

CALIFORNIA



INDIVIDUAL BUSINESS

PPO 3000

SCHEDULE OF BENEFITS

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 obtain Preauthorization of 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 obtaining Preauthorization of services will not apply toward your Calendar Year Deductible or Coinsurance Maximum. To avoid any penalty, please refer to “Preauthorization Requirements” in your *Certificate*.

Maximum Covered Expenses for Non-Participating Providers will not exceed the Limited Fee Schedule. Please refer to your *Certificate* “Definitions” section for an explanation of the Limited Fee Schedule.

Schedule of Benefits

	Participating Providers	Non-Participating Providers
Limiting Age for Dependent Children	Through age 18, or through age 23 if a full-time student	
Preauthorization List	Inpatient Hospital Services, Transplant Services, Outpatient Surgical Services in a Hospital or Free-Standing Surgical Center, Home Health Care Services	
Your Policy Maximum While Insured	\$5,000,000	
Calendar Year Deductible Individual Family maximum (<i>2x individual</i>) Deductible must be satisfied before benefits are paid.	\$3,000	
	\$6,000	
Calendar Year Coinsurance Maximum Individual Family maximum (<i>2x individual</i>)	\$4,000	\$8,000
	\$8,000 plus Deductible(s), Copayments and penalties	\$16,000 plus Deductible(s), Copayments, penalties and all amounts above the Limited Fee Schedule

Hospital and Facility Services

	Participating Hospitals	Non-Participating Hospitals
Additional Deductibles (per occurrence) Inpatient services Outpatient hospital and free-standing surgical services Emergency room services (<i>waived if admitted</i>) Failure to obtain Preauthorization of services (<i>waived with Preauthorization of services</i>)	Not applicable	Not applicable
	Not applicable	Not applicable
	\$200 per occurrence	
	\$250	\$500
Inpatient Hospital and Facility Services	70% after Deductible(s)	50% after Deductible up to \$500 maximum benefit per day. Covered Expenses for these services do not apply to Coinsurance Maximum ¹

Hospital and Facility Services
(continued)

	Participating Hospitals	Non-Participating Hospitals
Transplant Services Maximum benefit while insured	70% after Deductible(s)	Not covered
	\$5,000 donor maximum	
	\$2,000,000	
Chemical Dependency \$2,500 maximum benefit per Calendar Year	70% after Deductible(s)	50% after Deductible up to \$200 maximum benefit per day ¹
Mental Illness (other than SMI) \$2,500 maximum benefit per Calendar Year	70% after Deductible(s)	50% after Deductible up to \$200 maximum benefit per day ¹
Skilled Nursing Facilities	70% after Deductible(s)	Covered Person responsible for all charges over \$200 maximum benefit per day
	Up to 90 days per Calendar Year	
Outpatient Surgical and Facility Services	70% after Deductible(s)	50% after Deductible(s) up to \$500 maximum benefit per day ¹ Covered Expenses for these services do not apply to Coinsurance Maximum ¹
Hospice Care	70% after Deductible(s)	50% after Deductible(s) up to \$500 maximum benefit per day ¹ Covered Expenses for these services do not apply to Coinsurance Maximum ¹
	\$5,000 maximum benefit while insured	

Outpatient Provider Services

	Participating Providers	Non-Participating Providers
Physician Office Visits²	70% after Deductible(s)	50% of Limited Fee Schedule after Deductible*
Physician Services Other than Physician office visits	70% after Deductible(s)	50% of Limited Fee Schedule after Deductible*
Maternity Care Prenatal, postnatal and childbirth expenses	Not covered	Not covered
All Laboratory Services	70% after Deductible	50% of Limited Fee Schedule after Deductible*
All X-ray Services		
All Diagnostic Testing		

Wellness and Preventive Care

Wellness and Preventive Care¹ Preventive care for children with immunizations (<i>through age 18</i>) Mammogram screening Breast and pelvic exams Prostate cancer screening Detection of osteoporosis	70% after Deductible (including Lab and X-ray Services)	50% of Limited Fee Schedule after Deductible*
Periodic Health Evaluations (<i>age 19 and over</i>)	\$300 maximum benefit per Calendar Year	

Other Outpatient Provider Services
Participating Providers
Non-Participating Providers

	Participating Providers	Non-Participating Providers
Ambulance (<i>Medically Necessary transport</i>)	60% after Deductible	
Chemical Dependency² Outpatient services	70% after Deductible	50% of Limited Fee Schedule after Deductible*
One visit per day, 20 visits per Calendar Year		
Severe Mental Illness Specified diagnosis only	70% after Deductible	Not covered
Mental Illness (<i>other than SMI</i>) Outpatient services	70% after Deductible	50% of Limited Fee Schedule after Deductible*
One visit per day, 20 visits per Calendar Year		
Durable Medical Equipment	70% after Deductible	50% of Limited Fee Schedule after Deductible*
\$2,000 maximum benefit per Calendar Year		
Home Health Care (100 visits per Calendar Year) Infusion therapy services Infusion therapy drugs	70% after Deductible	50% of Limited Fee Schedule after Deductible* Covered Person responsible for all charges over \$500 maximum benefit per day
Prosthetic Devices	70% after Deductible	50% of Limited Fee Schedule after Deductible*
\$2,000 maximum benefit per Calendar Year		
Orthotic Devices	70% after Deductible	50% of Limited Fee Schedule after Deductible*
\$500 maximum benefit per Calendar Year; \$1,000 maximum benefit while insured		
Specialized Footwear	70% after Deductible	50% of Limited Fee Schedule after Deductible*
\$500 maximum benefit per Calendar Year; \$1,000 maximum benefit while insured		
Infertility Services	Not covered	Not covered
Prescriptions	Not covered	Not covered

¹ 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.

² Copayment-based services do not apply to Neuromuscular Skeletal Disorders, Rehabilitation Services, mental illness, Chemical Dependency services or surgery performed in the Physician's office.

* Percentage of the Limited Fee Schedule, plus you are responsible for all charges above the Limited Fee Schedule.

Important PPO Information

Participating Providers and Non-Participating Providers. The Policy provides benefits for Covered Services obtained from Participating Providers and Non-Participating Providers. Participating Providers are those Providers who have agreed to participate in the Company's Preferred Provider Organization and provide health care at negotiated fees. Non-Participating Providers have not agreed to negotiated fees or arrangements.

Emergency Services. When a Covered Person receives Emergency Services from a Non-Participating Provider, the Emergency Services will be paid as if rendered by a Participating Provider. Once the Covered Person can be safely transferred to a Participating Provider, the Covered Person must be transferred in order to continue receiving the Participating Provider level of benefits. If the Covered Person chooses not to transfer to a Participating Provider, all additional Covered Expenses incurred will be paid at the Non-Participating Provider level.

Using a Participating Provider May Lower Costs. Covered Services from a Non-Participating Provider may cost the Covered Person more than Covered Services from a Participating Provider. Covered Expenses for a Non-Participating Provider's services may be substantially lower than the actual charges. The Covered Person's responsibility includes the portion of Covered Expense not payable under the Policy, plus all of the Non-Participating Provider's charges that exceed the Covered Expense.

To minimize out-of-pocket costs, it is important that the Covered Person receives services from a Participating Provider.

Potential Savings by Using a Participating Provider

	Participating Provider	Non-Participating Provider
Negotiated Fees for Covered Services	Yes	No
Balance Billing for Covered Services	No	Covered Person responsible for 100% of charges that exceed the Coverage Expense
Inpatient Hospital Deductibles	Lower	Higher
Coinsurance Maximums	Lower	Higher

Change in Participation. If, while a Covered Person is confined in a Facility which is a Participating Provider, that Facility ceases to remain a Participating Provider, coverage will be provided throughout the period of confinement at the negotiated rate for that Facility before it ceased to be a Participating Provider.

If a Covered Person obtains authorization for services to be rendered by a Participating Provider, and the Participating Provider subsequently ceases to be a Participating Provider, coverage will be provided for the Preauthorized services at the negotiated rate for that Provider before the Provider ceased to be a Participating Provider.

Effect on Benefits. Preauthorization is required prior to obtaining certain services. Failure to obtain Preauthorization may result in additional expense by the Covered Person under the Policy as shown on this *Schedule of Benefits*. No benefits are payable unless the Company determines that Covered Services are Medically Necessary. The Policy has certain coverage maximums; some are Calendar Year maximums and some are benefit maximums while insured. Please review your *Schedule of Benefits* carefully to determine coverage.

Limited Fee Schedule. The Company offers Covered Persons a wide range of health care options within its Preferred Provider Organization (PPO). Covered Persons have access to quality care through our network and enjoy maximum subscriber savings. Although Covered Persons may choose a Non-Participating Provider, the Company uses a Limited Fee Schedule to determine the Covered Expense for services or supplies outside our network which may result in a higher Coinsurance payment, reduced benefits and higher out-of-pocket expenses. Please refer to the "Definitions" list in Section 4 of the *Certificate* for further information on the Limited Fee Schedule.