidrosis (excessive sweating)].]
EXC: 425.001.GE

[21.] [Charges for: [drugs used for Inpatient or Outpatient treatment of [Behavioral Health] [or] [Substance Abuse] [that exceed the maximum limit shown in the Benefit Summary for coverage under the [Behavioral Health provision] [or] [the Substance Abuse provision] [in the Medical Benefits section];]] [drugs used to treat hyperactivity, attention deficit and related disorders].]
EXC: 430.001.GE

[22.] [Charges for drugs or drug categories that exceed any maximum benefit limit under this plan.]
EXC: 435.001.GE

[23.] [Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition[, unless authorized by Us under this Outpatient Prescription Drug Benefits section before they are dispensed].]
EXC: 440.001.GE

[24.] [Charges for prescriptions, dosages or dosage forms used for the convenience of the Covered Person or the Covered Person's Immediate Family Member or Health Care Practitioner.]
EXC: 445.001.GE

[25.] [Drug charges Incurred outside of the United States;] [charges for drugs obtained from pharmacy provider sources outside the United States, except for Covered Charges that are received for Emergency Treatment.]
EXC: 450.001.GE

[26.] [Charges for: postage, handling and shipping charges for any drugs.]
EXC: 455.001.GE

[27.] [Charges for drugs prescribed by a [Non-[Select] Participating Provider] [or a] [[Non-Network] [Non-Participating] Provider];] [Charges for drugs dispensed at a Pharmacy that is a [Non-Participating] Pharmacy] [or a] [Specialty Pharmacy Provider].] [Charges for drugs dispensed at a Pharmacy that is not a [Mail Service Prescription Drug Vendor,] [Participating Pharmacy,] [or] [Specialty Pharmacy Provider].]
EXC: 460.001.GE

[28.] [Charges for Prescription Maintenance Drugs that are dispensed through a provider that is not a Mail Service Prescription Drug Vendor.] [Charges for Specialty Pharmaceuticals that are dispensed and/or distributed through a provider that is not a [Participating Pharmacy] [or] [Specialty Pharmacy Provider].]

EXC: 465.001.GE

[29.] [Charges for: [vaccines and other immunizing agents;] [biological sera;] [blood or blood products].]
EXC: 470.001.GE

[30.] [Charges for drugs for which prior authorization is required by Us and is not obtained.]
EXC: 475.001.GE

[31.] [Prescription Drugs previously classified with non-prescription status.]]
EXC: 485.001.GE

[**The following additional exclusions apply only to the Life Insurance Benefits section.**

We will not pay term life insurance benefits for death caused by any of the following:

[1.] [War or any act of war[, whether declared or undeclared.]

[2.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces.]

[3.] [[Suicide,] attempted suicide or self-inflicted Sickness or Injury[, while sane or insane,] [even if the Covered Person did not intend to cause the harm which resulted in death from the action which led to the self-inflicted Sickness or Injury].] [Attempted suicide or self-inflicted Injury, during the first two years coverage is in force.]

[4.] [Taking part in a riot or insurrection, or an act of riot or insurrection.]

[5.] [Participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]

[6.] [Voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

[7.] Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.

[8.] [Intoxication that includes, but is not limited to, operating a motor vehicle while intoxicated. Intoxication and intoxicated mean that the Covered Person's blood alcohol level at the time of the incident exceeded the blood alcohol level otherwise permitted by law or violates legal standards [for a person operating a motor vehicle] in the state where death occurs.]

We will not pay benefits under the Accidental Death Benefit provision for death caused directly from any of the following:

[1.] [War or any act of war, whether declared or undeclared.]

[2.] [Participation in the military service of any country or international organization[, including non-military units supporting such forces.]

[3.] [[Suicide,] attempted suicide or self-inflicted Sickness or Injury[, while sane or insane,] [even if the Covered Person did not intend to cause the harm which resulted in death from the action which led to the self-inflicted Sickness or Injury].]

[4.] [Taking part in a riot or insurrection, or an act of riot or insurrection.]

[5.] [Participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]

[6.] [Voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

[7.] [Injury while riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]

[8.] [Injury while acting as pilot, student pilot, crew member, flight instructor, or examiner on any aircraft.]

[9.] [Voluntarily taking, absorbing, or inhaling any gas, poison or drugs.]

[10.] [Disease, other than bacterial infection, occurring through an Accidental injury, or medical or surgical treatment of disease or infirmity.]]

EXC: 480.001.GE

[[XI.] [PRE-EXISTING CONDITIONS LIMITATION]

PRX: 005.002.GE

[**Pre-Existing Conditions Limitation**
We will not pay benefits under this plan for an otherwise Covered Charge that is related to a Pre-Existing Condition until the Covered Person has been continuously covered under this plan for [12 months]. [A condition that has been specifically excluded from coverage will continue to be excluded after [12 months] of continuous coverage].]
PRX: 010.002.GE

[**Credit for Deductible**
For a Covered Person who was covered under a prior plan on the day that plan was replaced by Our policy, We will credit [the full amount] [a partial amount] that was Incurred and applied to the Covered Person's deductible under the prior plan for the same Calendar Year under this plan. A Covered Person must provide Us with proof of the deductible amount that was satisfied under the prior plan.]]
PRX: 020.001.GE

[[XII.] [COORDINATION OF BENEFITS (COB)]

[You [or Your Covered Dependents] may have insurance coverage under more than one Plan. If benefits are available through any other Plan, We will take those benefits into account in calculating the amount of Covered Charges that may be payable by Us so that benefits from both Us and any other Plan are limited to the actual charges Incurred.

If a Covered Person is entitled to benefits provided by another Plan but does not claim them, We will consider the benefits to which a Covered Person is entitled as benefits that were provided. All claims should be submitted to Us and all other Plans at the same time so that proper benefits can be determined and paid.]

[**Definitions**
In addition to any specific terms that are defined under the Definitions [for Medical and Outpatient Prescription Drug Coverage] section, the following capitalized terms have the meanings given below:

[1.] [**Allowable Charge:** An Allowable Charge is any charge which is a Covered Charge under this plan and is, at least in part, covered under any other Plan. If a Plan provides benefits in the form of services rather than cash payments, We will determine a reasonable cash value for each service that is provided and that cash value will be considered the Allowable Charge and the amount paid by the other Plan. The difference between an Acute Medical Facility's semi-private room rate and private room rate is not an Allowable Charge unless the private room is Medically Necessary. Benefit reductions due to failure to comply with Plan provisions of the Primary Plan are not an Allowable Charge. [If both the Primary Plan and the Secondary Plan have contractual discount arrangements, the Allowable Charge will be determined by applying the greater of the two discounts.]]

[2.] [**Coordination of Benefits (COB):** Coordination of Benefits (COB) means that benefits are paid so that no more than 100% of the Allowable Charges for which the Covered Person is liable will be covered under the combined benefits received from all Plans.]

[3.] [**Insured:** The person in whose name the Plan is in force.]

[4.] [**Plan:** Any Plan which provides medical [or dental] benefits or services including, but not limited to:

[a.] [Group,] [blanket] [or] [franchise] insurance [that provides major medical benefits].]
[b.] [Group-type insurance which can be obtained and maintained only as the result of membership in or connection with a specific group or organization.]
[c.] [A service plan or contract, group or individual practice or other prepayment plan.]
[d.] [Any employer or employee self-insurance plan.]
[e.] [Coverage arranged by or through any trustee, union, employer or association.]
[f.] [The medical or dental benefits coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts (but only where permitted by law) or other medical or dental pay coverage.]
[g.] [Health coverage, whether issued or administered on a group or individual basis.]
[h.] [Group Blue Cross, group Blue Shield, group practice or prepaid group coverage.]
[i.] [Coverage under trust or association plans or plans sponsored by unions, employer groups, or employee benefit groups.]
[j.] [Medical coverage under automobile or no fault insurance, if coordination of benefits with such coverage is allowed by law.]]

[Plan does not include any of the following:

[a.] [An accident insurance plan.]

[b.] [Medicaid.]
[c.] [A group hospital indemnity insurance plan of [$100] per day or less.]
[d.] [A plan covering only ancillary benefits.]
[e.] [A limited benefit insurance plan.]]

[5.] [**Primary Plan:** A Plan in which benefits must be determined without considering the benefits of any other Plan. A Plan is primary if:

a. The Plan either has no rules for determining the order of benefits or has rules which differ from the rules in this plan; or
b. According to the Order of Benefit Determination provision, the Plan considers its benefits first.]

[6.] [**Secondary Plan:** A Plan in which benefits are determined after the benefits of the Primary Plan have been determined.]

[**How Benefits Are Paid**
If We are the Primary Plan, according to the Order of Benefit Determination provision in this section, We will pay benefits for Covered Charges that would have been paid under this plan without regard to this COB section.

If We are the Secondary Plan, according to the Order of Benefit Determination provision below, We will pay the lesser of:

1. The difference between the Allowable Charge and the amount paid by the Primary Plan; or

2. Benefits for Covered Charges that would have been paid under this plan without regard to this COB section.

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, they do not exceed the total Allowable Charge for any services or equipment.]

[**Order of Benefit Determination**
The Primary Plan and Secondary Plan are determined by using the following rules. Whichever rule below is the first to apply to the Covered Person's situation is the rule that will be used to determine which Plan is the Primary Plan and which is the Secondary Plan.

1. A Plan that does not have a COB provision, or has a provision that differs from this one, pays its benefits first.

2. A Plan that covers the person as the Insured pays its benefits before a Plan that covers the person as a dependent.

3. For a child whose parents are not divorced or separated:

   a. The Plan of the parent whose birthday (month and day only) falls earlier in the year pays its benefits first. It does not matter which parent is older.
   b. If both parents have the same birthday (month and day only), the Plan covering the parent for the longer time period pays its benefits first.
   c. If one Plan has this birthday rule and the other Plan does not and, as a result, the Plans do not agree on the order of benefits, the Plan that does not have the birthday rule pays its benefits first.

4. For a child whose parents are separated or divorced:

   a. If a court decree establishes which parent is responsible for the child's medical or dental expenses, the Plan of that parent pays its benefits before any other Plan that

covers the child as a dependent. This applies only if the Plan has actual knowledge of the terms of the court decree.

b. Otherwise, the Plan of the parent with custody pays its benefits before the Plan of the spouse of the parent with custody; and the Plan of the spouse of the parent with custody pays its benefits before the Plan of the parent without custody.

c. If a court decree establishes joint custody, without stating which one of the parents is responsible for the medical or dental expenses of the child, the Plans covering the child will follow the rules in item 3 above.

5. A Plan that covers the person as the Insured, who is neither laid off nor retired, or as a dependent of such an Insured pays its benefits before those of a Plan covering the person as a laid off or retired Insured or as a dependent of such an Insured. However, if the other Plan does not have this rule and, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

6. If a person is covered under a right of continuation pursuant to federal or state law and is also covered under another Plan, the Plan covering the person as the Insured or as a dependent of such an Insured pays its benefits before the Plan providing the continued coverage.

7. If none of the above rules apply, the Plan covering the person for the longer time pays its benefits first.]

[**Rights Under This Section**
We have the right to:

1. Release or obtain claim information from any Plan, individual or entity.

2. Pay Our covered benefits to any Plan or entity which has paid benefits that We should have paid.

3. Recover any overpayment made by Us from the person or entity to whom the payment was made.

We may obtain or release any information needed to carry out the intent of this section. You must inform Us if You [or Your Covered Dependents] have coverage under any other Plans when the Covered Person makes a claim.]]
COB: 005.002.GE

[[XIII.] [CLAIM PROVISIONS]
CLP: 005.002.GE

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

We must receive written or electronic notice of the services that were received due to a Sickness or an Injury for which the claim is made. Notice must be provided to Us within [60 days] after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, proof of loss must be sent to Us within [12 months] of the date of loss.

The proof of loss must include all of the following:

1. Your name and [certificate] [or] [policy] number.

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

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

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

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

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

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.]
CLP: 010.002.GE

[**Right to Collect Information**
To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within [30 days] of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

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

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

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

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

5. Have any examination completed as requested by Us.

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

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.]
CLP: 015.001.GE

[**Physical Examination**
We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits or when authorization is requested under the Utilization Review Provisions section. These exams will be paid by Us. [We also have the right, in case of death, to have an autopsy done where it is not prohibited by law.]]
CLP: 020.001.GE

[**Payment of Benefits**
When We receive due written proof of loss, benefits [for services provided by a [Non-Network] [Non-Participating] Provider] will be paid to the Covered Person [unless they have been assigned to a Health Care Practitioner, facility or other provider]. [Assignment of medical [and Prescription Drug] benefits to Health Care Practitioners, facilities and other providers is only allowed under this plan [if a Negotiated Rate or Contracted Rate is in effect with the provider rendering the services or supplies].] [We pay [Network] [Participating] Providers directly for Covered Charges.] Any benefits unpaid at Your death will be paid at Our option to Your spouse, [Your Domestic Partner,] Your estate or the providers of the services.

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

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

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may

be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.]
CLP: 025.001.GE

[**Rights of Administration**
We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.]
CLP: 035.001.GE

[**Claims Involving Fraud or Misrepresentation**
Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved fraud or misrepresentation, We will be entitled to a refund from You, the Beneficiary or the person receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly file a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.]
CLP: 040.001.GE

[**Claim Appeal**
You have the right to request a review of all adverse claim decisions. A review must be requested in writing within [180 days] following Your receipt of the notice that the claim was denied or reduced.]]
CLP: 045.001.GE

[[XIV.] [PREMIUM PROVISIONS]
PRE: 005.002.GE

[**Consideration**
This plan is issued based on the statements and agreements in the Covered Person's enrollment form, [any exam of a Covered Person that is required, any other amendment or supplements to the enrollment form] and payment of the required premium. [Each renewal premium is payable on the due date [subject to the Grace Period provision in this section].]]
PRE: 010.002.GE

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

[Your premium may be adjusted from time to time based on different factors including, but not limited to, Your [geographic area,] [and] [gender,] [and] [age] [and] [plan design]. All premium adjustments will be made to individuals on the basis of shared characteristics. After Your first year of coverage, You may request a review to reduce Your current premium. If a lower rate is available, a supplemental form may be required and You must meet our eligibility criteria to qualify for a reduced premium.] [The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.]

[The premium will not change during the first [1-12 month[s]] this plan is in force unless You change the coverage[, add or delete Covered Dependents,] or move to another zip code.]
PRE: 015.001.GE

[**Grace Period**
There is a grace period of [31 days] [10 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the unpaid premium was due.

Coverage will continue during the grace period unless You call Our office or give Us written notice to cancel the coverage. If a claim is payable for charges Incurred during the grace period, any unpaid premiums due will be deducted from the claim payment.]
PRE: 025.002.GE

[**Grace Period**
There is a grace period of [31 days] [10 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the unpaid premium was due and no charges Incurred during the grace period will be considered for benefits. If the premium is received during or by the end of the grace period, coverage will continue without interruption.]
PRE: 025.003.GE

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

[1.] [The lapse was not more than [30 days].]

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

[3.] [We approve Your [supplemental] enrollment form for reinstatement.]

The coverage will be reinstated on the date We approve Your enrollment form for reinstatement. [If We have not responded to Your enrollment form for reinstatement by the 45th day after We receive the enrollment form, the coverage will be reinstated on that date.]

[If the coverage is reinstated, loss resulting from an [Injury] [or] [Sickness] will be covered only if the [Injury] [or] [Sickness] is sustained on or after the date of reinstatement.] [Loss due to a Sickness will be covered only if the Sickness begins [more than] [10 days] after the date of reinstatement.] No benefits will be paid for such condition and related complications if during the time between the lapse date and the reinstatement date:

[1.] [Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or Prescription Drugs were prescribed] regardless of whether the condition was diagnosed or not diagnosed; or]

[2.] [The condition produced signs or symptoms.]

[The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

[a.] [The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or]
[b.] [The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.]

This limitation will apply until coverage has been in force for [12 months] after the reinstatement date, unless the condition has been specifically excluded from coverage.

In addition, death occurring between the lapse date and the reinstatement date will not be covered under the Life Insurance Benefits section.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed[, subject to any provisions included with or attached to this plan in connection with the reinstatement].]]
PRE: 030.001.001.GE

[[XV.] [RECOVERY PROVISIONS]

REC: 005.002.GE

[**Overpayment**

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

REC: 010.001.GE

[**Subrogation Right**

Subrogation is the process by which We seek reimbursement from another person or entity for a claim We have already paid. When benefits are paid on a Covered Person's behalf under this plan, We are subrogated to all rights of recovery a Covered Person has against any person, entity or other insurance coverage. This includes, but is not limited to, recoveries against:

[1.] [A third party.]

[2.] [Any liability coverage for a third party.]

[3.] [Other insurance that a Covered Person has, including uninsured or underinsured motorist coverage.]

This subrogation right extends to the proceeds of any settlement or judgment but is limited to the amount of benefits We have paid.

A Covered Person must:

1. Do nothing to prejudice or hinder any right of recovery; and

2. Execute and deliver any instruments and papers that may be required by Us; and

3. Cooperate with Us to assist Us in securing Our subrogation rights.

If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with a Sickness or an Injury for which We have paid benefits under this plan, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our subrogation right under this plan. We reserve the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect Our subrogation right.

Upon recovery of any portion of Our subrogation interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs incurred by the Covered Person and/or the Covered Person's attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our subrogation right, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.

If We are precluded from exercising Our subrogation right, We may exercise Our Right to Reimbursement provision in this plan.]

REC: 015.001.GE

[**Right to Reimbursement**
When We pay benefits under this plan, We have the right to recover an amount equal to the amount We paid if the Covered Person:

1. Seeks recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise; and

2. Recovers payment, in whole or in part, from any person, entity or other insurance coverage for the benefits that We previously paid under this plan.

This right to reimbursement extends to the proceeds of any settlement or judgment. This includes, but is not limited to, recoveries against:

[1.] [A third party.]

[2.] [Any liability coverage for a third party.]

[3.] [Other insurance that a Covered Person has, including uninsured or underinsured motorist coverage.]]

Reimbursement to Us will not exceed either the amount of benefits that We paid under this plan which the Covered Person recovered from any other person, entity or other insurance coverage or the amount recovered from any other person, entity or other insurance coverage as payment for the same Sickness or Injury, whichever is less.

You must reimburse Us for any payments that We make prior to a determination as to whether a Sickness or an Injury is work-related at the time that the Covered Person receives payment for the Sickness or Injury from another source. You must agree to:

1. Notify Us of any workers' compensation claim that a Covered Person makes; and

2. Reimburse Us even when workers' compensation benefits are provided by means of a settlement or compromise.

3. Cooperate with Us to assist Us in securing Our right to reimbursement.

The Covered Person must provide Us with timely written notification in the event that he or she suffers a Sickness or an Injury in which a third party might be responsible and the Covered Person seeks recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise.

Such a notice must inform Us of:

1. The nature of the Sickness or Injury; and

2. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Covered Person; and

3. A description of the Accident or occurrence that the Covered Person reasonably believes was responsible for the Sickness or Injury at issue and the approximate date(s) upon which such Accident or occurrence happened; and

4. The name of any legal counsel retained by a Covered Person in connection with any such Accident or occurrence.

If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with any such Accident or occurrence, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our right to reimbursement under this plan. We reserve the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect Our right to reimbursement under this plan.

Upon recovery of any portion of Our right to reimbursement interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs incurred by the Covered Person and/or the Covered Person's attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our right to reimbursement, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.]
REC: 020.001.GE

[**Workers' Compensation Not Affected**
Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.]]
REC: 025.001.GE

[[XVI.] [CONVERSION]

CNV: 005.002.GE

[**Enrollment, Premium and Effective Date for Conversion Coverage**
An eligible person who wants to obtain conversion coverage must submit a written enrollment form and the required premium to Us within [31 days] after coverage under this plan terminates. Evidence of insurability will not be required. However, rates may be affected.

If written enrollment is not made within [31 days] following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates.]
CNV: 005.005.GE

[**Enrollment, Premium and Effective Date for Conversion Coverage**
An eligible person who wants to obtain conversion coverage must submit a written enrollment form and the required premium to Us within [31 days] after coverage under this plan terminates. The plan may provide different benefit levels, covered services and premium rates. Coverage will be provided on a form that We use for providing conversion coverage at that time.

If written enrollment is not made within [31 days] following the termination of insurance under this plan, converting to an individual medical insurance plan may not be permitted.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates.]
CNV: 005.006.GE

[**Covered Dependent Conversion**
A Covered Dependent may be eligible to convert to another plan of medical insurance We offer if:

1. The Covered Dependent's insurance terminates due to a valid decree of divorce between the Certificate Holder and the Covered Dependent; or

2. The Covered Dependent's insurance terminates due to the death of the Certificate Holder; or

3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.]]

CNV: 015.002.GE

[[XVII.] [OTHER PROVISIONS]

OTH: 005.002.GE

[**Certificate Changes**

No change in the certificate will be valid unless approved by one of Our executive officers and included with this certificate. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.]

OTH: 010.002.GE

[**Clerical Error**

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

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

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

OTH: 015.002.GE

[**Conformity with State Statutes**

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

OTH: 020.001.GE

Continuation of Coverage

A Covered Dependent may be eligible to continue coverage under this plan after coverage would otherwise terminate due to loss to dependency or change in marital status. The benefits will be the same as those in effect on the date of termination. You must furnish written request for continuation to Us within 10 days after ceasing to be eligible for coverage. The continued coverage will end on the earliest of:

1. full coverage under any other group accident and health policy or contract. This includes being covered for conditions deemed to be pre-existing conditions under that plan;
2. the end of the period for which premiums are paid;
3. the period ending 120 days from the date continuation began;
4. the premium due date following the date the dependent becomes eligible for Medicare;
5. the date coverage under the plan would have otherwise terminated;
6. the date the Life Time Maximum Benefit amount is reached; or
7. the date the Master Group Policy ends.

The individual shall be eligible for conversion after exhaustion of continuation of coverage.

OTH: 021.002.AR

[**Enforcement of Plan Provisions**

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.]
OTH: 025.001.GE

[**Entire Contract**
This certificate is issued to the Certificate Holder]. The entire contract of insurance includes the group [master] Policy, a Covered Person's enrollment form, the Covered Person's certificate of insurance and any riders and endorsements.]
OTH: 030.002.GE

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

Medical documentation verifying the Covered Person's Total Disability must be submitted to Us within [60] days of termination. The extension will end when the Covered Person is no longer Totally Disabled, or at the end of a [365-day] period after the date the Covered Person's coverage terminated, whichever occurs first.]
OTH: 035.001.GE

[**Extension of Benefits** [**for Medical Coverage Only**]
If a Covered Person is Totally Disabled on the date this coverage terminates, We may extend benefits only for Covered Charges Incurred to treat the Sickness or Injury that directly caused the Total Disability provided that the Sickness commenced or the Injury was sustained while this plan was in force. Benefits are subject to all the terms, limits and conditions in this plan. [Premium payment will not be required during the extension of benefits period.] Medical documentation verifying Total Disability must be sent to Us within [60 days] after termination.

The extension will end on the earliest of:

[1.] [The date on which services are no longer required to treat the Sickness or Injury that caused the Total Disability.]

[2.] [The date the Covered Person is no longer Totally Disabled.]

[3.] [Payment of the Maximum Lifetime Benefit or any other maximum benefit for those services under this plan.]

[4.] [[90 days] from the date coverage would have terminated under this plan if there was no extension of benefits.]

[5.] [The date the Covered Person is eligible for Medicare.]

[6.] [The earliest date otherwise permitted by law.]]
OTH: 035.004.GE

[**Incentives, Rebates and Contributions**
[We may elect to furnish [or participate in programs with other organizations that furnish] [group applicants for coverage] [members of groups applying for coverage][individual applicants for coverage][Covered Persons] [individuals] [that meet common criteria or requirements determined by Us] [not to include health or claims history] with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted [or] [where other gifts or items of value may be offered or provided to You at no charge or a discount] [at a time or times] [or] [for a period] determined by Us.]]
OTH: 040.002.GE

[**Deductible Credit Program**
[[Beginning the earlier of the [January 1st –December 31st] [or] [January 1st –December 31st] that next follows the [[30th-365th] [day] [[0-12] [months] after Your Effective Date, You will receive a [5%-20%][$XXX] credit to Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible for each [[0-12]-month] period during which the Deductible less any accumulated credits has gone unsatisfied.] [Each [5%-20%][$XXX] credit will be based on Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [less any accumulated credits].] [At no time will Your [Individual] [Family] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits be less than [$XXX].]]

[When Covered Charges equal to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated credits have been Incurred and processed by Us, the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible will be satisfied for the remainder of that Calendar Year.] [On January 1st of the following Calendar Year, You will return to the [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible amount, as shown on Your Benefit Summary.]]]

[This Deductible Credit Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.001.GE

[**Deductible Reward Program**
[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied].] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Deductible Reward Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.002.GE

[**Multi Year Deductible**
[[You will receive a [one-time] [5%-25%][$XXX] Deductible [credit] [reward] [monthly] [quarterly] [semi-annually] [annually] [at renewal] to Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible [for a [18-60][-month period] [for the period shown on the benefit summary] [if [during a [[6-24]-month] period]] Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible has not been satisfied].] [At no time will Your [Individual][or] [Family][or] [Integrated] [and] [Network] [Participating][,][and] [Non-Network] [Non-Participating] Deductible less any accumulated [credits] [reward] be less than [$XXX][or the minimum HSA-Qualified deductible amount for HSA-Qualified plans].]]

[This Multi Year Deductible Program may be discontinued at any time by providing You with a prior [30-180]-day notice.]]
OTH: 041.003.GE

[**Misstatements**
If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.]
OTH: 045.001.GE

[**Rescission of Insurance and/or Denial of Claim**
[Within the first two years after the Effective Date of coverage,] We have the right to rescind or modify Your certificate of insurance coverage and/or deny a claim for a Covered Person if the enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a certificate of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.
OTH: 055.003.GE

[**Legal Action**
No suit or action at law or in equity may be brought to recover benefits under this plan until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process. No suit or action at law or in equity can be brought later than [3 years] from the date the expenses were Incurred.]
OTH: 060.001.GE

[**Forum**
[Any lawsuits or disputes arising under the terms of the group master Policy must be brought in the United States District Court for the Eastern District of Wisconsin.]
OTH: 065.001.GE

[**Modification of Your Coverage**

[The group master Policy may be changed at any time. We will give the [~~association~~trust] [Policyholder] [30 days] notice prior to any change.]

[We may modify the health insurance coverage for You [and Your Covered Dependents]. This modification will be consistent with state law and will apply uniformly to all certificates with Your plan of coverage. [You will be notified of any change.]]]]
OTH: 075.001~~3~~.GE