Comprehensive Major Medical Benefits for Individuals and Families

Your CompleteCare

Personal Health Insurance Plans

Now Featuring!

- *MyHealthCompass provider evaluation tools*
- *Medex Plus Traveler's Emergency Medical Assistance program*

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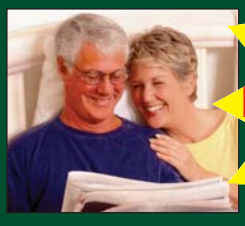
CompleteCare for Consumers of the New Generation



HSA-Qualified High Deductible Health Plans

What makes CompleteCare Personal Health Insurance Plans different?

The COMPLETECARE PERSONAL HEALTH INSURANCE PLANS are designed specifically to provide:

- A wide range of Preferred Provider Networks from which you can choose your providers. You may be able to reduce your premiums based on the network you select
- Access to a nationwide secondary Preferred Provider Network to help you keep your costs down in case you are outside your primary network's service area. One network, Private HealthCare Systems (PHCS), delivers nationwide network access
- Advanced health plans that range from traditional copay plans to cutting-edge designs priced at up to 50% less in premium
- 24-hour NurseLine provides toll-free access to experienced nurses
- A traveler's emergency program. MEDEX *Plus* offers travel evacuation benefits and 24/7 professional management of catastrophic medical incidents occurring 100 miles or more from home
- MyHealthCompass health care evaluation tools
- ***And much more!***

What is an Optional Personal Assistance Program and why does it help you?

A Personal Assistance Program focuses on you as a whole person by providing information and support for every type of personal concern—whether medical, family, financial, legal or emotional. Financial and legal assistance are available 8 am - 7 pm CST. **It's easy to use and completely confidential!** When you call, a professional will listen to you, answer your questions, assess your situation, and help you develop a plan of action.

Here are a few of the highlights of the optional Optum® Personal Assistance Program

- **In-person professional assessment** through more than 3,000 nationwide contracted affiliate counselors
- **National consultation networks for childcare and eldercare** problems, legal concerns, and financial issues
- **Critical Incident Stress Management** following traumatic community events or natural disasters
- **Referrals** to more than 62,000 national and community services
- **Audio Health Information Library** of 1,000 topics with fax-on-demand

MyHealthCompass

Automatically Included!
With MyHealthCompass™, you have access to powerful hospital and physician information that includes:

- **Quality Ratings -** Rankings according to complication and mortality rates, case volume and length of stay
- **Pricing Reports -** Price comparisons by hospital, medical procedure, payor and location—local, state, and national
- **Profiles -** Detailed information on hospitals and physicians, such as specialties, credentials, hospital affiliations and sanctions
- **Healthcare Secrets -** Easy-to-understand information on medical conditions and insurance issues

What medical expenses are covered under the insurance plan?

Your CompleteCare Personal Health Plan covers these medically-necessary medical expenses:
hospital room and board • medical supplies/hospital services • physician services • licensed emergency ambulance services when medically necessary • x-ray, laboratory and diagnostic tests • radiation therapy • chemotherapy, antibiotic therapy and infusion therapy • blood and its administration, but not the cost of blood or blood components if replaced by donation • initial supply but not replacement of casts, splints, trusses, crutches and braces (excluding dental braces and orthodontics) • initial supply of artificial limbs, larynx and eyes due to loss of limbs, larynx and eyes as the result of bodily injury sustained or sickness that begins while you are insured under the plan • rental (or at our option, lease or purchase) of a wheelchair, hospital bed, crutches, canes and other durable medical equipment • anesthetics, oxygen and their administration • ambulatory surgical center services.

Other covered services and benefits are outlined in this brochure; however, for complete details, please refer to the Certificate of Coverage (C-5028 or C-5031).

Deductible

This is the amount of covered charges you must incur before benefits are payable. Certain eligible expenses are not applied towards the deductible amount. These include applicable copay charges, wellness benefit expenses and, depending on plan choice, charges for mammograms, home health and hospice care.

Copay Choice, Copay Advantage, 50-50 Share, and Health Security Plans:

Covered medical expenses for each insured under the plan accumulate toward the in- and out-of-network deductibles. When three insured persons in a family satisfy their deductible, all other insured persons in the family will be deemed to have satisfied this requirement for the remainder of the calendar year. Deductibles for in- and out-of-network services accumulate separately.

Daily Deductible Plan:

Each insured under the plan must satisfy the deductible for each day before any expenses are payable.

The deductible is applied to covered expenses every day expenses are incurred until the covered persons' maximum out-of-pocket amount is satisfied for the calendar year. Thereafter, covered expenses are payable at 100% up to the plan limits.

Single Deductible Plan:

Covered medical expenses for each insured under the plan accumulate towards a single calendar year deductible, whether the charges are incurred in- or out-of-network. In addition, the calendar year deductible may be subject to change annually in order for the plan to remain Health Savings Account (HSA) qualified.

Network Physician Office Visit Copay Benefit

Copay Choice, Copay Advantage and 50-50 Share Plans:

Under the Copay Choice, Copay Advantage and 50-50 Share Plans, you pay your copay (unless the doctor's bill total is less than your copay amount, in which case, the amount of the bill is your copay for that visit) and the plan provides 100% coverage for the cost of your network physician office visit. Diagnostic x-rays and lab tests performed are subject to any applicable deductibles and coinsurance. Covered charges for services performed at out-of-network facilities are subject to deductible and coinsurance.

Copays do not apply towards your calendar year deductible or out-of-pocket maximum amount.

Emergency Room & Inpatient Confinement Copays

Copay Choice, Copay Advantage, 50-50 Share, and Health Security Plans:

Emergency room care benefits, which are subject to applicable coinsurance and deductible amounts, are also subject to a separate $100 copay. However, if you are admitted as an inpatient during your emergency room visit, we will waive this $100 copay. Inpatient hospital stays are subject to a $250 per confinement copay.

Calendar Year Out-of-pocket Maximum

After your eligible out-of-pocket expenses accumulate to reach the limit you selected, the plan will pay 100% of additional eligible charges up to the policy maximums ($1,000,000 per calendar year, $5,000,000 while insured).

Maximum out-of-pocket amounts do not include:

- any deductible amounts
- any copays
- expenses incurred for outpatient treatment of mental, nervous, or chemical dependency disorders
- charges excluded under the policy

Copay Choice, 50-50 Share, and Health Security Plans:

Once any two insured persons in an insured family satisfy their individual maximum out-of-pocket level in a calendar year, all other insured persons in that family will be deemed to have satisfied this requirement for the balance of that calendar year. Network and out-of-network expenses accumulate and are applied separately toward network and out-of-network out-of-pocket maximum amounts.

Copay Advantage Plan:

The Copay Advantage Plan has separate and distinct out-of-pocket maximums for Medical Services & Supplies and Inpatient & Surgical Services. After the out-of-pocket maximum for each type of services is met, that type of service is covered at 100% for the remainder of the calendar year.

Daily Deductible Plan:

The deductible is applied to covered expenses every day expenses are incurred until the covered persons' maximum out-of-pocket amount is satisfied for the calendar year. Thereafter, covered expenses are payable at 100% up to the plan limits.

Single Deductible Plan:

All covered medical expenses apply to the maximum out-of-pocket, including deductibles. This plan has only one common deductible and maximum out-of-pocket in a calendar year, regardless of the number of covered dependents. Once the maximum out-of-pocket amount has been met, the insured and any covered dependents are deemed to have satisfied this requirement for the balance of that calendar year. Calendar year maximum out-of-pocket amounts may be subject to change annually in order for the plan to remain HSA-qualified.

Emergency Care at Out-of-network Hospitals

If you are taken to an out-of-network hospital for a medical emergency, we will pay for covered services at network benefit levels. However, you must arrange for transfer to a network hospital within 48 hours or as soon as this transfer can take place without detriment to your health. Otherwise, covered services will be paid at out-of-network benefit levels.

Skilled Nursing Facility Care

After your applicable copay and/or deductible has been satisfied, covered medical expenses will be paid at the coinsurance level you have selected, up to $100 daily benefit, limited to 50 days per calendar year, per insured person.

Optional Benefits and Life Insurance

CompleteCare Personal Health Insurance Plans give you many choices to design a plan to fit your unique needs!

Deductibles
Many different in-network options, from zero to $10,000, depending upon the plan selected

Copays
Included on both Copay Plans and the 50-50 Share Plan

Coinsurance
Depending on the plan selected, your plan will pay 50%, 70%, 80% - even 100%!

Prescription Drug
Select a discount-only feature or have drugs paid under copays and coinsurance (varies by plan)

Optional Wellness Benefit

The CompleteCare Personal Health Plans offer an optional wellness benefit that provides coverage **up to $250** per covered person per calendar year for services intended to keep you well. After your selected copay (if any), **the plan pays 100% of covered charges** for such health promotion services as:

- **Routine physical exams**
- **Prostate cancer screening services**
- **Routine PAP smears and related lab charges**
- **Well-child care, including immunizations!**

Wellness services are covered when delivered by network providers. Well-child care and immunizations are subject to policy provisions and state requirements.

Optional Dependent Life Insurance

Persons insured under a CompleteCare Personal Health Plan may purchase optional dependent life insurance coverage for their spouse and any children, in the sums indicated in the following table:

Person to be covered	Amount of Coverage
Spouse	$2,000
Child(ren)	
14 days to 6 months	$ 100
6 months through 18 years	$1,000
Ages 19 to 24 if full-time student	$1,000

Optional Supplemental Accident Benefit

With the optional supplemental accident benefit, you decide whether the plan pays 100% of the first $500 or $1,000 of covered expenses incurred as the direct result of an accident.

Optional Additional Life Insurance Benefit

A minimum of $10,000 of life insurance is required on the primary insured person under a CompleteCare Personal Health Plan, except in Florida, Ohio, Oklahoma and Texas, as well as on Single Deductible plans, where life insurance is offered as an optional benefit.

Additional optional life insurance coverage is available up to $100,000.

In the event that an insured person dies while covered under the life insurance provisions of the plan, we will pay to that person's beneficiary the sum of insurance that was in-force under the policy at the time of the insured person's death (proof of death is required).

24-Hour Occupational Coverage

Included at no extra premium!

Qualified sole proprietors, partners, or business owners who are not covered by Workers' Compensation are eligible for 24-hour Occupational Coverage under their CompleteCare Personal Health Plan. Benefits may be payable for covered charges incurred by these insured persons for work-related injuries or sickness.

Optional Vision Benefits

Your CompleteCare Personal Health Plan includes an optional vision benefit offered through EyeMed. Through this program, you can enjoy immediate savings on eye care needs, including frames, bifocals, non-disposable contact lenses and many other items and services at more than 800 LensCrafters stores nationwide and thousands of independent providers affiliated with EyeMed.

There are two coverage options, with different copays for eye exams and prescription lenses.

Refer to the IAC Vision Plan Overviews for additional details. Check for state availability.

Prescription Drug Coverage

Prescription Drug Coverage Choices

❶ Discount Drug Feature

When an optional prescription drug benefit is not selected a discount drug feature is automatically included. This feature enables you to buy medications and other items that are available by prescription, for a discounted price at more than 56,000 ExpressScripts pharmacies across the nation.

- Available on all plans at no additional premium
- Discount savings off retail prices can run up to 25%
- All prescription drugs are discounted, including "lifestyle" medications that are not covered by the health plan
- If an optional outpatient prescription drug benefit is chosen, non-covered prescription items are not discounted

❷ Optional Outpatient Prescription Drug Benefits[1] (Oral contraceptives Included)

All Plans:

There are four coverage options available:

Rx Insurance Option
Generic Drugs
$25 copay
Brand name drugs: no deductible
Formulary - $100 copay
Non-formulary **-** $150 copay

Rx Deductible 250 Option
Generic Drugs
$15 copay,
Brand name drugs: $250 Deductible then:
Formulary - $30 copay + 20%
Non-formulary **-** $45 copay + 20%

Rx Deductible 500 Option
Generic Drugs
$25 copay
Brand name drugs: $500 Deductible
Formulary - $30 copay + 20%
Non-formulary **-** $45 copay + 20%

Rx Deductible 1000 Option
Generic Drugs
$25 copay
Brand name drugs: $1,000 Deductible
Formulary - $30 copay + 20%
Non-formulary **-** $45 copay + 20%

Maximum of 3 prescription drug deductibles per family, per calendar year.
Prescription drug copayments, deductibles and coinsurance do **not** apply toward health plan deductibles or out-of-pocket maximums.

HSA Qualified *Single Deductible* Plans Only:

There is an additional coverage option for these plans:

Rx HSA Option
Prescription drugs are covered as any other illness, subject to deductible and coinsurance.
Expenses for covered prescription drugs apply towards the health plan deductible and out-of-pocket maximums.

[1] Prescription drugs are made available at a discounted price. However, the discount applies only to covered prescription items. If an optional outpatient prescription drug benefit is chosen, non-covered prescription items are **not discounted.**

Prescription Drug Formulary

When an optional prescription drug benefit is selected, a prescription drug formulary applies. The prescription drug formulary is a tool used to improve quality assurance and effective cost management within the outpatient prescription drug benefit. The formulary is a list of quality generic and brand name medications offering the potential for cost savings. Formularies are quite common in health care plans today. There are often two or more medications used to accomplish the same therapeutic effect. When your physician prescribes one of the listed medications, if medically appropriate, you will have a lower out-of-pocket cost for that prescription.

Most physicians are aware of the need for cost effective drug therapy and work with formulary programs. In the event you or your physician are reluctant to choose a particular medication from the formulary list, you are not required to do so. The formulary system is voluntary and intended to be a participating effort by all involved parties to help contain the ever-rising costs of health care through effective drug therapy management. When non-formulary brand name prescription drugs are used, a higher copay applies.

Maximum Allowable Cost (MAC)

When a brand-name medication is dispensed because of an insured person's preference and a less expensive FDA-approved generic medication could have been dispensed, the insured person's out-of-pocket costs may be increased. The out-of-pocket costs will be increased by the difference in the price of the insured's preferred brand medication and the established Maximum Allowable Cost (MAC) price for the generic equivalent.

MAC pricing is a statistically derived maximum allowable base price that will be paid for prescription drugs for which a less expensive, FDA-approved generic equivalent is available. This method assures that the cost to the plan does not increase when an insured person makes a decision to use a more expensive product. MAC pricing increases generic utilization and helps to equitably control the cost of outpatient prescription drugs dispensed.

Mail Order and Internet Purchases

Enjoy the convenience of mail order and/or Internet purchases by ordering up to a 3-month supply of your prescription drugs and items at a time. You can use your discount feature or your optional drug coverage benefit to purchase prescription drugs and items. When using your optional drug coverage benefit, **only 2 months' payment applies to each 3-month supply**!

Hospital Room and Board

Your CompleteCare Personal Health Plan covers hospital room and board charges according to the plan you selected, on the basis of the average semi-private room rate. If the hospital does not have semi-private rooms, the plan will pay the base amount of 90% of that hospital's lowest-priced private room.

Intensive Care

Intensive care room and board provided through network hospitals will be paid at the most common rate for intensive care units.

If provided through out-of-network facilities, they will be paid at up to 3 times the most common semi-private room rate. Observation room and intermediate care unit services will be paid at a rate of up to 2 times the most common semi-private room rate.

Non-Surgical Back Treatment (Chiropractic Care)

Covered expenses for non-surgical back treatment are payable up to $500 per person per calendar year, on an outpatient basis. Deductible and coinsurance apply.

Home Health Care

After applicable deductible has been satisfied, covered medical expenses will be paid at the coinsurance level you have selected, up to 21 visits per calendar year, per insured person.

Mammography and Breast Screening

Subject to schedule and/or state mandates. See certificate of coverage for details.

Copay Choice, Copay Advantage & 50-50 Share Plan:

In-network, after applicable copay, mammography and breast screening services are covered at 100%.

Out-of-network, deductible and coinsurance apply.

Health Security Plan:

In-network, after applicable deductible, mammography and breast screening services are covered at 100%.

Out-of-network, deductible and coinsurance apply.

Daily Deductible Plan:

In-network, mammography and breast screening paid at 100% with no daily deductible.

Out-of-network, daily deductible applies.

Single Deductible Plan:

In- or out-of-network, deductible and coinsurance apply to mammography and breast screening.

Mental & Nervous Conditions, Substance Abuse & Chemical Dependency Treatment

The maximum benefit for mental & nervous and chemical dependency treatment is $10,000 combined per person, while insured. Covered charges **do not** accumulate towards the plan's maximum out-of-pocket amounts.

Outpatient Mental & Nervous & Chemical Dependency

Applicable deductible & coinsurance apply. Up to $25 per visit, maximum of 50 visits or $1,250 per calendar year.

Inpatient Mental & Nervous

Applicable copay, deductible & coinsurance apply. Maximum of 10 inpatient days, up to $2,500 per calendar year.

Inpatient Chemical Dependency

Benefits are not provided for inpatient chemical dependency treatment, unless otherwise mandated by law.

MEDEX *Plus* Travelers Emergency Program

MEDEX *Plus* offers travel evacuation benefits and 24/7 professional management of catastrophic medical incidents that occur 100 miles or more from home.

MEDEX *Plus* professionals will coordinate medical care, transportation, communication in 16+ languages, and resources for travelers - anywhere in the world! See the MEDEX *Plus* plan overview for details.

Organ Transplant Benefit

The plan includes access to the **United Resource Networks** (URN) for organ transplants. In addition to contracting with providers and *Centers of Excellence*, this specialized network offers expertise, patient advocacy and case management services. URN helps to ensure that you receive the highest levels of care for these complex services. When you use one of the URN *Centers of Excellence,* an allowance of up to $5,000 is available for necessary travel and room and board expenses for a companion, or, two companions, if the insured is a minor.

When you use URN providers for transplant services, covered medical expenses will be paid up to the plan maximum benefit of $5,000,000 while insured, up to $1,000,000 in a calendar year. If services are received from a provider in your selected PPO network, the maximum benefit allowed is $250,000. If these services are received from out-of-network providers, then the maximum benefit allowed is $100,000 while insured. See the certificate of coverage for details.

Hospice Care

The plan will pay covered medical expenses for hospice care for up to 6 months. Pre-certification is required. The plan will also cover bereavement support services for the insured person's family during the 3-month period after death, up to $250.

Complications of Pregnancy

Complications of pregnancy are covered the same as any other illness. Normal pregnancy is not a covered benefit. See Major Medical Exclusions and Limitations and Pre-certification Requirements for details.

Covered Charges

Covered charges include provider network contracted charges or necessary, reasonable and customary charges for out-of-network providers for expenses that are necessary for the treatment of injury or sickness that is not excluded from your coverage.

"Necessary, reasonable and customary" means the usual charge made for necessary medical services and supplies generally furnished for sickness or injuries of comparable severity and nature in the geographic area in which the services or supplies are furnished.

In determining what should be considered necessary, reasonable and customary for services and supplies, we use and subscribe to a standard industry reference source that collects data and makes it available to member companies. The database used reflects the amounts charged by providers for health care services based on the smallest geographic zip code areas generating a statistically credible charge distribution. This data is updated and published twice per year. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers who are not included in the database. We then use a specific representative percentile of that range of charges to determine the necessary, reasonable and customary charge for all people who are insured under this policy.

Eligibility

If you are under age 65, you and your eligible dependents may be eligible to purchase a CompleteCare Personal Health Insurance Plan. You can apply by completing an application for participation and by qualifying for coverage according to the plan's medical underwriting guidelines.
Eligible dependents include:

- Your legally recognized spouse (under age 65)
- Your unmarried child(ren) under age 19
- Your unmarried child(ren) ages 19 to 25*

*Unmarried children ages 19 to 25 will be considered eligible dependents if they are dependent upon you for maintenance and support and are enrolled on a full-time basis in an accredited school or college. We define "full-time basis" in this instance as being enrolled in and attending the accredited school or college in each and every semester (or quarter) for a minimum of 12 credit hours.

Rate Guarantee

Your initial monthly premiums are based on several factors, including, but not limited to, your age, your spouse's age (if applicable), the number of children you have covered under the plan, and your home address.

We guarantee that your rates will not change for the initial 12 months of coverage from your effective date unless one or more of the following events occur during that time:

- You move to a new residence
- Provider access fees change
- Administrative fees change

Accidental Death & Dismemberment

Your CompleteCare Personal Health Plan life insurance benefit includes accidental death and dismemberment coverage. Upon receipt of notice and due proof that an insured person sustained any of the losses listed in the table below, the plan will pay the sums indicated. These losses must be the direct result of accidental bodily injury that occurred not more than 90 days prior to the date that the loss was sustained.

Table of Losses

In the event of the loss of:	The plan will pay:
Life	The Principle Sum
Both hands or both feet	The Principle Sum
Sight of both eyes	The Principle Sum
One hand & one foot	The Principle Sum
One hand & sight of one eye	The Principle Sum
One foot & sight of one eye	The Principle Sum
One hand	1/2 Principle Sum
One foot	1/2 Principle Sum
Sight of one eye	1/2 Principle Sum

With respect to hands or feet, "loss" means severance at or above the joint. Eyes "loss" means entire, irrevocable loss of sight.

Effective Date of Coverage

You may request that your coverage under your CompleteCare Personal Health Plan become effective on either the 1st or the 15th of the month. We must receive your application before the effective date you have requested. If your application is approved, your coverage will become effective on the monthly premium due date that coincides with or on the next following date on which the application is approved. Your applicable premium must be paid before your policy goes into effect. If the company is unable to approve your application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

Any dependent(s) whom you want to include under the plan must not be hospitalized and must be able to perform the same activities that they were able to perform at the time that you submitted your application. If these requirements are not met, your application will be disapproved and a new application will be required if you wish to be considered for coverage at a future date.

Child(ren) Only Coverage

Child(ren) only coverage is available for applicants 2-17 years of age. When covered children attain age 18, they can be issued coverage under their own individual plan and charged an adult rate if they reside in a state where the coverage is available. Premium is based on the rates applicable to the state in which the child resides. Children of foreign nationals with legal residency in the United States are not eligible for coverage.

Applications for child(ren) only coverage will be declined if either parent or legal guardian of the child(ren) to be included under the coverage is currently an expectant parent or has undergone infertility testing within one (1) year of the date of application for the child(ren) only coverage.

Accidental Death & Dismemberment Exclusions

Benefits are not payable under the Accidental Death and Dismemberment coverage for any loss caused by, contributed to, or resulting directly from:
● any act of war, whether declared or undeclared, riot or insurrection, or resulting from service in the military, naval or air forces of any country or in any auxiliary or civilian noncombatant unit auxiliary to or serving with such forces ● travel or flight in, or descent from, any aircraft except as a fare-paying passenger on a licensed commercial aircraft operating on a regular schedule between established airports ● suicide, attempt at suicide or by intentionally self-inflicted injuries while sane or insane ● sickness, disease, or mental infirmity, or medical or surgical treatment or diagnosis thereof, or bacterial or other infection (except infection which occurs through and as a result of a visible wound caused by accidental bodily injury) ● participating in or commission of, or attempting to commit an assault or felony, or a loss to which a contributing cause was the insured person's being engaged in an illegal occupation ● bodily injury sustained as a consequence of intoxication or influence of any narcotic unless administered on the advice of a legally qualified physician ● the voluntary ingestion of poison, inhaling of gas, or asphyxiation ● the ingestion of any drug, sedative or narcotic, unless prescribed by a physician.

Guarantee of Renewability

This health plan renews annually on a common renewal date after the initial 12-month rate guarantee. With a common renewal date, all health plans renew on the same date. Common renewal dates allow for more stability in premium rates and more accurate rate pooling.

Coverage under your CompleteCare Personal Health Plan will be renewed each month unless we notify you that we will not renew your coverage for any of the following reasons:

- Your premium is not paid according to the terms of the policy
- You or your insured dependent(s) have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the policy
- You or your insured dependent(s) enter into full-time military service
- You no longer reside, live or work in the service area for which we are authorized to do business
- We decline to renew all health insurance in the individual market (subject to our giving you at least 180 days' advance written notice.)

Pre-existing Conditions and Admitted Health History

Health conditions that are fully disclosed in writing on a CompleteCare Personal Health Plans application are covered from the effective date of coverage under the policy unless the condition is specifically excluded by endorsement or health condition rider attached to the certificate of coverage.

Pre-existing Condition Limitation

Your CompleteCare Personal Health Plan includes limitations on coverage for pre-existing conditions. No benefits will be payable for any charges in connection with a bodily injury or sickness for which you or your covered dependent:

- received medical treatment, including the taking of medication prescribed by your doctor;
- received medical advice or consulted with a doctor; or
- experienced distinct symptoms which would have caused an ordinarily prudent person to seek medical diagnosis or treatment during the 12 months immediately preceding the effective date of coverage under your CompleteCare Personal Health Plan.

This pre-existing condition limitation will not apply to charges incurred in connection with that bodily injury or sickness after the first of the following events occur:

- you have been continuously covered under your CompleteCare Personal Health Plan for 12 months and you have not received any medical care or treatment for that pre-existing bodily injury or sickness during those 12 months; or
- you have been continuously covered under your CompleteCare Personal Health Plan for 24 months.

Reduced Benefits Due to Medicare Eligibility

If you or your insured dependent incur covered expenses for services or supplies for which benefits are payable under both Medicare and your CompleteCare Personal Health Plan, Medicare will always be your primary coverage and this plan will pay as a secondary plan. That means that your CompleteCare Personal Health Plan will pay the balance of covered expenses that remain after Medicare benefits are paid.

The maximum amount payable under your CompleteCare Personal Health Plan will be the lesser of either the amount that we would have paid in the absence of Medicare's payment or the amount of those covered expenses, minus Medicare's payment. We must receive verification of Medicare's payment or refusal of payment for those expenses incurred under Medicare Part A or Part B before we will consider paying benefits.

Termination Provisions

We can refuse to renew coverage for a certificate holder:

- when a premium is not paid in accordance with the terms of the group policy, or we have not received timely premium payments;
- when a certificate holder or his or her insured dependent has committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the group policy;
- when a certificate holder or his or her insured dependent enters full-time service in the military, naval or air forces, or any branch thereof;
- in the case of coverage through a network plan, the certificate holder no longer resides, lives, or works in the service area for which we are authorized to do business;
- subject to our giving each certificate holder at least 90 days advance written notice, if we are refusing to renew the group policy; or
- subject to our giving each certificate holder at least 180 days advance written notice, if we are refusing to renew all health insurance in the individual market.

Major Medical Exclusions & Limitations

Expenses for any of the following are excluded from coverage under your CompleteCare Personal Health Plan:

● expenses incurred in connection with a pre-existing condition ● any confinement, treatment, service, supply or prescription which is (a) not the result of bodily injury or sickness, (b) not recommended by a physician; or (c)not medically necessary ● normal pregnancy or voluntary abortion, except that complications of pregnancy will be treated the same as any other illness ● experimental or investigational medical treatment ● bodily injury or sickness arising from an occupation, except for owners, proprietors or partners who are not covered under Workers' Compensation or occupational disease law and who have selected the 24-hour occupational coverage option ● confinement, treatment, services or supplies provided by a government owned or operated facility, unless the covered person is legally required to pay for those services ● bodily injury or sickness resulting from war or any act of war, declared or undeclared, or while on active duty with any military, naval or air force of any country or international organization ● newborn nursery care ● dental care, except for treatment of injury to sound, natural teeth within 90 days of the date of an injury ● treatment or surgery for prognathism, retrognathism, microtrognathism, or to reposition the maxilla, mandible, or both, unless due to an injury incurred while covered under the policy ● treatment for temporomandibular joint dysfunction (TMJ) ● cosmetic surgery ● routine eye exams, glasses, visual therapy, or contact lenses ● radial keratotomy and keratectomy ● hearing aids or fitting thereof ● contraceptive devices ● charges incurred as the result of participating in a riot or insurrection or commission of a felony or while imprisoned ● acupuncture, except when used in lieu of anesthetic ● routine physical exams, except as provided under the Wellness benefit ● routine removal of corns, calluses or toenails ● charges for treatment for obesity or weight reduction ● charges for provider services if that provider is: (a) a close relative; (b) lives in the same household; or (c) is your employer (except for charges rendered during a hospital stay) ● charges incurred due to an attempted suicide or intentionally self-inflicted injury or sickness while sane or insane ● treatment for mental, nervous or chemical dependency disorders, except as provided for in the certificate of coverage ● Charges related to: (a) procedures to restore or enhance fertility; (b) reversal of sterilization; (c) penile implants; or (d) fertility and sterility studies ● impregnation techniques, including but not limited to artificial insemination, invitro fertilization, intra-fallopian transfers or genetic counseling ● sexual reassignments or sexual dysfunctions or inadequacies ● hospital and physician charges for weekend admissions occurring between noon on Friday and noon the following Sunday for non-emergency procedures, unless medically necessary or surgery is scheduled for the following day ● congenital conditions, except with respect to children covered from birth under the policy ● custodial care ● services or supplies for which no charge is made or the Insured Person is not required to pay ● charges for services received or supplies purchased outside of United States unless incurred while traveling and approved for use in the United States ● any service or supply related to the implant of an artificial organ ● education or training materials ● equipment, other than durable medical equipment, including but not limited to: modifications to motor vehicles or homes such as wheelchair ramps or lifts, water therapy devices, exercise equipment, etc. ● any service or supply to eliminate or reduce dependency or an addiction to tobacco, including but not limited to; nicotine withdrawal programs, nicotine products such as transdermal patches and gums, hypnotism or goal oriented behavioral therapy ● any surgical removal of an organ or tissue unless medically necessary ● private duty nursing ● charges related to human organ or tissue transplants except as provided in the certificate of coverage ● personal convenience services or supplies ● non-prescription medication ● charges for voice training for a lisp.

Pre-certification Requirements

Pre-certification is a screening process that uses established medical criteria to determine whether the proposed length of a hospital stay, a proposed treatment plan, or proposed services and supplies are medically necessary and appropriate. Pre-certification may also include proposing alternative treatment plans, concurrent length of stay reviews and discharge planning.

Your plan requires that the following services and supplies be pre-certified:

- all proposed inpatient hospital confinements
- all proposed stays in an extended care or skilled care nursing facility
- all proposed home health services
- all proposed hospice services
- complications of pregnancy (must be pre-certified within 7 days of diagnosis)
- prescription drug orders for growth hormones, immuno-suppressants, AZT or HIV antiretroviral medication, "off label" use, orphan drugs, investigative new drugs and Group C cancer drugs
- in addition, all outpatient tests and services should be precertified

In non-emergency situations you must contact the pre-certification service at least 7 days before incurring expenses on account of any of the above occurrences. Simply call the pre-certification service listed on your health plan identification card. They will contact your doctor for any necessary additional information.

In an emergency, you should go directly to the hospital to receive immediate care. If you are then admitted as an inpatient in the hospital, you must contact the pre-certification service within 48 hours of admission, or as soon as reasonably possible. Your doctor must verify that an emergency existed.

If you do not pre-certify an inpatient hospital stay as outlined above or complications of pregnancy, you will be responsible for an additional $500 deductible per occurrence. If you do not pre-certify any of the medications listed above, then NO benefits are payable toward their cost. If you follow pre-certification requirements, these additional deductible amounts will be waived.

Pre-certification is not a guarantee of payment. We will determine eligibility, covered expenses and benefits to be paid in accordance with the master policy.

CompleteCare Personal Health Insurance Plans

Solid Protection with Family Value

Underwritten by: FSL Fidelity Security Life Insurance Company

The Insurance Company

The CompleteCare Personal Health Insurance Plans are underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry. While the A- (Excellent) rating reflects the company's outstanding financial performance and capitalization, it is not a warranty of the company's present or future financial position. A.M. Best reports that companies rated A- (Excellent) "have strong ability to meet their obligations to policyholders over a long period of time."

The Association

In the states of Arkansas, Indiana, Michigan and Missouri, the CompleteCare Personal Health Insurance Plans are made available through the National Consumers Awareness Association.

The National Consumers Awareness Association is a non-profit association that offers its members access to numerous health, purchasing/general consumer, travel and business-related benefits. All membership dues are used solely for the administration of member benefits. Administrative offices for the National Consumers Awareness Association are located in St. Louis, Missouri.

The Third-Party Administrator

Insurers Administrative Corporation (IAC), located in Phoenix, Arizona, is a licensed and bonded third-party administrator currently celebrating its 25th year of serving the insurance community.

IAC offers total services of underwriting, billing and claims administration for the CompleteCare Personal Health Plans. With more than 350 employees serving the insurance needs of individuals and employers in the areas of medical, dental, vision, life and AD&D, critical care coverage, self-funding, 401K and Section 125 plans, IAC is one of the nation's largest third-party administrators.

Important Notice

The information included in this brochure is an outline of features, plan provisions, benefits and other information about the CompleteCare Personal Health Plans. Plans offered may be subject to change. It is not intended to serve as legal interpretation of the benefits, which are provided under the Master Policies issued to the Multiple Unit Security Trust II (M-5028) and to the National Consumers Awareness Association (M-5031). The exact provisions governing the insurance contract are contained in the Master Policy underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Some provisions, benefits, exclusions or limitations may vary depending on your state of residence. Certain terms and conditions apply. Any provision of this Policy that is in conflict with any applicable federal or state law is hereby amended to meet the minimum requirements of such law. For complete details about the CompleteCare Personal Health Plans, please refer to the Certificate of Coverage (C-5028 or C-5031, C-9004). Vision benefits described herein are governed by policy form M-9004, and are underwritten by Fidelity Security Life Insurance Company. Services provided through MyHealthCompass, Optum® and MEDEX are not insurance benefits and are not underwritten by Fidelity Security Life Insurance Company.

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