PLAN SUMMARY
PREFERRED PROVIDER POLICY
MAJOR MEDICAL EXPENSE COVERAGE

This insurance coverage is provided by Provident American Life & Health Insurance Company. This coverage provides different levels of benefits depending on whether a participating provider or a non-participating provider is used.

If you have questions or need additional information, you may write to us at our Home Office at:

Provident American Life & Health Insurance Company
2500 DeKalb Pike
Norristown, PA 19404

or you may contact us, toll-free, at 1-800-519-9175.

A participating provider is a provider (who is not a close relative of the covered person) of health care services or supplies who has agreed to participate in our preferred provider network. Our preferred provider network is a selected network of physicians, hospitals and other health care providers who have agreed to deliver health care services at negotiated prices to us.

This coverage contains different levels of benefits based upon whether you use a participating or non-participating provider. We require you to notify us before you receive certain covered services, including hospital admissions. The provider may assist you in this process.

You receive the highest level of benefits when you use a participating provider. Participating providers agree to provide health care services at negotiated prices. Participating providers have agreed not to bill you more than the negotiated amount. These providers have agreed to file your claim for you and reimbursement will be made directly to them for covered services you receive.

SCHEDULE OF BENEFITS

MAXIMUM LIFETIME BENEFIT AMOUNT: $5,000,000

DEDUCTIBLE AMOUNT (Options):
- $500, $1,000, $2,500 Each Calendar Year for GOLD PLAN C1
- $250, $500, $1,000 Each Calendar Year for PLATINUM PLAN C2

MAXIMUM DAILY ROOM BENEFIT: Semi-private

COINSURANCE:
When you use a participating provider after you satisfy your deductible amount, you pay: GOLD PLAN C1-20% of the next $5,000 of covered expenses; PLATINUM PLAN C2-10% of the next $2,500 of covered expenses.
We pay 100% of covered expenses thereafter for the balance of the calendar year.
When you use a non-participating provider after you satisfy your deductible amount, you pay: GOLD PLAN C1-40% of the next $5,000 of covered expenses; PLATINUM PLAN C2-30% of the next $2,500 of covered expenses; plus under all Plans there is an additional $1,750 co-pay for confinement in a non-participating provider hospital, an additional $750 co-pay for services rendered by a non-participating provider ambulatory surgical facility, and an additional $150 co-pay for outpatient testing rendered by a non-participating provider. We pay 100% of covered expenses thereafter for the balance of the calendar year.

All benefits are based on usual, reasonable and customary charges.

STOP LOSS MAXIMUM:
GOLD PLAN C1: $5,000
PLATINUM PLAN C2: $2,500

PHYSICIAN OFFICE VISITS:
When you use a participating provider: $15 office visit copay.
When you use a participating provider: $15 copay for charges for x-rays, lab and diagnostic tests performed in a physician’s office during a physician office visit and which are billed by the physician. Thereafter we pay 100% of covered expenses incurred subject to a maximum benefit of $200 per visit. Expenses incurred in excess of the $200 maximum benefit will be subject to any applicable deductibles and benefit percentages.
When you use a non-participating provider: $40 office visit copay
When you use a non-participating provider: Charges other than the office visit charge are subject to deductible and coinsurance.

For Plans with a deductible greater than $2500 there is no physician office visit copay and no copay for x-rays, lab and diagnostic tests; all covered expenses are subject to deductible and coinsurance.

PRESCRIPTION DRUG CARD BENEFIT CO-PAYMENT:
When you use a participating pharmacy: $5 for generic drugs; $15 for named brand drugs*
When you use a non-participating pharmacy: $5 for generic drugs; $15 for named brand drugs, then we pay 90% of the average wholesale price of the drug*

* After satisfaction of the separate calendar year Rx deductible of $50 per covered person;
Calendar Year Maximum Benefit $2,500 per covered person for GOLD PLAN C1 and $5,000 per covered person for PLATINUM PLAN C2

YOU WILL BE RESPONSIBLE FOR THE FIRST $500 OF ANY COVERED EXPENSE IN ADDITION TO ANY DEDUCTIBLE, CO-PAYMENT AND COINSURANCE AMOUNTS EACH TIME YOU FAIL TO OBTAIN PRECERTIFICATION OF CARE.

COVERED EXPENSES

Covered Hospital Charges Include:
1. room, board, and general nursing care, not to exceed the semi-private room rate. The most common semi-private room rate will be covered for confinement in a private room. If a facility contains only private rooms, coverage will be limited to 90% of the private room rate; Coverage is provided for inpatient care for 48 hours following a mastectomy and for 24 hours following a lymph node dissection for the treatment of breast cancer.

2. confinement in an intensive or specialized care unit which provides four or more hours of nursing care per day; covered expenses are limited to an amount not greater than 3 times the hospital’s semi-private room rate;
3. emergency room treatment, services, and supplies; and
4. miscellaneous medical services and supplies provided on an inpatient basis.

Covered Treatment Provided by:
1. a physician; and
2. a therapist for diagnosis and treatment performed for rehabilitative treatment.

Other Covered Charges Include:
1. any preexisting condition after the expiration of twelve (12) months following the covered person’s effective date of coverage under the policy.
   A preexisting condition will also be considered a covered charge if it is duly disclosed in the application for coverage of the covered person and otherwise covered by the policy, unless the condition is specifically excluded by endorsement or rider attached to the policy.
2. outpatient x-ray and laboratory tests; Outpatient testing shall include the following benefits for lead poisoning screening: one baseline lead poisoning screening test for children at or around twelve months of age; and lead poisoning screening and diagnostic evaluations for children under the age of six years who are at high risk for lead poisoning in accordance with guidelines and criteria set forth by the Division of Public Health.
3. anesthetics and their administration;
4. treatment in an urgent care facility;
5. blood or blood plasma and its administration, if not replaced;
6. artificial limbs, eyes, larynx and orthotic appliances; however, replacements are only covered for children needing replacements due to growth and when prescribed by a physician;
7. medically necessary supplies, including casts, non-dental splints, trusses, crutches or non-orthodontic braces;
8. oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment;
9. complications of pregnancy;
10. durable medical equipment, including rental of a wheelchair, hospital-type bed or iron lung, not to exceed the purchase price of such equipment. At our option, benefits may be available for purchase of such equipment payable in monthly installments while coverage under the policy remains in force;
11. local licensed ground ambulance service or air ambulance service within the 48 contiguous states (certified as medically necessary by a physician) to the nearest hospital that we determine is qualified to treat the covered injury or illness; benefits will be limited to a maximum of $600 per occurrence;
12. treatment or service in a state approved freestanding ambulatory surgical center or facility, which is not part of a hospital;
13. dental treatment or care required as a result of a covered injury to sound natural teeth occurring within 6 months of the injury;
14. open cutting operations to the feet; the removal of all or part of one or more nail roots; and services in connection with the treatment of metabolic or peripheral vascular disease;
15. any charge for cosmetic or reconstructive purposes, or complications of cosmetic procedures, when such service is: incidental to or follows a covered injury or illness occurring while the policy is in force; performed on a covered dependent who is 19 years of age or less because of congenital disease or anomaly as determined by the attending physician so long as the covered dependent was covered continuously under the policy from birth;
   Coverage shall include breast reconstruction incident to mastectomy. This shall include surgery to a breast for which mastectomy was not required, in order to restore or achieve breast symmetry.
16. up to a maximum of 15 visits in each calendar year for spinal manipulation, manual or electrical muscle stimulation, and other manipulative or ultra sound therapy when performed by a physician;
17. Charges for the following transplants and replacements shall be included as any other illness or injury: a. cornea, artery or vein, and kidney transplants; b. joint and heart valve replacements; c. implantable prosthetic lenses in connection with cataracts; d. prosthetic by-pass or replacement vessels; e. bone marrow transplants; f. skin grafts; g. heart, heart and lung, liver, and pancreas transplants. All organ transplants are subject to the precertification requirement.

The policy does not cover organ transplants which: are animal to human transplants; use artificial and/or mechanical organs; are experimental, investigational or unproven; or are not generally accepted by the general medical community as an effective treatment for a covered injury or illness.

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

Benefits provided for treatment in a psychiatric day treatment facility shall be determined as if necessary care and treatment were in-patient care and treatment in a hospital. Each full day of treatment in a psychiatric day treatment facility shall be considered equal to one-half of one day of treatment of a nervous or mental disorder in a hospital or in-patient program for the purpose of determining policy benefits and benefit maximums. We require that the treatment be provided by a day treatment facility that treats a patient for not more than eight hours in any 24-hour period, that the attending physician certifies that such treatment is in lieu of hospitalization, and that the psychiatric treatment facility is accredited by the Program for Psychiatric Facilities, or its successor, or the Joint Commission on Accreditation of Hospitals.

With respect to the benefits payable for this covered expense, the following definition applies:

"Psychiatric Day Treatment Facility" means a mental health facility which provides treatment for individuals suffering from acute, mental and nervous disorders in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Treatment in a crisis stabilization unit or a residential treatment center for children and adolescents shall be determined as if necessary care and treatment were in-patient care and treatment in a hospital. Each two days of treatment in a crisis stabilization unit or a residential treatment center for children and adolescents will be considered equal to one day of treatment of a nervous or mental disorder in a hospital or in-patient program for the purpose of determining policy benefits and benefit maximums. Treatment provided through crisis stabilization units shall be reimbursed for facilities licensed or certified by the Texas Department of Mental Health and Mental Retardation.

With respect to the benefits payable for this covered expense, the following definitions apply:

"Crisis Stabilization Unit" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"Residential Treatment Center for Children and Adolescents" means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Coverage is provided for the treatment of serious mental illness (schizophrenia; paranoid and other psychotic disorders; bipolar disorders - hypomanic, manic, depressive and mixed; major depressive disorders - single episode or recurrent; and schizo-affective disorders - bipolar or depressive), subject to a calendar year maximum of 45 days for inpatient treatment.

19. Charges for the treatment as an outpatient in an outpatient mental health treatment center subject to a maximum benefit of $20 per visit for a maximum of 60 visits per calendar year and shall be subject to the deductible and benefit percentages the same as any other covered illness. Benefits
shall include group and individual outpatient treatment rendered by a physician. Charges shall include charges made by a hospital for the necessary care and treatment of nervous or mental disorders furnished to a covered person while not confined as a hospital inpatient; charges for services rendered or prescribed by a health care provider who is required to be recognized as a physician by state law, and who is licensed to practice, for the necessary care and treatment of nervous or mental disorders furnished to a covered person while not confined to a hospital as an inpatient; or charges made by an outpatient mental health treatment center for the necessary care and treatment of a covered person provided in the treatment center.

20. home health care. This benefit will cover up to 60 home health care visits in each calendar year, not to exceed the usual, reasonable and customary weekly cost for care in a convalescent nursing facility. Covered expenses include: part-time or intermittent home nursing care by, or under the direction of a graduate registered nurse (RN) and at least one physician; part-time or intermittent home health aide services that consist only of care for the covered person, and which are medically necessary, as part of the home health care plan. The services must be under the direction of a graduate registered nurse (RN); physical, occupational, respiratory or speech therapy performed for rehabilitative treatment; nutrition counseling provided by or under the direction of a registered dietitian as part of the home health care plan; or medical supplies, medical equipment, drugs and medicines prescribed by a physician and laboratory services provided by or on behalf of a hospital but only to the extent that they would have been covered under the policy if the covered person had remained in the hospital; or the evaluation of the need for, and development of, a plan by a physician or a graduate registered nurse (RN). Such services must be requested by the physician and approved by us. The physician must review the plan at least every two months and certify the continued medical necessity of the plan.

Home health care services must be: approved through our precertification process. Review of medical necessity may be periodically required; provided in lieu of confinement in a hospital or skilled nursing facility which would otherwise be medically necessary; and provided or coordinated by a state licensed or Medicare certified home health care agency or certified rehabilitation agency.

Specifically excluded from coverage under this benefit are the following: services of a social worker; transportation services; and meals.

21. hospice care. This benefit will cover charges incurred for up to six months, limited by a lifetime maximum benefit of $5,000 per covered person. Covered expenses include charges incurred for the following hospice services: part-time intermittent home nursing care by, or under the direction of, a graduate registered nurse (RN); physical, respiratory or speech therapy; medical supplies, including drugs and biologicals and the use of appliances, but only to the extent they would have been covered under the policy if the covered person had remained in the hospital; nutrition counseling provided by or under the direction of a registered dietitian as part of the active hospice management plan; and counseling services by a licensed clinical social worker, pastoral counselor, or counselor for an immediate family member, the primary care giver and individuals with significant personal ties to a covered person who is terminally ill;

Hospice services must be: approved through our precertification process. Review of medical necessity may be periodically required; under active management through a hospice which is responsible for coordinating all hospice care services; provided only if the physician submits written certification to us that the insured is terminally ill with a life expectancy of six months or less.

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

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

22. Convalescent nursing facility care. This benefit is payable for charges related to convalescent confinement which: follows a hospital confinement for which at least three consecutive days of daily
room and board charges were covered expenses under the policy; and begins within 14 days after
the covered person is released from such hospital confinement.

Only charges for the following services and supplies furnished by the convalescent nursing facility
during the convalescent confinement are covered expenses: room and board, including charges
made by the convalescent nursing facility as a condition of occupancy, or on a regular daily or weekly
basis such as general nursing services. If private room accommodations are used, the daily room
and board charge allowed will not exceed the convalescent nursing facility’s average semi-private
charges or an average semi-private rate made by a representative cross section of similar institutions
in the area; medical services customarily provided by the convalescent nursing facility with the
exception of private duty or special nursing services and physician’s fees; and drugs, biologicals,
solutions, dressings and casts, but no other supplies;

23. low dose mammography as follows: Annual testing for women age 35 or older;
24. emergency treatment received outside of the United States;
25. Fees of registered nurses or licensed practical nurses for private duty nursing while not confined in
a hospital, up to a maximum benefit of $2,000 per covered person per calendar year;
26. Chemotherapy and radiation therapy or treatment;
27. Physical, respiratory or speech therapy when rendered by a licensed therapist;
28. Routine physical exams after the covered person has been covered under the policy for 24
consecutive months. Benefits are limited to $100 per examination for each covered person per
benefit period. Benefit period is defined as every two years. Satisfaction of the deductible and co-
payment is not required for this benefit, however, the coinsurance will apply;
29. Medical treatment, services or supplies rendered to a newborn covered dependent solely for the
purpose of health maintenance and not for the treatment of an illness or injury. Included are charges
for physicians, medical examinations, special studies, x-rays and laboratory tests, immunizations and
supplies for preventative health care and circumcision and for routine care furnished from the
moment of birth. Hospital room and board nursery charges are covered. This benefit ends when the
newborn covered dependent is discharged from the hospital;
30. Pap smears for the detection of cervical and endometrial cancer, and the physician’s office visit in
connection with the pap smear. There is no physician’s office visit co-payment, and the deductible
and benefit percentage apply;
31. Outpatient services which provide for CA-125 for monitoring ovarian cancer subsequent to treatment;
however, such charges shall not be payable if such treatment is for routine screening only;
32. Prostate cancer screening known as Prostate Specific Antigen (PSA) test for males age 50 or older.
Coverage shall include an annual medically recognized physical examination for the detection of
prostate cancer, and annual testing for a covered person who is at least 40 years of age with a family
history of prostate cancer or another prostate cancer risk factor.
33. homeopathic treatment rendered by a licensed homeopathist, subject to a maximum benefit of $50
per visit and $500 per calendar year per covered person. This benefit does not include coverage for
supplies used by the provider. This benefit is not subject to the co-payment and coinsurance
requirements.
34. Child health supervision services for the periodic examination of covered dependent children.
Benefits are payable for the following age intervals: birth, one month, two months, four months, six
months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four
years, five years and six years. This benefit is not subject to the co-payment, deductible and
coinsurance requirements.

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

35. Diabetes self-management training, provided by a health care practitioner who is licensed, registered or certified in the State of Texas to provide appropriate health care services. Self-management training includes: training provided to a qualified covered person after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies; additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified covered person's symptoms or condition that requires changes in the qualified covered person's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

With respect to the benefits payable for this covered charge, a “qualified covered person” means an individual who is covered under the policy, and who has been diagnosed with insulin dependent or noninsulin dependent diabetes, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels.

36. Medically necessary diagnosis and surgical treatment of conditions affecting the temporomandibular joint, and which result from an accident, a trauma, a congenital defect, a developmental defect, or a pathology. With respect to the benefits payable for this covered charge, the temporomandibular joint includes the jaw and the craniomandibular joint.

37. Medically accepted bone mass measurement, provided to a qualified individual who is covered under the policy, for the detection of low bone mass and to determine the person’s risk of osteoporosis and fractures associated with osteoporosis. With respect to the benefits payable for this covered charge, a “qualified individual” means a postmenopausal woman who is not receiving estrogen replacement therapy; an individual with vertebral abnormalities, primary hyperthyroidism or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy or is being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

38. Medically necessary care and treatment of chemical dependency, substance abuse, alcohol and drug rehabilitation. Benefits shall be provided on the same basis as any other illness, subject to the following guidelines recommended by law for each series of covered treatments:

- up to 14 days for inpatient hospital or 24-hour residential detoxification services;
- between 14 and 35 days for adult admissions, and between 14 and 60 days for adolescent admissions, for inpatient rehabilitation/treatment or partial hospitalization services; and
- 4 to 12 weeks, with meetings occurring at least 12 hours per week, for intensive outpatient rehabilitation/treatment services.

Coverage for chemical dependency, substance abuse, alcohol and drug rehabilitation is limited to a lifetime maximum of three separate series of treatments for each covered person.

A series of treatments is a planned, structured and organized program to promote chemical free status which may include different facilities or modalities and is complete when the covered person is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient rehabilitation treatment services or a series of these levels of treatments without a lapse in treatment or when a covered person fails to materially comply with the treatment program for a period of 30 days.

With respect to the benefits payable for this covered expense, the following definitions apply:

"Chemical Dependency" means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

"Chemical Dependency Treatment Center" means a facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also: affiliated with a hospital under a contractual agreement with an established system for patient referral; or accredited as such a facility by the Joint Commission...
on Accreditation of Hospitals; or licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or licensed, certified or approved as a chemical dependency treatment program or center by any state agency having legal authority to so license, certify or approve.

"Controlled Substance" means a toxic inhalant or substance designated as a controlled substance in Chapter 481, Health and Safety Code.

"Toxic Inhalant" means a volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.

39. Prescription Drug Card Benefit - Subject to separate calendar year drug deductible, co-payment, if any, and calendar year maximum benefit per covered person, payment for the remaining cost for up to a 34-day supply or 100 units, whichever is greater, of covered prescription drugs, taken as directed by a physician, and provided to a covered person through a participating pharmacy. The full cost of the covered prescription must be paid for prescriptions provided to a covered person through a non-participating pharmacy. A claim form is required and the approved charges will be reimbursed to you based on 90% of the average wholesale price of the drug less the covered person’s co-payment and separate drug deductible.

Coverage is provided for all formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for covered expenses for other drugs available under the policy, but only on the order of a physician.

All medical benefits for emergency services, whether provided by a participating provider or by a non-participating provider, will be payable at the participating provider benefit level, subject to any co-payment, coinsurance and/or deductible amounts. Emergency services are those medical services provided to a covered person within 72 hours following an injury or an emergency.

An emergency is a medical condition of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, illness or injury is of such a nature that failure to get immediate medical care could result in: placing the patient’s health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; serious disfigurement; or in the case of a pregnant woman, serious jeopardy to the health of the fetus. Medical attention and surgery must be provided within 72 hours following the onset of a condition, injury or illness.

If a medically necessary service is not available from a participating provider, your participating provider may refer you to a non-participating provider and the covered expenses will be considered for payment at the participating provider benefit level. Some individual providers practice in more than one location. On occasion, an individual provider may be a participating provider at one location, but a non-participating provider at another location. In such cases, services will be reimbursed at a non-participating provider level subject to determination of usual, reasonable and customary charges. Be sure to check the provider’s participating status before services are rendered and at the location where the covered person is seeking care.

You are responsible for payment of the required premium for this insurance, any deductible, coinsurance and co-payment amounts shown in the Schedule of Benefits, any expenses not covered by the policy and any charges which exceed usual, reasonable and customary amounts.

EXCLUSIONS, LIMITATIONS AND REDUCTIONS

The following charges may not be used to satisfy the deductible amount. In addition, except as specifically provided for in the Policy, we will not pay for any such charges incurred for:

1. preexisting conditions;
2. expenses incurred before the effective date;
3. expenses incurred after coverage under the policy terminates, regardless of when the condition originated;
4. expenses covered by any rider attached to the policy providing additional benefits;
5. any conditions specifically excluded by riders or exclusions attached to the policy;
6. expenses incurred to treat complications resulting from treatment or conditions which are not covered under the policy;
7. experimental, investigational, or unproven services;
8. expenses determined by us to be educational;
9. amounts in excess of the usual, reasonable and customary charges made for services or supplies covered under the policy;
10. expenses the covered person is not required to pay, which are covered by other insurance, or which would not have been billed;
11. care in government institutions unless the covered person is obligated to pay for such care;
12. expenses which are payable under workers’ compensation or employers’ liability laws;
13. treatment received outside of the United States;
14. charges incurred by a covered person while on active duty in the Armed Services. Upon written notice to us of entry into such active duty, the unused premium will be returned on a pro-rated basis;
15. expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection;
16. expenses incurred or expense related thereto, while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony;
17. pregnancy or childbirth, except for complications of pregnancy;
18. charges incurred for voluntary termination of pregnancy;
19. any drug, supply, treatment or procedure that prevents conception and/or childbirth;
20. diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method other than by natural means; in vitro fertilization, artificial insemination or similar procedures whether the covered person is the donor, recipient or surrogate;
21. charges incurred, prior to the date the covered person has been covered under the policy for six consecutive calendar months for the care or treatment of (a) hernia, (b) tonsils, (c) adenoiditis, (d) any disease or disorder of the reproductive system or gall bladder, (e) rectal disease or disorder, (f) bunions, (g) varicose veins, or (h) laminctomy, discectomy or spinal fusion. Any such condition may also be excluded as a preexisting condition. This limitation shall not apply to any covered person admitted to a hospital on an emergency basis and such condition is not excluded as a pre-existing condition. If admitted on an emergency basis the symptoms must be severe and occur suddenly. Medical attention and surgery must be provided within 72 hours following the onset of an injury or illness.

The six-month exclusion will not apply to a covered person receiving treatment for any disease or disorder of the reproductive system, or receiving treatment for rectal disease or disorder, if such treatment is due to a malignancy, provided such treatment is not being rendered to a preexisting condition. If the disease or disorder of the reproductive system or the rectal system is a preexisting condition, benefits will be payable in accordance with the Policy’s provisions for preexisting conditions.

22. sex transformation, sexual dysfunctions or sexual inadequacies; or reversal of sterilization;
23. physical exams or other services or supplies not needed for medical treatment;
24. prophylactic treatment, including surgery or diagnostic testing;
25. programs, treatment, or procedures for tobacco use cessation;
26. expenses resulting from suicide or attempted suicide, whether sane or insane;
27. charges incurred which result from: (a) the voluntary taking of drugs, except those taken as prescribed by a Physician, (b) the voluntary taking of poison, (c) the voluntary inhaling of gas, or (d) being under the influence of alcohol;
28. expenses resulting from intentional self-inflicted injury;
29. dental treatment or care;
30. orthodontia or other treatment involving the teeth and supporting structures;
31. nonsurgical treatment by any method for jaw joint problems including temporomandibular joint
dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction
or other conditions of the joint linking the jaw bone (mandible) and skull and the complex of muscles,
nerves and other tissues related to the joint;
32. radial keratotomy or surgical correction of refractive error; eye refractions; vision therapy; routine
vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses;
the purchase, fitting or adjustment of eyeglasses or contact lenses; frames or contact lenses for the
treatment of aphakia;
33. routine hearing exams to assess the need for or change to hearing aids; the purchase, fittings or
adjustments of hearing aids;
34. cosmetic or reconstructive procedures, services or supplies;
35. charges for breast reduction unless medically necessary, or complications arising from these
procedures;
36. Charges for breast augmentation, or complications arising from these procedures;
37. medications and drugs, including vitamins and vitamin mineral supplements, available over-the-
counter (OTC) whether or not by a physician's prescription order;
38. any drug or other item used for the treatment of hair loss;
39. treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions or the removal
of one or more corns, calluses or toenails;
40. charges for blood or blood plasma that has been replaced;
41. treatment of autism;
42. treatment of acne;
43. weight loss programs, diets, or treatment of obesity, including surgery for reconstruction or repair
of a gastric bypass as a result of such condition;
44. transportation charges;
45. rest and/or recuperation cures or care in an convalescent nursing home or facility, extended care
facility, skilled nursing facility, or home for the aged, whether or not part of a hospital, unless
specifically provided for in the policy;
46. services or supplies for personal comfort or convenience, including custodial care or homemaker
services;
47. services and/or supplies furnished and/or provided by a member of your immediate family or a
person who ordinarily resides in the home of the covered person;
48. any charges incurred in connection with a hospital admission on Friday or Saturday unless the
attending physician states in writing that the admission was an emergency and medically necessary;
49. immunizations not necessary for the treatment of an illness or injury;
50. expenses incurred for occupational therapy; or
51. acupuncture unless the charges incurred are in lieu of anesthesia.
52. Prescription Drug Card Benefits will not be paid for: (a) drugs taken by or administered to a covered
person while he or she is a patient in a hospital, skilled nursing facility, convalescent hospital,
nursing home, rest home, sanitarium, or any similar institution; (b) contraceptive devices or supplies
(unless prescribed by a Doctor for therapeutic purposes) or drugs for fertilization; (c) experimental
drugs, even though a charge is made to the covered person; (d) any drug labeled, "Caution - Limited
by Federal law to Investigation Use"; (e) drugs delivered, administered or injected by the prescriber
to the covered person; (f) immunization agents, biological sera, blood or blood plasma; (g) services
or appliances, therapeutic devices including hypodermic needles, syringes, support garments, other
non-medical items, regardless of their intended use; (h) charges incurred for prescriptions payable under Workers’ Compensation insurance or employer’s liability laws; (i) growth hormones, drugs prescribed for weight control, smoking deterrents, Rogaine, Retin A (covered for covered persons under age 25), drugs prescribed for cosmetic purposes, vitamins and minerals regardless of the purpose for which prescribed (except prescribed prenatal vitamins are covered); and charges incurred during the balance of the calendar year after the Prescription Drug Card Calendar Year Maximum Benefit has been paid.

Prescription Drug Card Benefits will be paid for medically necessary diabetes equipment and diabetes supplies provided to a covered person for the treatment of diabetes and associated conditions. In addition, and upon the approval of the United States Food and Drug Administration, benefits will be paid for new or improved diabetes equipment or supplies if medically necessary and appropriate as determined by a physician or other health care practitioner.

With respect to benefits payable for diabetes and associated conditions, the following definitions apply:

“Diabetes equipment” means blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices and podiatric appliances for the prevention of complications associated with diabetes.

“Diabetes supplies” means test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels and glucagon emergency kits.

Pre-Existing Conditions-Limitation
A charge incurred by a covered person which results directly or indirectly from a pre-existing condition is excluded from coverage under the policy until the end of either a continuous period of twelve (12) months commencing on or after the effective date of the covered person’s coverage, during which the covered person has received no medical advice or treatment in connection with such illness or injury, or the end of the twelve month period commencing on the effective date of the covered person’s coverage. A pre-existing condition is an illness or injury that is not otherwise excluded from the covered person’s coverage by name or specific description on the date of the person’s loss and for which medical advice or treatment was received by a covered person during the 6 months prior to the effective date of the covered person’s coverage.

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

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

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

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

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

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

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

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

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

Termination of a participating provider’s participation in the preferred provider network, except for reason of mental incapacity or professional behavior, will not release the physician from his or her obligation to treat a covered person and arrange for appropriate referrals. If a covered person has special circumstances, such as a disability, acute condition, or life threatening illness or is past the 24th week of pregnancy and is receiving medically necessary treatment, the participating provider may continue to be reimbursed at the participating provider benefit level even though he or she has terminated from the preferred provider network. Special circumstances means a condition such that the treating physician reasonably believes that discontinuing care by him or her could cause harm to the covered person. Special circumstances must be identified by the treating physician who must contact the preferred provider network and request that the covered person be permitted to continue treatment under his or her care and must agree not to seek payment from the covered person for any amounts for which that person would not be responsible if the physician were still a participating provider. Such reimbursement at the participating provider benefit level, will only be applicable to treatment rendered for 90 days from the effective date of his or her termination as a participating provider.

Attached is a current list of participating providers and the service area. The service area means a geographic area or areas set forth in the medical insurance policy or the participating provider contract. We are prohibited from retaliating against a covered person, a physician or a provider because a complaint has been filed on behalf of the covered person. We are similarly prohibited from retaliating against a physician or provider who has appealed a decision made by us.

This summary provides a very brief description of the important features of the preferred provider plan. This is not the insurance contract and only the actual policy provisions will control. The policy sets forth, in detail, the rights and obligations of both you and your insurance company. It is important that you read your certificate carefully.