MEDICAL ENHANCED 10.0™

Schedule of Benefits & Plan Design
Supplemental Plan A Benefit

Annual Plan Year Deductible[1,3]	**$10,000**
Out of Pocket Maximum[1,3,4]	**$17,900**
Annual Plan Year Limit [1,2]	**$100,000**
Lifetime Maximum[1,2]	**$1,000,000**

Schedule of Benefits

This plan does not utilize a network. All services listed below are subject to Reference Based Pricing (RBP). The maximum amount the plan will pay for any covered service is 140% of the Medicare Reimbursement Rate. The member will be financially responsible for any amounts that exceed 140% of the Medicare Reimbursement Rate.

Plan Provisions	Prior Auth Required	Member Pays
HOSPITAL/FACILITY SERVICES		
Inpatient Hospitalization (Including Mental & Behavioral Health or Substance Abuse)	Yes	20% Coinsurance after Deductible is met
Other Inpatient Services (Surgery, labs, imaging, physician services and other services)	Yes	20% Coinsurance after Deductible is met
Outpatient Surgery	Yes	20% Coinsurance after Deductible is met
Non-Surgical Outpatient Procedures (Required to be performed at a facility)	Yes	20% Coinsurance after Deductible is met
Emergency Room Services	No	20% Coinsurance after Deductible is met
Chemotherapy, Radiation and Other Non-Experimental Cancer Treatments	Yes	20% Coinsurance after Deductible is met
Dialysis	Yes	20% Coinsurance after Deductible is met

[1]The deductible, out of pocket maximum, annual plan year limit, and lifetime maximum apply separately to each covered member.

[2]The member will be responsible for 100% of any amounts exceeding the annual limit or lifetime maximum.

[3]Amounts paid by the member for charges above the plan's 140% of Medicare reimbursement rate do not count toward the deductible or out of pocket maximum.

[4]The out of pocket maximum represents the maximum amount a member is required to pay under the plan's deductible and coinsurance requirements during a plan year. A member may incur additional out of pocket expenses for (i) uncovered services, (ii) covered services billed in excess of 140% of the Medicare Reimbursement Rate, or (iii) amounts in excess of the Annual Plan Year Limit or Lifetime Maximum.

Exclusions

Pre-existing Conditions

The pre-existing condition limitation will apply for as long as the plan is in force. For example, if a person was treated for colon cancer in the 12 months prior to purchasing the plan, that would be a pre-existing condition. The plan would not pay benefits for any services or treatments related to that person's colon cancer for as long as the person has the plan.

"Pre-existing condition" means an illness, injury, or condition:

1. For which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under the plan; or
2. That manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the plan.

Other Exclusions and Limitations

No benefits are payable for or relating to any of the following:

1. Substance Abuse / Addiction Treatment Facilities
2. Dental procedures or treatments. Exception to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan
3. Any other medical service, treatment, or procedure not covered under this Plan
4. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by this Schedule of Benefits or otherwise explicitly provided for in the Plan, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation
5. Unrelated screening tests, examinations and therapies that the participant has no symptoms or diagnosis
6. Cosmetic surgery and expenses incurred by cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: a) accidental injury, correction of congenital deformity within six (6) years of birth, or as a treatment of a diseased condition b) mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures
7. Any claim related to an injury arising out of or in the course of any employment for wage or profitt
8. Claims which would otherwise be covered by a Worker's Compensation policy for which a participant is entitled to benefit
9. Any claim arising from service received outside of the United States, except for the reasonable cost of claims billed by the Veterans Administration or Department of Defense for benefits covered under this Plan and not incurred during or from service in the Armed Forces of the United States
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to the use of illegal drugs unless the claim arose due to a drug addiction
14. Claims due to an act of war, declared or undeclared, not including acts of terrorism
15. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational

21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
27. Claims for disability resulting from reversal of sterilization
28. Claims for telephone consultations, the completion of forms, or failure to keep scheduled appointments
29. Recreational or diversional therapy
30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
32. Claims that arise primarily due to medical tourism
33. Treatments for sexual dysfunction
34. Skilled nursing facilities
35. Durable medical equipment, prosthetics and orthotic devices
36. Home health care, hospice care, private duty nursing, or long-term care
37. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
38. Claims for temporomandibular joint syndrome
39. Claims for biotech or specialty drugs
40. Any claim which is not explicitly covered in the schedule of benefits
41. Genetic testing unless explicitly covered in the schedule of benefits
42. Alternative, complementary or homeopathy medicine- including but not limited to acupuncture, acupressure, aquatic or massage therapy, yoga or biofeedback training.
43. Hearing and vision care (including eyeglasses, contact lenses, hearing aids (or examinations for the fitting thereof) or radial keratotomy
44. Non-emergency care when traveling outside the U.S.
45. Any services that are covered, or would be covered except for annual utilization limits, by the Base Plan that must be purchased along with this Supplemental Plan.
46. Routine well-baby care of newborn infant while inpatient
47. Pregnancy Benefits - including office visits and childbirth/delivery professional and facility services.

"The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan."