THE TAXPAYERS NETWORK
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THE TAXPAYERS NETWORK

Taxpayers Network Inc.

Your source for comprehensive comparative data and public policy news

Taxes • Government Expenditures
Health and Long Term Care Financing
Global Trade • Retirement
Commerce and Economic Development

ABOUT THE TAXPAYERS NETWORK

The Taxpayers Network (TNI) is a non-profit social welfare organization founded in 1992 with the mission of educating its members and the general public about government and public policy. In addition to disseminating valuable information to the nation's policymakers, The Taxpayers Network conducts and publishes research with the goal of generating policy discussions in many issue areas, including:

- Government Programs and Expenditures
- Taxation
- Economic Prosperity
- Social Security and Retirement Programs
- Global Trade
- Education

The Taxpayers Network is an individual membership organization that has tens of thousands of members in more than 40 states.

Taxpayers Network members receive:

- The "Network News" newsletter
- Access to the TNI Network Member Benefit Package*
- Free featured publications including the "50 State Comparison" guide**
- Discounts on educational programs
- Free access to The Taxpayers Network members-only website including archived documents and research
- Free admission to Taxpayers Network meetings

* applies to standard membership
** available upon request

THE TAXPAYERS NETWORK STANDARD MEMBERSHIP BENEFIT PACKAGE INCLUDES:

- **Enrollment in the TNI Pharmacy Savings Program**
  (receive 20% off the average wholesale price on prescription drugs at over 45,000 retail pharmacies nationwide)

- **Enrollment in the TNI Vision Benefit Program**
  (savings of up to 60% at over 20 national and regional vision care providers)

- **Enrollment in the TNI Diabetic Savings Program**
  (savings of up to 50% a month on diabetic supplies)

- **Access to the TNI Chiropractic and Alternative Health Care Savings Program**
  (receive up to 50% off chiropractic services at 12,000 chiropractic locations nationwide)

- **Access to Health Insurance**
  (available in selected states)

- **Enrollment in the TNI Travel Discount Program**
  (savings at major hotel chains and car rental agencies)

- **And many more benefits!**

American Medical Security from PacifiCare

MedOne®

A selection of health insurance plans for Individuals & Families

Florida, Illinois, Michigan, Missouri, Nebraska, Ohio, Oklahoma, Pennsylvania, South Carolina and Wisconsin

MedOne

A selection of health insurance plans for Individuals & Families

Expertise — Choice — Customer Focus.

What you want from your health insurance company.

Expertise

At American Medical Security from PacifiCare (AMS), health plans for individuals and families are what we do best. Over the years, we've used our expertise to design plans that give you more choices, more options, and more ways to get the most from your premium dollar.

Choice

We place an emphasis on choice — your choice. Our wide selection of health insurance products for individuals allows you to develop a plan that's based on your health and economic requirements. Plus, you can enhance your coverage to meet your health needs by selecting prescription drug coverage or dental insurance.

Customer Focus

From questions about a claim to verifying providers, we'll get you the answers you need. With American Medical Security, you'll always talk to a friendly customer service representative.

Because we value your health, you'll have access to resources so you can get the most from your health plan. Whether you need to speak to a registered nurse, research hospitals, participate in an online wellness program, or order prescriptions online; we give you the tools to put knowledge at your fingertips.

Expertise — Choice — Customer Focus.

What you'll receive from American Medical Security.

This brochure applies to: Florida, Illinois, Michigan, Missouri, Nebraska, Ohio, Oklahoma, Pennsylvania, South Carolina and Wisconsin.

This does not imply that agents maintain agent licenses in all states listed.

Contents

Deductible:

The amount of covered expenses you pay each calendar year before benefits are paid under the Policy.

Preferred Provider Organization (PPO):

A group of health-care providers contracted to provide medical services at negotiated rates.

Copayment (Copay):

A fixed fee that you pay toward charges.

Coinsurance:

The insurance plan's level of coverage after the calendar-year deductible is satisfied. After the coinsurance is met, the insurer pays 100% of covered expenses for the remainder of the calendar year.

With AMS, the choice is yours.

You can choose from the lower out-of-pocket costs of a traditional health insurance plan to the lower premium of a high-deductible plan. Or maybe it's the tax savings possible from a health savings account (HSA) paired with an insurance plan that you're looking for — the choice is yours.

Below you'll find a brief overview of our three plan designs.

MedOne *Plus*®

MedOne Plus, AMS' premier product, provides you the value of a traditional health insurance plan that uses a preferred provider organization (PPO). This plan design features:

- Lower deductibles and out-of-pocket costs.
- Coverage with only one copayment for most office visits and preventive services.
- A wide range of copayments, deductibles, and coinsurance amounts to fit your health-care needs.

Mary has two small children who make frequent visits to the doctor's office. She prefers the single copay and the lower out-of-pocket costs of MedOne Plus.

MedOne *Plus*®

MedOne *Security*® *(Not available in PA)*

MedOne Security can be a cost-effective product if you prefer insurance for major medical expenses. This plan design features:

- A wide range of premium-saving higher deductibles and facility copayments to choose from.
- Coverage for emergencies and major illness.

Jim, a recent college graduate, rarely visits the doctor's office but wants to be sure he has coverage should he have an accident or serious illness. He's decided that MedOne Security is for him.

MedOne *Security*®

MedOne *HSAvings*℠

MedOne HSAvings paired with an HSA is ideal if you'd like greater control of your health-care dollars with potential tax savings. This plan design features:

- A lower premium with a high-deductible.
- An aggregate deductible where a family's eligible expenses are pooled together to meet one deductible.

Fred and Michelle like their money to work for them, so they choose MedOne HSAvings. They prefer a higher deductible plan and like the possibility of tax savings when paired with a health savings account.

MedOne *HSAvings*℠

Plan Information

Eligibility

If you'd like to apply for a MedOne health insurance plan, you must be a member in good standing of the Taxpayers Network Inc. (TNI) Association, age 18 or over and under age 65. All applicants must meet the insurer's underwriting requirements and be U.S. citizens or be in the U.S. by a permanent resident card. A copy of the permanent resident card (form I-551) is required. Your dependents who wish to have coverage must be a lawful spouse and/or unmarried child under age 19. If the child is a full-time student at an accredited school, college, or university, coverage is provided to age 25.

EarlyCare Coverage (child only)

When you need to purchase coverage for a child only, choose MedOne Security or MedOne Plus plans EarlyCare option. EarlyCare coverage is ideal for providing child protection as an alternative to employer-sponsored coverage, when a divorce decrees child coverage is mandatory, or for grandparents who want to ensure grandchildren have coverage. Parents or legal guardians can apply for coverage for eligible children. Eligible applicants include unmarried children age 14 days to 19 years or to age 25 if the child is a full-time student at an accredited school, college, or university. Parents or legal guardians must also be members in good standing of the TNI Association.

EarlyCare coverage is ideal for providing child protection as an alternative to employer-sponsored coverage, or for grandparents who want to ensure grandchildren have coverage.

Value-Added Services and Discounts

These noninsurance services are provided through a contractual agreement with third parties, and are not administered or underwritten by us. Unless indicated, these services are available to most AMS customers.

Helpful Customer Service
When you call AMS, you can expect prompt, friendly service and accurate information about claims, general coverage, and benefits.

24–hour Nurse Line and Audio Library*
From rashes to headaches, allergies to stomach pain, the 24-hour information program is a great source of general health information to supplement your physician's care. Simply call the 24-hour Nurse Line toll free at any time to speak with an experienced, registered nurse about your health concerns. You also have the option of listening to prerecorded information on many health topics in the Audio Library.

Prescription Discount
When you purchase your prescription drugs at a member pharmacy, you pay the entire cost of your prescription drug but at the discounted cost. (See pages 7, 9, and 14 for coverage options.)

Dental Discounts
AMS and **CARE**INGTON International have an agreement to provide MedOne insureds with a dental discount program. Thousands of participating dentists nationwide present discounts on a variety of common dental services—from cleanings and exams to crowns and prosthetics. Dental insurance with broad coverage is available to replace the **CARE**INGTON discount program. (See page 14 for more information.)

Vision Care Discounts
Laser Vision Discounts: Our vision care discount provider has made arrangements with laser surgery facilities and doctors to offer discounts. Eyewear Discounts: Vision care discount doctors offer valuable savings, including discounts on pairs of prescription glasses (lenses and frame) not covered by an eyewear benefit. You can also save on the cost of your contact lens exam when you receive contact lens services from a vision care discount provider.

** The 24-Hour Health Information Program's intent is to provide general information regarding common health questions or conditions. If you have a specific question relating to a condition or medical course of treatment for yourself or others, please consult your physician. If you believe you need emergency room services, call 911, or its local equivalent, or go to the nearest medical facility for treatment.*

Insurance Plan Features

Unless indicated, these plan features are included with all MedOne plan designs.

TravelCare®
The TravelCare benefit allows insureds who are traveling outside their networks' primary service areas to receive care from a nationwide PPO network. Receive care from a nationwide provider and get network-level coverage that may mean less out-of-pocket expense for you. ***To receive this insurance benefit, select an insurance plan design using a PPO.***

On-the-Job Protection
On-the-Job Protection offers 24-hour coverage for eligible medical expenses due to work-related injury or sickness.

Non-tobacco Use Discount
If you don't use tobacco, you may receive premium savings.

PPO Networks
A network of credentialed doctors, clinics, hospitals, and other health-care providers are contracted to provide medical services at negotiated fees. Network providers are compensated for services covered under the Policy at predetermined rates which are usually less than the provider's customary rates. Network provider charges for covered services are considered reasonable and customary. AMS may replace the network at any time. You'll receive advance notice of changes.

Term Life AD&D Insurance
Insurance plans include $10,000 Term Life AD&D insurance for the primary insured. (In FL and WI, Term Life AD&D coverage is optional.)

Receive up to $1,000 Cash
If you find an overcharge on a hospital or medical bill, we may pay you up to 50% of the savings, to $1,000 cash per calendar year.

MedOne *Plus*

Choosing a MedOne Plus Plan Design

MedOne Plus provides you the value of a traditional health insurance plan that uses a preferred provider organization.

1. Carefully review both of the MedOne Plus plan designs listed below. Choose either the PPO Benefit Plan 100% or the PPO Benefit Plan.
2. After you select your plan design, choose an office visit copay and network deductible amount.
3. If you select the PPO Benefit Plan, you'll also need to choose your network coinsurance amount (either 80% or 50%).
4. When an office visit copay is selected, both plan designs allow you to select the X-ray and Lab Option (XL), which will upgrade your selection to a PPO Benefit Plan 100% XL Option or PPO Benefit Plan XL. If you anticipate medical imaging or lab procedures, this option may be worth considering. See description on page 14.
5. Select optional benefits such as dental insurance and prescription drug coverage to enhance your plan. See page 14 and 15 for more information.

Features	PPO Benefit Plan 100%	PPO Benefit Plan
Lifetime Maximum		
Per insured	$5 Million	$5 Million
Office Visit Copay Options		
A fixed fee that you pay toward network office visit charges. When no copay (none) is selected, or when a non-network provider is used, charges for the office visit are payable after deductible and coinsurance.	☐ $30 ☐ $40 ☐ None	☐ $30 ☐ $40 ☐ None
Deductible Options	Network	Network
The amount of covered expenses you pay each calendar year before benefits are paid under the insurance Policy.	☐ $ 1,000 ☐ $ 1,500 ☐ $ 2,500 ☐ $ 5,000 ☐ $ 7,500* ☐ $10,000* *Not available with $30 copay.	☐ $ 500 ☐ $ 750 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000
Coinsurance Options	Network	Network
The level of coverage for eligible expenses provided by the insurance plan after the calendar year deductible is satisfied.	100%	☐ 80% of $10,000 ☐ 50%* of $8,000 *Not available with all networks or in all states.
Individual Out-of-Pocket Maximum		
The maximum amount you pay per calendar year for covered expenses, plus your selected deductible. See example on page 16.	$0	☐ $2,000** ☐ $4,000*** **Only available with 80% option. ***Only available with 50% option.
XL Option		
This option pays 100% to $150 per covered person, per calendar year for Network routine and non-routine x-rays and laboratory tests. **See page 14 for details.**	☐ PPO Benefit Plan 100% XL Option	☐ PPO Benefit Plan XL Option

Insurance plans provide only limited benefits for services provided by non-network providers. Services received from non-network providers are subject to a separate non-network deductible, which is double the amount of the network deductible amount, and a separate coinsurance. Network/non-network coinsurance amounts are as follows: 100%/70%, 80%/50%, and 50%/50%. Refer to the state variation pages in the back of this brochure for coinsurance variations that may otherwise apply.

Note: Classic Benefit plans (Non-PPO) are also available. Premiums may be higher than PPO plans.

The Following Coverage Applies to 100%, 80%, and 50% Options

Physician Office Visit

Network Office Visit
Copay then 100%

When no copay (none) is selected, charges for the office visit are payable after deductible then coinsurance, then 100%.

Wellness Benefit

Network Office Visit
Copay then 100%

Network X-ray/lab
(PSA, Pap smear, and mammogram)
Deductible, coinsurance,then 100%

When no copay (none) is selected, network charges for the office visit are payable after deductible, coinsurance, then 100%. Routine non-network charges are not covered unless mandated in your state. Please refer to the state variations for details.

Radiology (X-ray) Test/Pathology (lab) Test

Deductible, coinsurance, then 100%

If the XL buy-up option is selected, see page 6 for coverage details.

Surgery and Anesthesiology Fee

Deductible, coinsurance, then 100%

Routine Vision Exam

$10 copay, then 100%

Inpatient and Outpatient Facility Charges

Deductible, coinsurance, then 100%

Physician Inpatient Hospital Visit

Deductible, coinsurance, then 100%

Emergency Room Charges

$100 copay, deductible, coinsurance, then 100%

Copay is waived if immediately confined. Copay applies to both network and non-network emergency room charges.

Ambulance (air and ground)

Deductible, coinsurance, then 100%

Prescription Drug

Drug discount program

Drug discount program is not an insurance benefit.

Prescription Drug Coverage Options

Choose from these deductibles; **$0, $500 or $1,000, then the following coverage applies:**

Retail		Mail Order	
Generic drug	**Brand name**	**Generic drug**	**Brand name**
$15 copay; 30-day supply	50% coinsurance; 30-day supply	$30 copay; 90-day supply	$60 copay; 90-day supply

When generic is available and you choose brand, you pay the difference between the two. If selected, separate prescription drug deductibles and coinsurance levels are per person, per calendar year.

Insurance plans provide only limited benefits for services provided by non-network providers. Services received from non-network providers are subject to a separate non-network deductible, which is double the amount of the network deductible amount, and a separate coinsurance. Network/non-network coinsurance amounts are as follows: 100%/70%, 80%/50%, and 50%/50%. Refer to the state variation pages in the back of this brochure for coinsurance variations that may otherwise apply.

Note: Classic Benefit plans (Non-PPO) are also available. Premiums may be higher than PPO plans.

MedOne *Security* (Not available in Pennsylvania)

Choosing a MedOne Security Plan Design

MedOne Security provides you the coverage for emergencies and major illnesses or injuries while limiting your premium amount.

1. Carefully review each of the MedOne Security PPO Facility Copay plan designs listed below. Choose either the 100%, 80%, or 50% option.
2. After you select your plan design, choose an office visit copay and network deductible amount.
3. Select optional benefits such as dental insurance or prescription drug coverage to enhance your plan. See page 14 and 15 for more information.

	PPO Facility Copay Plan		
Features	100% Option	80% Option	50% Option
Lifetime Maximum			
Per insured	$5 Million	$5 Million	$5 Million
Office Visit Copay Options			
A fixed fee that you pay toward network office visit charges. When no copay (none) is selected, or when a non-network provider is used, charges for the office visit are payable after deductible and coinsurance.	☐ $40 ☐ None	☐ $30 ☐ $40 ☐ None	☐ $30 ☐ $40 ☐ None
Deductible Options			
The amount of covered expenses you pay each calendar year before benefits are paid under the insurance Policy.	Network ☐ $ 5,000 ☐ $ 7,500 ☐ $10,000	Network ☐ $ 1,000 ☐ $ 1,500 ☐ $ 2,000 ☐ $ 4,000 ☐ $ 5,000* ☐ $ 7,500* ☐ $10,000* *Not available with $30 copay.	Network ☐ $ 1,000 ☐ $ 1,500 ☐ $ 2,000 ☐ $ 4,000 ☐ $ 5,000* ☐ $ 7,500* ☐ $10,000* *Not available with $30 copay.
Inpatient/Outpatient Facility Charges			
The facility copays apply to both Network and Non-network facility charges.	$500 inpatient copay and $250 outpatient copay, deductible, coinsurance, then 100% when choosing deductible options from $1,000-$4,000. -OR- $1,000 inpatient copay and $500 outpatient copay, deductible, coinsurance, then 100% when choosing deductible options from $5,000-$10,000.		
Coinsurance Options			
The level of coverage for eligible expenses provided by the insurance plan after the calendar year deductible is satisfied.	Network 100%	Network 80% of $10,000	Network 50%** of $8,000 **Not available with all networks or in all states.
Individual Out-of-Pocket Maximum			
The maximum amount you pay per calendar year for covered expenses, plus your selected deductible. See example on page 16.	$0	$2,000	$4,000

Insurance plans provide only limited benefits for services provided by non-network providers. Services received from non-network providers are subject to a separate non-network deductible, which is double the amount of the network deductible amount, and a separate coinsurance. Network/non-network coinsurance amounts are as follows: 100%/70%, 80%/50%, and 50%/50%. Refer to the state variation pages in the back of this brochure for coinsurance variations that may otherwise apply.

The Following Coverage Applies to 100%, 80%, and 50% Options

Physician Office Visit

Network Office Visit
Copay then 100%

When no copay (none) is selected, charges for the office visit are payable after deductible then coinsurance, then 100%.

Wellness Benefit

Network Office Visit
Copay then 100%

Network X-ray/lab
(PSA, Pap smear, and mammogram)
Deductible, coinsurance, then 100%

When no copay (none) is selected, charges for the office visit are payable after deductible, coinsurance, then 100%. Routine non-network charges are not covered unless mandated in your state. Please refer to the state variations for details.

Radiology (X-ray) Test/Pathology (lab) Test

Deductible, coinsurance, then 100%

Surgery and Anesthesiology Fee

Deductible, coinsurance, then 100%

Routine Vision Exam

$10 copay, then 100%

Physician Inpatient Hospital Visit

Deductible, coinsurance, then 100%

Emergency Room Charges

$100 copay, deductible, coinsurance, then 100%

Copay is waived if immediately confined. Copay applies to both network and non-network emergency room charges.

Ambulance (air and ground)

Deductible, coinsurance, then 100%

Prescription Drug

Drug discount program

Drug discount program is not an insurance benefit.

Prescription Drug Coverage Options

Choose from these deductibles; **$0, $500 or $1,000, then the following coverage applies:**

Retail		Mail Order	
Generic drug	**Brand name**	**Generic drug**	**Brand name**
$15 copay; 30-day supply	50% coinsurance; 30-day supply	$30 copay; 90-day supply	$60 copay; 90-day supply

When generic is available and you choose brand, you pay the difference between the two. If selected, separate prescription drug deductibles and coinsurance levels are per person, per calendar year.

Insurance plans provide only limited benefits for services provided by non-network providers. Services received from non-network providers are subject to a separate non-network deductible, which is double the amount of the network deductible amount, and a separate coinsurance. Network/non-network coinsurance amounts are as follows: 100%/70%, 80%/50%, and 50%/50%. Refer to the state variation pages in the back of this brochure for coinsurance variations that may otherwise apply.

An Alternative Approach to Funding Health-Care Costs for Individuals

The cost for health care and health insurance has risen in recent years. As a result, individuals are looking for solutions. And AMS has a health insurance solution that can help individuals and families.

Many individuals prefer a health insurance plan with lower premiums. They want protection from financial losses that may result from a hospitalization or other catastrophic event but are willing to pay expenses for less serious medical services. Pairing a tax-preferred federal health savings account (HSA)* with a high-deductible health plan (HDHP) may be the answer.

What Is a Health Savings Account (HSA)?

An HSA is a federal tax-deductible savings account set up at a financial institution to save money exclusively for payment of qualified medical expenses. This account must be used in conjunction with a high-deductible health plan that meets government requirements.

What Is a High-Deductible Health Plan (HDHP)?

An HDHP has a higher calendar-year deductible than typical health insurance plans and has a maximum limit on the annual out-of-pocket amount for covered expenses. These amounts are determined by the federal government. They follow the Department of Labor's Consumer Price Index and may change from year to year.

About HDHPs

HDHPs must meet federal guidelines. For 2006, the deductible must be at least $1,050 for individual coverage and $2,100 for family coverage.

Those with family coverage meet a family deductible, and eligible expenses for all family members contribute to that deductible. When the family calendar-year deductible is met by any combination of family members, the insurance plan pays benefits for the entire family.

HDHPs also have maximum limits on the annual out-of-pocket amounts for covered expenses. The amounts paid to meet the deductible are applied to the maximum out-of-pocket amounts.

MedOne HSAvings*

AMS has designed MedOne HSAvings to meet federal government HDHP requirements. The broad selection of available deductibles and coinsurance levels allows you to find a plan design that fits your budget needs. Best of all, there are no copays. Optional benefits include routine wellness, dental, and prescription drug buy-ups.

** Both the family and individual deductible plans have been designed to meet the HSA high-deductible health plan requirements of Federal Law (26 U.S.C. Sec. 223). This law contains several requirements regarding the tax deductibility of HSAs. Please consult with a tax and legal adviser to determine whether the HSA will qualify as tax deductible. HSAs are not insurance and are administered by other financial institutions.*

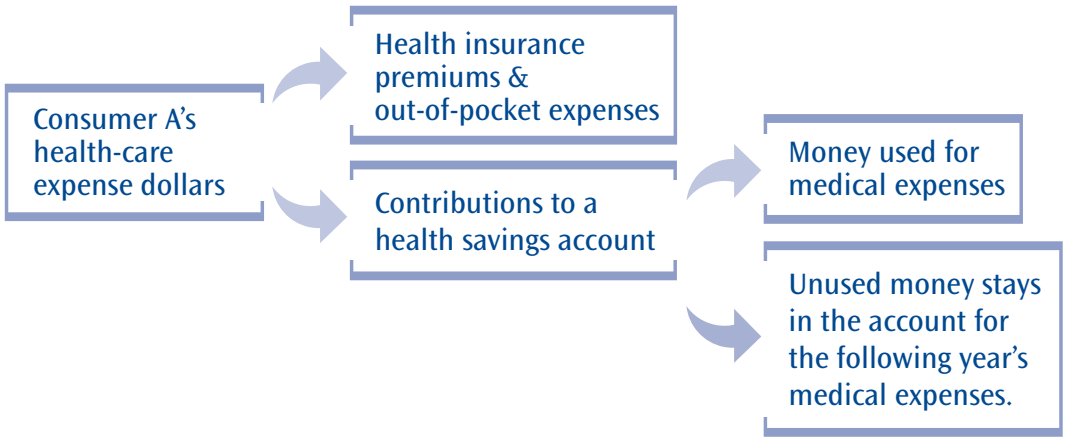
How To Take Advantage of an HSA

1. *Obtain a MedOne HSAvings plan.*
2. *Set up an HSA with a financial institution.*
3. *Contribute to the HSA.*
4. *Use HSA dollars to pay for qualified medical expenses.*
5. *Realize tax savings when computing taxable income on tax returns.*

How It Works

Health Plan with an HSA

When an HSA is used together with an HDHP, health-care expense dollars are split between health insurance and the HSA. The HSA owner decides the amount to deposit in the HSA. At the end of the year, any money that hasn't been used can remain in the HSA for the following year's medical expenses. The following diagram illustrates the benefits of an HSA.



Health Plan without an HSA

Without an HSA, health-care expense dollars go entirely to health insurance.

HSA Contributions and Withdrawals

Contributions. The amount an individual or family may contribute to the HSA is determined by the federal government and may change. The 2006 yearly limits are set at the amount equal to the insurance plan's deductible or $2,700 for individual coverage and $5,450 for family coverage, whichever is less.

Contributions can be made for any full calendar month provided the HSA owner's HDHP coverage was in effect on the first day of that month. Excess contributions, if not withdrawn, may be taxed at the owner's current tax rate plus an excise tax of 6%.

Withdrawals. The HSA owner decides where to spend HSA health-care dollars within guidelines established by the federal government. Visits to physician offices, dental care, nursing care, psychiatric care, and chiropractic care are examples of eligible expenses listed in IRS Publication 502, which is available at the IRS Web site, www.irs.gov.

If funds are withdrawn for unqualified expenses, those funds can't be deducted from taxable income, and, if the HSA owner is under the age of Medicare eligibility, a 10% penalty may apply. Cosmetic surgery, nutritional supplements, and childcare are examples of unqualified expenses. The HSA owner is responsible for determining if an expense qualifies according to federal government rules and can be paid with HSA funds.

HSA Eligibility

Anyone who has an HDHP and meets government requirements may open an HSA. MedOne HSAvings is designed by AMS to meet these requirements.

HSA Tax Advantages

Tax-deductible. *Qualified contributions to the HSA are 100% tax-deductible.*

Tax-free. *Qualified medical expense withdrawals are tax-free. Dollars can be used to pay for items not usually covered by health insurance, such as eyeglasses, dental care, and much more, as specified by IRS Code 213(d).*

Tax-deferred. *Accumulated interest earnings are tax-deferred. Savings not used accumulate year after year and may be used to fund retirement needs at age 65.*

Family Deductible Plan

Your lifetime maximum per covered person is $5 million.

	Deductible Options	Coinsurance Options
100% Option	**Network**	**Network**
	☐ $ 2,500 ☐ $ 3,000 ☐ $ 4,000 ☐ $ 5,000 ☐ $ 5,500 ☐ $ 6,000 ☐ $ 7,500 ☐ $10,000	100%
80% Option	**Network**	**Network**
		80% of
	☐ $ 2,500	☐ $10,000 ☐ $20,000 ☐ $30,000
	☐ $ 3,000	☐ $10,000 ☐ $20,000 ☐ $30,000
	☐ $ 4,000	☐ $10,000 ☐ $20,000 ☐ $30,000
	☐ $ 5,000	☐ $10,000 ☐ $20,000
	☐ $ 5,500	☐ $10,000 ☐ $20,000
	☐ $ 6,000	☐ $10,000 ☐ $20,000
	☐ $ 7,500	☐ $10,000
50% Option*	**Network**	**Network**
		50% of
	☐ $ 2,500	☐ $ 5,000 ☐ $10,000 ☐ $15,000
	☐ $ 3,000	☐ $ 5,000 ☐ $10,000
	☐ $ 4,000	☐ $ 5,000 ☐ $10,000
	☐ $ 5,000	☐ $ 5,000 ☐ $10,000
	☐ $ 5,500	☐ $ 5,000
	☐ $ 6,000	☐ $ 5,000
	☐ $ 7,500	☐ $ 5,000

*Not available with all networks or in all states.

Choosing a MedOne HSAvings Plan Design

MedOne HSAvings provides you with the possibility of tax savings when paired with a health savings account (HSA).

1. Carefully review each of the MedOne HSAvings plan designs listed (family options on page 12 and individual options on page 13). Choose either the 100%, 80%, or 50% option.
2. After you select your plan design, choose a network deductible amount, then a network coinsurance amount.
3. Select an optional benefit such as dental insurance or prescription drug coverage to enhance your plan. See page 14 and 15 for more information.

To determine your out-of-pocket maximum, add your selected deductible to your coinsurance option. See example on page 16.

Family Aggregate Deductible

Eligible expenses for covered family members contribute to meeting the family deductible. When the family deductible is met by any combination of family members, the insurance plan pays benefits for the entire family.

Insurance plans provide only limited benefits for services provided by non-network providers. Services received from non-network providers are subject to a separate non-network deductible, which is double the amount of the network deductible amount, and a separate coinsurance. Network/non-network coinsurance amounts are as follows: 100%/70%, 80%/60%, and 50%/50%. Refer to the state variation pages in the back of this brochure for coinsurance variations that may otherwise apply.
Note: Classic Family Benefit plans (Non-PPO) are also available. Premiums may be higher than PPO plans.

Individual Deductible Plan

Your lifetime maximum per covered person is $5 million.

100% Option

Deductible Options — Network	Coinsurance Options — Network
☐ $ 1,500	100%
☐ $ 2,000	
☐ $ 2,500	
☐ $ 2,800	
☐ $ 3,000	
☐ $ 3,500	
☐ $ 4,000	
☐ $ 5,000	

80% Option

Deductible Options — Network	Coinsurance Options — Network
	80% of
☐ $ 1,500	☐ $ 5,000 ☐ $10,000 ☐ $15,000
☐ $ 2,000	☐ $ 5,000 ☐ $10,000 ☐ $15,000
☐ $ 2,500	☐ $ 5,000 ☐ $10,000
☐ $ 2,800	☐ $ 5,000 ☐ $10,000
☐ $ 3,000	☐ $ 5,000 ☐ $10,000
☐ $ 3,500	☐ $ 5,000 ☐ $10,000
☐ $ 4,000	☐ $ 5,000

50% Option*

Deductible Options — Network	Coinsurance Options — Network
	50% of
☐ $ 1,500	☐ $5,000
☐ $ 2,000	☐ $5,000
☐ $ 2,500	☐ $5,000
☐ $ 2,800	☐ $5,000

*Not available with all networks or in all states.

Individual and Family Wellness

This option pays 100% to $300 per covered person, per calendar year. See page 14 for details.

To determine your out-of-pocket maximum, add your selected deductible to your coinsurance option. See example on page 16.

Covered Expenses Apply to Both Family and Individual Deductible Plans

Physician Services
- Professional fees
- Inpatient and outpatient services
- Emergency room services

Wellness (Routine) Benefit
(Eligible only when received from a network provider unless otherwise mandated)
- Physical exams
- Pap smears
- Prostate screening
- Mammograms
- Lab and X-ray

Pathology (lab) and Radiology (X-ray) Tests
- Diagnostic
- MRI and CAT scans

Surgery and Anesthesiology Fee
- Inpatient and outpatient

Hospital and Facility Services
- Inpatient and outpatient care
- Diagnostic tests, lab, and X-ray
- Emergency room and urgent care

Complications of Pregnancy

Transplants

Ambulance
- Ground and air transportation

Skilled Nursing Care
- 30 days per calendar year

Home Health Care
- 20 visits per calendar year

All eligible services are subject to deductible, then coinsurance to the out-of-pocket maximum, then 100%.

Insurance plans provide only limited benefits for services provided by non-network providers. Services received from non-network providers are subject to a separate non-network deductible, which is double the amount of the network deductible amount, and a separate coinsurance. Network/non-network coinsurance amounts are as follows: 100%/70%, 80%/60%, and 50%/50%. Refer to the state variation pages in the back of this brochure for coinsurance variations that may otherwise apply.
Note: Classic Individual Benefit plans (Non-PPO) are also available. Premiums may be higher than PPO plans.

Additional Plan Information

Optional Benefits

The following optional benefits, and those which were discussed on the previous grid pages, are available at an additional cost.

XL (X-ray and Lab) Option (MedOne Plus)

The XL Option pays 100% to $150 per covered person, per calendar year for network routine and non-routine x-rays and laboratory tests. Eligible x-ray and lab charges in excess of the XL benefit are covered subject to your selected deductible and coinsurance, then 100%. This benefit applies to services performed in a physician's office setting. The XL Option is available when you choose a plan design with a $30 or $40 office visit copay.

Prescription Drug Coverage Options (MedOne Plus, MedOne Security)

The prescription drug coverage options provide benefits for covered expenses including the generic version of a prescription drug or the brand-name drug if no generic exists. The coverage options include a separate $0, $500, or $1000 prescription drug deductible then applicable copayment or coinsurance for covered generic and brand name drugs. (For description of benefits, see chart.)

Choose from the following deductibles; $0, $500 or $1,000, then the following benefits apply:

Retail	
Generic drug	**Brand name**
$15 copay; 30-day supply	50% coinsurance; 30-day supply

Mail Order	
Generic drug	**Brand name**
$30 copay; 90-day supply	$60 copay; 90-day supply

Prescription Drug Coverage Option (HSAvings)

When purchasing the Prescription Drug Coverage Option, your eligible prescription drug expenses apply to your medical deductible and coinsurance. When using a member pharmacy you receive prescription drugs at a reduced cost. You pay the reduced cost at the member pharmacy and they will either submit the information to us electronically or give you a receipt so you can submit it to us. Prescriptions purchased at a non-member pharmacy are not eligible for a reduced cost. However, eligible charges will apply to your non-network medical deductible and coinsurance when you submit your receipt to us. Once the deductible is satisfied for either network or non-network, the medical coinsurance level will cover your prescriptions.

Wellness (Routine) Option (HSAvings)

The Wellness (Routine) Option pays 100% up to $300 per covered person, per calendar year for network routine physical exams, X-rays and laboratory tests, mammograms, Pap smears, and prostate screenings. Eligible charges in excess of the Wellness (Routine) Option benefit are subject to normal insurance plan benefits. This benefit does not apply to services received in a hospital setting.

This Wellness (Routine) Option is not available with the Classic MedOne HSAvings Plans.

Supplemental Accident Benefit

The Supplemental Accident Benefit (SAB) provides first-dollar coverage for each accidental injury ($300 for MedOne Plus and MedOne Security, $500 or $1000 for MedOne HSAvings). SAB benefits are payable the same whether a network or a non-network provider is seen. Depending on your plan design, you can choose from a maximum of $300, $500 or $1,000 per occurrence with covered expenses payable at 100%, and remaining charges subject to copayments, deductibles, and/or coinsurance. The initial treatment must be received within 72 hours of the accident or injury, and the claim for expenses must be received within 90 days of the accident or injury.

Optional Dental Insurance for Individuals

Combining the Optional Dental insurance with your MedOne health insurance plan gives you a more comprehensive coverage package. When elected, Optional Dental replaces the CAREINGTON International Discount Dental Program. Optional Dental gives you some of the same coverages as employer-based dental insurance programs.

Optional Dental coverage is available only at the time a MedOne health insurance plan is applied for or up to 45 days after the application is signed.

Waiting Period Information—Waiting periods apply from the original effective date of Optional Dental coverage. (See chart). Credit for coverage with a prior carrier is not applicable to the waiting periods. A waiting period is the period of time before the insured is eligible for benefits under the Policy.

Optional Dental Services	Coverage	Waiting Period
Calendar Year Deductible	$50 per person (3 per family max.)	N/A
Calendar Year Maximum	$750 per person	N/A
Preventive Oral evaluations and cleanings (twice per calendar year). Topical fluoride treatments (for dependent children to age 16).	80% of eligible expenses (after deductible)	No waiting period
Basic Services X-rays; sealants for dependent children (to age 16); nonsurgical extractions; simple restorative services; stainless steel crowns on primary teeth; repair of crowns, inlays, bridgework, or dentures.	60% of eligible expenses (after deductible)	6-month waiting period
Major Services Endodontics; periodontics; crowns, inlays, onlays, and veneers; oral surgery; dentures, bridges, and partials.	50% of eligible expenses (after deductible)	18-month waiting period

Voluntary Term Life and AD&D Insurance

Protect your family against financial misfortune caused by death or accidental dismemberment by purchasing one of our optional Term Life and AD&D Insurance benefit levels—to $300,000 of coverage is available (subject to underwriting approval).

Voluntary Dependent Term Life Insurance

This Dependent Term Life Insurance option provides additional security in case of the death of a family member (spouse, child age 14 days to 19 years, or a child who's a full-time student until age 25). Dependent Term Life coverages are available only to dependent family members covered on the health insurance plan. (See chart).

Voluntary Dependent Term Life Amounts

Spouse Age/Amount Chart:

Age	Amount
0-40	$7,500
41-50	$6,000
51-55	$4,500
56-60	$3,000
61-64	$1,500
65+	None

Dependent Child: $5,000 for each covered dependent child age 14 days to 19 years, or if a full-time student, until age 25.

Term Life and AD&D, and Dependent Term Life Insurance are group products available to individuals.

Covered Expenses

Benefits are subject to applicable copayment, deductible, coinsurance, and maximum allowable charges. All benefits for services are subject to Policy provisions.

Maximum Allowable Charge

We use a number of national standards to determine maximum amounts payable for medical services. If charges from a non-network provider are above these maximum amounts, the insured person may be subject to additional charges (above copays and coinsurance).

Physician Visit Charges

Covered services include physician office visits.

Other Medical Professional Charges

Covered services include physician hospital visits; non-routine injections and injectable drugs; and physical, respiratory, and occupational therapy.

Wellness Benefit

Routine services are available to each covered person as described on the product features pages.

Services are not covered when using a Classic Benefit Plan or if they are being done for employment, school, travel, buying insurance, marriage, or family planning.

Other Covered Expenses

Covered services include radiology and pathology tests and prescription drug benefits (if a Prescription Drug Coverage option is purchased).

Surgery and Anesthesiology Charges

Covered services include surgery, anesthesiology, post-operative care, and oral surgery performed in a physician's office or in a hospital as an inpatient or outpatient

Vision Exam

Coverage includes one comprehensive eye exam every 12 months including refraction. Benefits are payable at 100% after a $10 copay when services are received from a vision benefit network provider.

Benefits are payable to a maximum of $38 after a $10 copay when services are rendered by a vision benefit non-network provider.

Note: The vision benefit network is separate from the medical network if a PPO insurance plan is chosen.

Hospital and Other Facility Charges

Covered services include semi-private room and board, intensive care, and other facility charges, such as inpatient and outpatient care and emergency room fees.

Complications of Pregnancy

Complications of pregnancy are covered the same as any sickness for any insured female. Complications do not include expense for normal pregnancy and childbirth.

Newborns

Coverage is included for a newborn or sick baby for 31 days from birth. It includes surgery and treatment of injury, sickness, birth defects, and medically necessary treatment for cleft lip and cleft palate. To continue coverage, an application form must be received by AMS within 31 days from the date of birth. An additional premium may be required.

Home Health Care

Covered services include part-time physical, respiratory, occupational, and speech therapy and part-time or intermittent skilled home care and health aide services. Covered to 20 visits per calendar year.

Skilled Nursing Care

Includes coverage for room, board, routine services, and skilled nursing care for 30 days per calendar year.

Hospice Care

Part-time nursing care and home health aide services are included to eight hours a day. Physical therapy, services, supplies, prescription drugs, and case management are also included.

Transplants

When using the Transplant Provider Network, eligible services are covered at 100% after a $5,000 copay per transplant (or your deductible for MedOne HSAvings) to a $1 million lifetime maximum. Outside the Transplant Provider Network, eligible services are covered at 70% after a $10,000 copay per transplant (or your deductible for MedOne HSAvings) to a lifetime maximum of $250,000. Transplant benefits are combined to a total maximum of $1,000,000 per lifetime, per insured. (Copays do not track to the insurance plan's total out-of-pocket maximum.)

When the covered transplant patient travels more than 100 miles from home to use the Transplant Provider Network, the insurance plan provides a $5,000 lifetime maximum per insured travel benefit. This lifetime maximum covers travel, food, and lodging for the patient and one companion (not available with MedOne HSAvings).

Covered services include the transplant of kidney, liver, pancreas, heart, lung, kidney/pancreas, heart/lung, allogenic bone marrow, autologous bone marrow, stem cell, and donor expenses as defined in the Policy. Subject to prior approval. Artificial organs are not covered.

Note: The transplant provider network is separate from the medical network if a PPO insurance plan is chosen.

Billing Options

With MedOne insurance plans, you have the option of annual, semiannual, or quarterly direct billing. Monthly and other mode of payments can be made by automatic bank draft withdrawals or list billing.* Credit cards (VISA® or MasterCard®) will also be accepted for the first month premium only.

** List Bill is not available in all states, check with your sales representative for details.*

Out-Of-Pocket Maximum (MedOne Plus, MedOne Security)

The out-of-pocket maximum is a specific limit on the amount of covered expenses you pay per calendar year. When an individual out-of-pocket maximum level has been reached, you no longer pay medical deductible or coinsurance for that individual for the remainder of that calendar year. The family out-of-pocket maximum is twice the individual amount.

To reach a family medical deductible maximum, two members of your family must each meet an individual deductible. Once the family out-of-pocket maximum is met, no additional medical deductible or coinsurance will be taken for any family member for the remainder of that calendar year.

Non-network medical deductibles and coinsurance amounts credit toward both the network and non-network out-of-pocket maximums. The network medical deductible and coinsurance apply only to the network out-of-pocket maximum. Copays do not apply toward out-of-pocket maximums and are collected before and after the out-of-pocket maximums have been met.

Example of how to calculate your out-of-pocket maximum: The deductible ($5,000) + 20% (your portion) of $10,000 = $5,000 + $2,000 = $7,000 out-of-pocket maximum.

Refer to the product features pages for network and non-network information.

Out-Of-Pocket Maximum (MedOne HSAvings)*

The out-of-pocket maximum is a specific limit on the amount of covered expenses you pay per calendar year. When an individual out-of-pocket maximum level has been reached, that individual no longer pays medical deductible or coinsurance for the remainder of that calendar year. Covered out-of-pocket expenses for all family members contribute to meeting the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, none of the family members pay medical deductible or coinsurance for the remainder of that calendar year.

Non-network medical deductibles and coinsurance amounts credit toward both the network and non-network out-of-pocket maximums. The network deductible and coinsurance apply only to the network out-of-pocket maximum.

Example of how to calculate your out-of-pocket maximum: The individual deductible ($3,500) + 20% (your portion) of $10,000 = $3,500 + $2,000 = $5,500 out-of-pocket maximum.

Refer to the product features pages for network and non-network information.

** This insurance plan's deductible and out-of-pocket levels are intended to satisfy government rules applicable to HDHPs. The rules may change annually. Deductible and out-of-pocket levels may be adjusted at the beginning of each year to stay within these rules. We'll notify you of any changes as soon as reasonably possible.*

Insurance Plan Provisions

Pre-existing Condition Limitation

Medical insurance plans include a pre-existing condition limitation of 12/12/12 unless otherwise indicated under state variations.

A pre-existing condition means (1) a condition for which a person received medical care, treatment, services, medication, diagnosis, or consultation 12 months before the insured person's effective date of coverage or (2) a condition that produced symptoms that are distinct and significant enough to establish the onset of a condition or that the condition manifested itself, where a person learned in medicine would be able to diagnose the condition because of those symptoms, or where the symptoms would cause an ordinarily prudent person to seek diagnosis or treatment. Pre-existing conditions are covered after a period of 12 months, during which time the person has been continuously covered under the Policy.

We will waive the pre-existing limitation for conditions that are fully and completely disclosed on the application; however, we may place an exclusion or impairment rider on a certain condition(s).

Rating and Renewability

Premium rates are calculated based on a variety of factors. As allowed by state law, these factors may include geographic location, provider network, distribution channels, selected benefits, age, gender, tobacco use, classes, health status of you and your insured dependents, the length of time you are insured under the insurance plan, health status of the entire pool of insureds in which you are included, administrative costs, and other factors. Your initial premium rates are guaranteed for the first 12 months of coverage providing you maintain residence in the same geographic location. Thereafter, we reserve the right to periodically adjust the premium rates charged for your coverage under the Policy. We will provide you with advance written notice a minimum of 30 days prior to the effective date of a premium change, unless state law requires additional notice.

Premiums may also change on the next premium due after the date when:

- You or your insured dependent attain a higher age;
- A dependent is added to or terminated from the insurance plan; or
- Any benefit is changed, including but not limited to, increases or decreases in a benefit, or the addition or removal of a benefit from the insurance plan.

If a premium change is for one of the reasons stated above, we will notify you as soon as possible about the change. If we find that premiums are incorrect, we will:

- Make a refund to you for any amount of overpaid premiums; or
- Request payment from you for any amount of underpaid premiums.

We reserve the right to adjust administrative and/or service fees. We will notify you prior to any change. Coverage is guaranteed renewable except when:

- Premium was due and not paid.
- We determine fraud or material misrepresentation under the terms of the contract.
- We do not renew all insurance plans with the same type and level of benefits in the state.
- We no longer sell similar health coverage in a given state.
- You or your dependents no longer reside in the network service area, if covered by a network insurance plan.
- You move to a state where, by law, we are not licensed to do business.
- The group Policy terminates.

You may terminate insurance at any time by providing us written notice prior to the requested termination date. The termination date will be the first of the month. Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) requires various changes to individual health insurance plans. In some states, the insurer must guarantee issue such insurance plans to eligible persons who lose coverage under a prior group health plan. Such persons are not required to satisfy another pre-existing condition limitation. The new insurer may require copies of a Certificate of Creditable Coverage to determine how to apply the pre-existing condition limitation. Eligible individuals are guarantee issue to a state sponsored (risk pool) plan.

An eligible individual means a person who meets all of the following requirements:

- Has a total of 18 of more months of continuous creditable coverage.
- Most recent prior creditable coverage was under a group health plan, and the group health plan was not terminated for fraud or intentional misrepresentation of material fact.
- Most recent prior creditable coverage was not terminated for nonpayment of premium by the individual.
- Is not eligible for coverage under Medicare or Medicaid.
- Has elected continuation coverage under COBRA or a similar state program, and has exhausted or will soon exhaust this coverage.
- Is not covered by another plan.
- Has had less than a 63-day break in coverage from the most recent group plan.

Creditable coverage includes health insurance coverage and other health coverage, such as coverage under other group health plans, short-term medical coverage, Medicaid, Medicare, military-sponsored health care, and similar plans. Creditable coverage does not include accident-only coverage, long-term care coverage, liability or workers' compensation insurance, automobile medical payment insurance, or other similar insurance.

Reinstatement of Coverage

If your coverage has lapsed for nonpayment of premium, you may be able to apply for reinstatement of coverage (not available in all states). If your coverage lapses and reinstatement is available in your state, you'll receive information about how the process works. Reinstatement is not guaranteed.

Excess/Subrogation/Right of Reimbursement

We do not pay benefits when other insurance also pays for the same medical expenses. We subrogate to the extent of our payment when a party causes or is liable to pay for our insured party's injury or sickness. Insureds are required to repay us from any settlement, judgment, or any other payment received from any other source.

Precertification Penalty

Certain procedures that you or your doctor do not precertify with us are subject to a penalty of 10% of covered eligible charges to a maximum of $1,000 per confinement, procedure, or occurrence.

Limitation and Exclusions

Please read carefully.

Medical

No medical insurance coverage is provided for any of the following unless specified elsewhere as a covered benefit for:

Alcoholism, drug abuse, mental or nervous disorders • Any treatment or supply for hair loss or growth • Any weight loss method • Attempted suicide or intentional self-inflicted injury or sickness while sane or insane • Blood products replaced by donation or blood storage except for scheduled surgery • Bony protuberances or misalignment of forefoot and toes including bunions, spurs, and hammertoe • Care provided by a family member or by a person residing with you • Cesarean-section delivery • Civil or criminal battery or felony • Cost of brand-name drugs in excess of the cost of generic drugs • Cost to rent durable medical equipment that exceeds the cost to purchase the item • Custodial care • Dental surgery except as defined under the Policy • Dental treatment from chewing injury or dental implants • Drugs obtainable without a written prescription •Emergency room treatment if no emergency exists • Exams, x-rays, and tests for routine physicals when using a non-network provider or if exams, x-rays, and tests are being done for employment, school, travel, buying insurance, marriage, or family planning • Expense for which no benefit is described • Experimental or investigative procedures, devices, or drugs • Eye exams, eyeglasses, contact lenses, or surgery to improve eyesight • Hearing aids or exams • Hospital costs for admission from 8 a.m. Friday to 11:59 Sunday except for an emergency or scheduled surgery • Immunizations • Items used only for comfort such as a humidifier • Learning disabilities or developmental disorders, testing or training for education or vocation, vision therapy, or

speech therapy except for injury or functional defect • Marriage, family, or sex counseling • Multiple surgeries done at the same time; secondary procedures are covered up to one-half the cost of each additional procedure • Normal pregnancy • On-the-job injury or sickness for you and your spouse unless enrolled and approved by us for the On-the-Job Protection Benefit • Orthognathic reconstructive surgery • Plastic or cosmetic surgery unless for reconstruction caused by a covered injury, sickness, or mastectomy • Pre-admission testing in a hospital not done within seven days before scheduled admission • Pre-existing conditions • Prescription drug charges except in hospital or hospice, unless the prescription drug rider is purchased • Private duty nursing • Riot • Routine injection of drugs • Sclerotherapy for varicose veins • Services and supplies furnished by a government plan, hospital, or institution unless by law you must pay • Services and supplies not medically necessary, not recommended/approved by a doctor, or not provided within the scope of a doctor's license • Services or supplies charged in excess of the maximum allowable charge • Services or supplies provided by your employer or provided after insurance terminates • Services or supplies provided free of charge • Sex change operations and complications; testing and treatment for impotency or infertility; any treatment, procedure, drug, or device to prevent or promote conception • Skilled nursing facility confinement beyond 30 days per calendar year • Sterilization • Strained or flat feet; instability or imbalance of feet or ankles; orthopedic shoes or supplies; cutting or removal of corns, calluses, or toenails except for diabetes or similar disease • Therapeutic restoration of nerve system and body structures by manipulation and treatment of human body structures including the spine • TMJ and related disorders • Treatment of the following conditions during the first six months you are insured by the Policy: hemorrhoids, hernia, tonsillectomy or adenoidectomy (except covered for an emergency), and varicose veins • Treatment outside of the U.S. except for an emergency • War or military service • Well baby care.

Accidental Death & Dismemberment

No accidental death and dismemberment benefit is payable for loss resulting from:

Air travel or flight except as fare-paying passenger • Committing or attempting to commit civil or criminal battery or felony • Driving while legally intoxicated or while using non-prescribed drugs • On-the-job injury or sickness • Participating in a riot • Sickness unless a direct result of covered injury or from accidental ingestion of a contaminated substance • Suicide or intentional self-inflicted injury or sickness • Voluntary taking of sedative, drug, or inhaling gas unless prescribed or administered by a doctor • War or military service.

Dental

The following dental expenses are not covered:

Any dental supplies including, but not limited to take-home fluoride, prescription drugs and nonprescription drugs • Any dental procedures for which benefits are payable under the medical insurance provision of the certificate • Athletic mouth guards • Attempted suicide or intentionally self-inflicted injury while sane or insane • Broken appointments • Changing vertical dimension, restoring occlusion, bite registration, or bite analysis • Charges for dental services that are not documented in the dentist's records • Correcting congenital malformation • Cosmetic procedures • Cost to complete claim forms • Dental implants and related services • Dental treatment, appliance, or device related to periodontal splinting, correction of abrasion, erosion, attrition, abfraction, bruxism, or desensitizing of teeth that can be restored by other means • Diagnostic casts • Due to your participation in a riot or committing a felony • Duplicate dentures • Engaging in an illegal occupation • Expenses incurred during a waiting period • For services incurred prior to you and your covered dependent's effective date under the Policy • Gold foil restorations • Harmful habit appliances • Hospital and related anesthesia charges • Initial placement of full or partial dentures, or bridges, to replace natural teeth lost before the effective date of insurance • Lab procedures • Local anesthesia • Myofunctional therapy • Occurring during or arising from your course of occupation or employment • Occlusal guards • Oral hygiene instruction • Orthodontia • Orthognathic surgery • Participating in a professional or semi-professional contest for compensation, wage or salary • Photographs • Physical therapy • Plaque control • Precision or semi-precision attachments • Procedures not included in the classes of eligible dental expenses, not dentally necessary, not rendered or not rendered within the scope of the dentist's license • Procedures that cost in excess of the maximum allowable charge • Provided by a government plan or educational institution as allowed by law • Removal of sound functional restorations; temporary crowns and temporary prosthetics • Replacement of bridges, crowns, inlays, onlays, or veneers within seven years of the last replacement, except for loss of natural tooth • Replacement of bridges, crowns, dentures, inlays, onlays, or veneers if they can be repaired or restored • Replacement of full or partial dentures within five years of the last replacement, except for loss of natural tooth • Replacement of lost or stolen appliances or retainers • Services not incurred by the insurance termination date • Services payable by workers' compensation, whether you are eligible or are covered • Services received outside the U.S. except for emergency treatment for pain • Services rendered by a family member or someone who lives with you or provided free without insurance • Sterilization fees • Teeth that are not periodontally sound or have a questionable

prognosis as determined by us • Thermonuclear or atomic explosion or resulting exposure to radiation • Treatment of fractures, cysts, TMJ or related conditions • Treatment of halitosis and any related procedures • War or military service.

Vision

The following vision expenses are not covered:

Any eye examination, or any corrective eyewear, required by an employer as a condition of employment • Corrective surgical procedures such as, but not limited to, Radial Keratotomy, Photo-refractive Keratectomy and corneal modulation • Corrective vision treatment of an experimental or investigative nature • Medical or surgical treatment of the eyes • Orthoptics or vision therapy training and any associated supplemental testing.

State Variations

Benefits are subject to Policy provisions, applicable deductibles, benefit maximums, and maximum allowable charges unless otherwise indicated below.

Florida

- Coverage is included for a newborn for 31 days from birth, for surgery and treatment of injury, sickness, including necessary care or treatment of congenital defects, birth abnormalities or prematurity. To continue coverage, an application form must be received within 31 days from the date of birth. An additional premium may be required. Covered expenses include transportation to and from the nearest facility available to treat a newborn's condition, to $1,000. Coverage for a newborn of a covered dependent child terminates 18 months after birth.
- Mammography screening is included for covered females age 35 and over, subject to a limited schedule. Also, coverage is included for one or more mammograms per year for females at risk of breast cancer.
- Manipulative Therapy is covered the same as any sickness.
- Temporomandibular Joint Dysfunction (TMJ) is covered the same as any other joint disorder subject to plan provisions.
- Child health supervision services for covered dependent children from the moment of birth to age 16 include: physician delivered or physician supervised services which include a history, physical exam, developmental assessment, anticipatory guidance, appropriate immunizations and lab tests. There is a maximum of 18 visits per child at specified ages. Benefits are limited to one visit payable to one provider for all services provided at each visit. Services are not subject to deductible or copayment but are subject to coinsurance provisions.
- Pap Smears include cervical cancer screening same as any other sickness.
- Eligible individuals are guarantee issue to selected health plans.
- An eligible individual means a person who meets all of the following requirements: Has a total of 18 of more months of continuous creditable coverage, with less than a 63-day break from the most recent coverage. Most recent coverage was under a group plan, governmental plan, church plan; or the most recent creditable coverage was under an individual plan that terminated because the insurer became insolvent, the insurer discontinued offering all individual coverage in Florida, or for a network plan, the insured no longer lives in the Florida service area of the insurer. Has elected continuation coverage under COBRA or a similar state program, and has exhausted or will soon exhaust this coverage. Was not terminated for nonpayment of premiums, fraud, or intentional misrepresentation of material fact. Is not eligible for coverage under a group plan, health conversion policy, Medicare, or Medicaid; and does not have other health insurance coverage.
- The following are removed from Limitations & Exclusions: TMJ and related disorders; Therapeutic restoration of nerve systems and body structures by manipulation and treatment of human body structures including the spine; Immunizations and replaced with: immunizations except for children to age 16; Plastic or cosmetic surgery unless for reconstruction caused by a covered injury, sickness, or mastectomy and replaced with: plastic or cosmetic surgery unless for reconstruction caused by a covered injury, sickness, or mastectomy, only when the injury or sickness occurred while insured under the Policy.
- Specimen testing is required for all primary applicants age 18 through 59. A licensed paramedical examiner will contact you to coordinate an appointment that is convenient for you. The specimen will be tested for HIV, drugs of abuse, and tobacco use.
- Government Early Intervention Program is Payer of Last Resort. When allowed by the health insurance plan, coverage is provided for early intervention services and supplies for eligible infants and toddlers under the age of 36 months, even if a government plan, hospital, or institution furnishes the services and supplies. Government plans or program funds for qualified early intervention services and supplies are only available when the services or supplies are not otherwise covered by any other insurance plan.

Illinois

- One baseline mammogram for women 35-39 years of age, a mammogram for women under age 40 whenever it is determined to be medically necessary by a doctor and one annual mammogram for women 40 years or older.
- Physical exams, immunizations, and related services from birth to age nine. Dependent children from birth to age one are covered to $500, then $150 per calendar year thereafter for dependent children who are not yet age nine. Benefits are subject to applicable deductible, coinsurance and/or copayments.

- Colorectal cancer examinations and laboratory tests as prescribed by a physician.
- When insureds seek medical care for an emergency medical condition and cannot reasonably reach a PPO provider, charges from a non-network provider will be reimbursed at the PPO coverage level until the insured person can reasonably be expected to safely transfer to a PPO provider.
- Eligible individuals are guarantee issue to a state sponsored (risk pool) plan.
- When allowed by the health insurance plan, coverage is provided for early intervention services and supplies for eligible infants and toddlers under the age of 36 months, even if a government plan, hospital, or institution furnishes the services and supplies. Government plans or program funds for qualified early intervention services and supplies are only available when the services or supplies are not otherwise covered by any other insurance plan.

Michigan

- Substance Abuse Benefit is payable for intermediate and outpatient services for alcohol and drug abuse. Therapeutic techniques for substance abuse, include but are not limited to: chemotherapy, counseling, detoxification, and other ancillary services, same as any other sickness. The annual maximum is adjusted according to the "Consumer Price Index" and applies to the substance abuse benefit maximum.
- Physical exams, immunizations, and related services from birth to age nine. Dependent children from birth to age one are covered to $500, then $150 per calendar year thereafter for Dependent children who are not yet age nine.
- Coverage includes one baseline mammogram from age 35 through age 39; one mammogram annually from age 40 and older; or as determined Medically Necessary by a Doctor.
- Pap Smears include cervical cancer screening same as any other sickness.
- The pre-existing condition limitation is 6/12/12. An impairment rider must relate to a condition for which medical advice, diagnosis, care or treatment that was recommended or received 6 months before application and shall not extend more than 12 months following the effective date of coverage.
- Eligible individuals are guarantee issue to a carrier of last resort.
- The Excess/Subrogation/Right of Reimbursement provision is replaced with the following: We do not pay benefits when other insurance also pays for the same medical expenses, except this provision does not apply to non group contracts issued as hospital indemnity, surgical indemnity, specified disease or other non group accident and sickness policies. We subrogate if a party causes or is liable for the insured's injury or sickness and the insured receives benefits under the Policy and also recovers from other sources. We may have the right to recover payments made to the insured. Insureds are required to repay us from any settlement, judgement or any other payment received from any other source.

Missouri

- Coverage from birth to age 5. Benefits for immunization services are not subject to deductible, copayment, or coinsurance.
- Contraceptive Drugs and Devices are covered at the same benefit level as for other prescription drugs and devices, if the health insurance plan includes prescription drug coverage.
- Routine Mammograms are covered same as any other sickness. Benefits are subject to deductible and coinsurance.
- The following Medical Limitations and Exclusions is removed: Attempted suicide or intentional self-inflicted injury or sickness while sane or insane. And replaced with: Suicide or any attempt at suicide while sane, or intentionally self-inflicted injuries.
- The following Accidental Death & Dismemberment and Dental Exclusion is removed: Suicide or intentional self-inflicted injury or sickness. And replaced with: Suicide or any attempt at suicide while sane, or intentionally self-inflicted injuries.

OPTIONAL BENEFITS

Optional Benefits are available at an additional cost.

- The Chemical Dependency benefit offer includes outpatient coverage through a nonresidential treatment program, or partial or full-day program services to a maximum of 26 days per calendar year, and inpatient coverage for residential treatment programs to a maximum of 21 days per calendar year. Coverage is also provided for medical or social setting detoxification to a maximum of 10 episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation. Benefits are subject to applicable copays, deductible and coinsurance.
- The Mental Illness benefit offer provides coverage for mental health services for a recognized mental illness rendered by a licensed professional on an outpatient basis. Inpatient services are covered the same as any other illness. Inpatient hospital treatment for a recognized mental illness is covered the same as any other illness, to a maximum of 90 days per calendar year.
- The Mental Health benefit offer includes two sessions per calendar year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker for the purpose of diagnosis or assessment. These sessions are not subject to any conditions of pre-approval. Benefits are subject to applicable copays, deductible, and coinsurance.

Note: The Chemical Dependency/Mental Health/Mental Illness optional benefit offers can be elected individually or in the following combinations:
- *Chemical Dependency & Mental Illness benefit offers*
- *Chemical Dependency & Mental Health benefit offers*

Nebraska

- Non-PPO life threatening services are covered at the network benefit level to the extent necessary to screen and stabilize a covered person in connection with an emergency medical condition.
- Physical exams, immunizations, and related services from birth to age nine. Dependent children from birth to age one are covered to $500, then to $150 per calendar year thereafter for Dependent children who are not yet age nine. Benefits are subject to applicable deductible, coinsurance and/or copayments.
- Pap Smears include cervical cancer screening same as any other sickness.
- Utilization Review–Means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, providers, or facilities. You, your doctor, a hospital, or other healthcare provider on your behalf, should call the number on the back of the ID card to precertify the service or treatment with us, at least 72 hours prior to any scheduled admission or planned procedure. When receiving emergency care, please notify us by the end of the next business day following the treatment or service. You, your representative, or your provider acting on your behalf, have the right to submit a grievance pertaining to the utilization review.
- Eligible individuals are guarantee issue in a state sponsored (risk pool) plan.

Ohio

- Eligible inpatient, intermediate primary care, and outpatient services for alcoholism have a combined total per insured, per calendar year of $550.
- Physical exams, immunizations, and related services from birth to age nine. Dependent children from birth to age one are covered to $500, then to $150 per calendar year thereafter for Dependent children who are not yet age nine.
- Mammograms include one baseline mammogram from age 35 through age 39; one screening every two years (or one per year if the woman has risk factors) from ages 40-50, one screening per year from ages 50-65. Mammogram benefits are payable subject to the Medicare reimbursement rate which is subject to change.
- Pap Smears include cervical cancer screening same as any other sickness.
- The Excess/Subrogation/Right of reimbursement provision is replaced with the following: We subrogate to the extent of our payment when a party causes or is liable to pay for our insured party's injury or sickness. Insureds are required to repay us from any settlement, judgement or any other payment received from any other source.
- Eligible individuals are guarantee issue to a health plan.
- When receiving services for transplants outside of the provider network, eligible services are covered at 70% after a $10,000 copay per transplant (or your deductible for MedOne HSAvings) to a lifetime maximum of $700,000. Transplant benefits are combined to a total maximum of $1,000,000 per lifetime, per insured.

Oklahoma

- Manipulation and treatment of spine and other body structure to restore normal function of nerve system. Covered the same as any sickness.
- Mammograms are covered expenses for physician and facility services are payable at the physician office visit benefit level. The plan allows one exam age 35-39 to a maximum of $115 and one exam yearly age 40 and over at no charge to the patient, not subject to deductible, copayment, or coinsurance.
- Physical exams, immunizations, and related services from birth to age 18.
- The basic immunization services from birth to age 18 is covered; not subject to applicable deductibles, copayments, and coinsurance.
- At least one annual prostate cancer screening is provided for all men over age fifty (50) and in men over age forty (40) who are at increased risk of developing prostate cancer as determined by a physician. Benefits payable for prostate cancer screening are limited to a maximum of $65.00 per screening and are not subject to plan deductibles.
- The pre-existing condition limitation is 6/12/12.
- Voluntary Dependent Term Life option provides additional security in case of the death of a family member (spouse, child age 14 days to 21 years, or a child who is a full-time student until age 25).
- The following Limitation and Exclusion is removed: Therapeutic restoration of nerve system and body structures by manipulation and treatment of human body structures including the spine.
- When receiving services for transplants outside of the provider network, eligible services are covered at 70% after a $10,000 copay per transplant (or your deductible for MedOne HSAvings) to a lifetime maximum of $700,000. Transplant benefits are combined to a total maximum of $1,000,000 per lifetime, per insured.

Pennsylvania

- OB/GYN Annual Exams are covered expenses include pelvic exam, clinical breast exam and routine pap smear subject to applicable copay, coinsurance, and according to plan provisions; not subject to deductible or dollar amount.
- Childhood Immunizations are included for the insured, covered spouse and covered dependents to age 21; covered expenses are subject to applicable copayments and coinsurance; not subject to deductibles or dollar limits.
- We will provide benefits for an annual mammography screening for the presence of breast cancer. This benefit is provided to a female Insured Person 40 years of age or older. The benefit will be provided to a female Insured Person under age 40 when determined Medically Necessary by a Doctor. Benefits are subject to applicable copayment and deductible.
- Network/non-network coinsurance amounts are as follows: MedOne Plus 100%/80%, 80%/60% and 50%/50%; MedOne HSAvings 100%/70%, 80%/60% and 50%/50%. MedOne Security is not available.
- When receiving services for transplants outside of the provider network, eligible services are covered at 70% after a $10,000 copay per transplant (or your deductible for MedOne HSAvings) to a lifetime maximum of $250,000 for HSAvings and $800,000 for MedOne Plus. Transplant benefits are combined to a total maximum of $1,000,000 per lifetime, per insured.

South Carolina

- Complications of Pregnancy includes coverage for non-elective C-sections.
- An annual pap smear test for female insureds.
- One baseline mammogram for women between age 35-39; a mammogram every two years for women age 40 through 49; and one every year for women age 50 or older; or in accordance with the most recently published American Cancer Society guidelines.
- Prostate Cancer Exam coverage includes examinations, screenings, and laboratory work for diagnostic purposes in accordance with the most recent published guidelines of the American Cancer Society.
- Physical exams, immunizations, and related services from birth to age nine. Dependent children from birth to age one are covered to $500, then $150 per calendar year thereafter to age nine.

Wisconsin

- Nervous & Mental Health, Alcoholism, & Other Drug Abuse Benefit — Inpatient care is covered to the lesser of 30 days or 90% of $7,000 per policy year. Outpatient care is covered to 90% of $2,000 per policy year. Transitional treatment is covered to 90% of $3,000 per policy year. All benefits combined will not exceed $7,000 per policy year.
- Home care includes physical, respiratory, occupational, and speech therapy; part-time or intermittent home health aide services. Covered to 40 visits per calendar year.
- Manipulative therapy is covered same as any sickness.
- Skilled Nursing Care includes coverage for 30 days per confinement.
- Mammograms as recommended by the American Cancer Society, are provided same as any sickness.
- Temporomandibular joint dysfunction (TMJ) services are provided the same as any sickness.
- Eligible wellness benefit services are covered when using a network or non-network provider.
- Childhood immunizations are included from birth to six years of age, not subject to copayment, deductible and coinsurance.
- All medical plans include a pre-existing condition limitation period of 6/12/12.
- Eligible individuals are guarantee issue to a state sponsored (risk pool) plan.
- Newborn and adoptive children are covered for 60 days from the date of birth or placement for injury, sickness, and birth defects, whether or not family coverage is in force. For coverage to continue beyond 60 days, an application form must be completed and an additional premium may be required.
- An eligible dependent also includes a child of an unmarried dependent child until that unmarried dependent child reaches the age of 18 years.
- Grandchildren Coverage — Provides the same coverage for all children of the insured's child until the insured's child is 18 years of age.
- The Excess/Subrogation/Right of Reimbursement provision is replaced with the following: We subrogate to the extent of our payment when a party causes or is liable to pay for our insured party's injury or sickness. Insureds are required to repay us from any settlement, judgement or any other payment received from any other source. We will not recover unless the insured is made whole by the responsible party. If the insured disagrees with us about whether he/she is made whole, a decision will be made in court or arbitration.
- The following Limitation and Exclusion is removed: Experimental or investigative procedures, devices, or drugs; and replaced with: experimental or investigative procedures, devices, or drugs, except for certain drugs used to treat HIV infection.
- The following Limitations and Exclusions are removed: TMJ and related disorders; Treatment of the following conditions during the first six months you are insured by the Policy: hemorrhoids, hernia, tonsillectomy, or adenoidectomy (except covered for an emergency), and varicose veins; Therapeutic restoration of nerve system and body structures by manipulation and treatment of human body structures including the spine.

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This is an outline only and not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the Group Policy TNI1000. Applicable law will apply with respect to pre-existing condition limitations, eligibility, rating, and renewability.

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