

PLAN 80/1000

INDEMNITY SCHEDULE OF BENEFITS

Deductibles & Policy Maximums¹

Calendar Year Deductible	
Individual	\$1,000
Family maximum	\$2,000
Additional Deductibles² (per occurrence) <i>Services are subject to applicable Calendar Year Deductible, Coinsurance, and benefit maximums</i>	
Inpatient services	\$500
Outpatient surgical services	Not applicable
Emergency room services <i>(Waived if admitted)</i>	\$100
Failure to obtain Preauthorization of services <i>(Waived with Preauthorization of services)</i>	\$500
Coinsurance Maximum	
Individual	\$5,000
Family maximum	\$10,000
Your Policy Maximum While Insured	\$5,000,000

Inpatient Benefits¹

Emergency Room Services	80% of Covered Expense after satisfying the Deductible
Inpatient Alcohol, Drug or Other Substance Abuse Detoxification³	80% of Covered Expense after satisfying the Deductible
Inpatient Hospice Care	80% of Covered Expense after satisfying the Deductible
Maximum benefit	\$5,000 combined maximum for Inpatient and Outpatient benefits while insured
Inpatient Hospital Services	80% of Covered Expense after satisfying the Deductible
Inpatient Maternity and Newborn Care	80% of Covered Expense after satisfying the Deductible
Labor, delivery and postnatal hospital services	
Inpatient Mental Illness Services³ <i>(other than SMI and SED)</i>	80% of Covered Expense after satisfying the Deductible
Maximum benefit	\$2,500 Inpatient maximum per Calendar Year
Inpatient Rehabilitation Care	80% of Covered Expense after satisfying the Deductible
Inpatient Skilled Nursing Facilities	80% of Covered Expense after satisfying the Deductible
Maximum benefit	Up to 90 days Inpatient per Calendar Year
Organ Transplant and Transplant Services	80% of Covered Expense after satisfying the Deductible
Bone marrow, stem cell and organ transplants	
Donor maximum	
National preferred transplant facility	\$15,000 per occurrence
Company authorized transplant facility	\$5,000 per occurrence
Maximum benefit while insured	Up to Policy Maximum

Outpatient Benefits¹

<p>Physician Office Visits <i>Services include the detection and treatment of an Injury or Sickness during a Physician Office Visit including associated Covered diagnostic X-ray and Laboratory services</i> Allergy Testing and Treatment Breast and pelvic cancer screening including mammogram Screening Detection of osteoporosis Colorectal cancer screenings Prostate cancer screening Periodic health evaluations for children (through age 18) including age appropriate immunizations, laboratory tests, height and weight evaluation, vision screening</p>	<p>80% of Covered Expense after satisfying the Deductible</p>
<p>Periodic Health Evaluations (age 19 and over) Hearing screening Vision screening Immunizations and adult boosters Routine laboratory tests (age and gender appropriate) Weight evaluation Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>\$300 per Calendar Year Maximum</p>
<p>Acupuncture Services Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>\$1,000 combined per Calendar Year Maximum</p>
<p>Alcohol, Drug or Other Substance Abuse³ Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>1 visit per day, 20 visits per Calendar Year</p>
<p>Ambulance <i>(Emergency services and specified transfers)</i></p>	<p>80% of Covered Expense after satisfying the Deductible</p>
<p>Corrective Appliances Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>\$500 combined per Calendar Year Maximum; \$1,000 while insured</p>
<p>Durable Medical Equipment Rental, purchase or repair Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>\$2,000 combined per Calendar Year Maximum</p>
<p>Home Health Care Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>100 visits combined maximum per Calendar Year</p>
<p>Hospice Services Home care for crisis period and acute care management Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>\$5,000 combined maximum for Inpatient & Outpatient benefits while insured</p>
<p>Infertility Services Maximum benefit</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>\$2,000 combined maximum for Inpatient and Outpatient benefits while insured</p>
<p>Infusion Therapy Infusion Therapy Drugs</p>	<p>80% of Covered Expense after satisfying the Deductible</p> <p>Covered Person responsible for all charges over \$500 maximum benefit per day</p>
<p>Injectable Drugs</p>	<p>80% of Covered Expense after satisfying the Deductible</p>

Outpatient Benefits¹ (continued)

Laboratory Services <i>(other than Physician Office Visits)</i>	80% of Covered Expense after satisfying the Deductible
Maternity Care Physician office visits, lab and radiology services Prenatal, post-partum, maternity care	80% of Covered Expense after satisfying the Deductible
Medical Rehabilitation Therapy Speech, physical, occupational therapy Maximum benefit	80% of Covered Expense after satisfying the Deductible \$1,000 combined per Calendar Year Maximum
Mental Illness Services³ <i>(other than SMI and SED)</i> Maximum benefit	80% of Covered Expense after satisfying the Deductible 1 visit per day, 20 visits per Calendar Year
Neuromuscular Skeletal Services Maximum benefit	80% of Covered Expense after satisfying the Deductible \$1,000 combined per Calendar Year Maximum
Outpatient Surgery Same day services performed at a Hospital or free standing surgical center	80% of Covered Expense after satisfying the Deductible up to \$750 maximum benefit per day
Prosthetics Maximum benefit	80% of Covered Expense after satisfying the Deductible \$2,000 combined per Calendar Year Maximum
Radiology Services <i>(other than Physician Office Visits)</i>	80% of Covered Expense after satisfying the Deductible
Severe Mental Illness (SMI) Services <i>(including Serious Emotional Disturbance of a Child (SED))</i> Specified diagnosis only	80% of Covered Expense after satisfying the Deductible
Specialized Footwear Maximum benefit	80% of Covered Expense after satisfying the Deductible \$500 combined per Calendar Year Maximum; \$1,000 while insured
Specialized Scanning, Imaging and Laboratory Services CT, SPECT, PET, MRA, MRI, ultrasounds, EKG, EEG, AMG and nuclear medicine studies	80% of Covered Expense after satisfying the Deductible
Urgent Care Services <i>(per occurrence)</i>	80% of Covered Expense after satisfying the Deductible

Outpatient Prescription Drugs²

	Participating Retail Pharmacy	Non-Participating Pharmacy
<i>Copayment applies per Prescription Unit or up to 30 days</i>	100% after Copayment of:	80% after Copayment of:
Generic Formulary Copayment	\$10 Copayment	\$10 Copayment
Brand-Name Formulary Copayment	\$35 Copayment	\$35 Copayment
Non-Formulary Copayment	\$50 Copayment	\$50 Copayment
Prescription Drug Deductible	None	
Mail Service Program	100% after 2 Copayments per 3 Prescription Units or up to a 90-day supply	

¹ Maximum Covered Expenses for Non-Participating Providers will not exceed the Usual and Customary charge. Please refer to the Definitions Section in the Certificate for an explanation of Usual and Customary.

² Copayments or Additional Deductibles for Covered Expenses do not apply toward the Calendar Year Deductible.

³ Coinsurance for this type of Covered Expense does not apply toward the Coinsurance Maximum, and the percentage payable for this type of Covered Expense does not increase to 100% due to satisfaction of any Coinsurance Maximum.

NOTE: This Policy has certain benefit maximums, some are Calendar Year maximums and some are benefit maximums while insured. Please review this information carefully so you will understand your benefits under this plan.

Preauthorization is required prior to obtaining certain benefits. Failure to Preauthorize services will result in a reduction in the benefits payable for Covered Expenses under the Policy. The Company will conduct a retroactive review to determine the Medical Necessity of the service, and services deemed not Medically Necessary will not be eligible for benefits under the Policy. Additional out-of-pocket expenses incurred by you for not Preauthorizing services will not apply toward your Calendar Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to "Preauthorization Requirements in your *Certificate*."

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