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Health Plans

For Individuals and Families

Nevada *Personal SelectSM/Personal SDHPSM*



UnitedHealthcare[®]

PacifiCare[®]

Health Insurance Plans Designed with You in Mind...



PacifiCare® places its focus on you.

We not only want to provide you with a quality health insurance plan, but anchor it with the resources you can use to help maintain a healthy lifestyle.

Over the years, individuals like you have placed their insurance needs with PacifiCare Life Assurance Company (PLAC). During that time we've listened to the concerns of our customers. We understand the issues you face when purchasing insurance.

It's that experience that allows us to design a variety of plans for you and your loved ones. Whether you're a recent graduate, self-employed, or a family of four looking for coverage, you may find a PacifiCare health insurance plan that works for you.

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And because your well-being is as important to us as it is to you, we give you the tools that may help you manage your health. Like accessing medical information from a registered nurse, researching a diagnosis, or ordering prescriptions through mail order at your convenience.

At PacifiCare it's health insurance designed with you in mind.

You want a health insurance plan that works for you. When you're looking for an insurance plan, PacifiCare offers products that are as varied as your individual needs.

Deductible:

The amount of covered expenses you pay before benefits are paid under the policy.

Preferred Network (Network):

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 maximum is met, the insurer pays 100% of most covered expenses for the remainder of the calendar year.

Personal Select

Personal Select plans are designed with a wide variety of options to fit your needs and budget. These plan designs feature:

- Lower deductible and out-of-pocket costs.
- A wide range of deductibles to fit your health-care needs.



Someone like Amber wants a health insurance plan that not only fits within her budget, but also provides the coverage she needs for her and her family. Her choice is Personal Select.

Personal Select**Personal SDHP**

Personal SDHP has network-based health insurance plans designed for individuals that lead a healthy, active lifestyle. These plan designs feature:

- A self directed account (SDA) quarterly allowance to use on preventive services.
- Saving the unused portion of your SDA or rolling it over each quarter, or each year.
- Coverage for emergencies and nonpreventive services.



People like Mary and Carl live a healthy lifestyle and like greater control of their medical expenses. They may prefer a plan with an SDA where the funds can be used to pay for preventive services. A good choice is Personal SDHP.

Personal SDHP

Eligibility

If you'd like to apply for an individual health insurance plan, you must be age 18 or over and not eligible for Medicare. All applicants must meet the insurer's underwriting requirements. 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 through age 25.

Plan Administration

As part of our corporate affiliations, PacifiCare Life Assurance Company (PLAC) works directly with American Medical Security Life Insurance Company (AMS) in the administrative functions for PacifiCare health insurance plans. The AMS functions include processing claims and applications for coverage, issuing policies, collecting premium, and providing customer service.

Child Only Coverage

Child-only coverage may be ideal for providing health insurance coverage instead of employer-sponsored coverage, when a divorce decree states 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 through age 25 if the child is a full-time student at an accredited school, college, or university.

Value-Added Services and Features

Some noninsurance services are provided through a contractual agreement with third parties and are not administered or underwritten by AMS or PLAC. Unless indicated, these services are available to most PacifiCare 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 Nurseline 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 Nurseline toll free at any time to speak with an experienced, registered nurse about your health concerns. You also have the option of listening to recorded information on many health topics in the Audio Library.

TravelCare®

When traveling in the United States, you may see any licensed medical provider. If you receive care from a contracted provider, you may save money.

Preferred Network

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.

** The 24-Hour Nurseline and Audio Library'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 services, call 911, or its local equivalent, or go to the nearest medical facility for treatment.*

*** Contracted Networks may change during your policy term.*

PacifiCare Personal Select Plans

Features	20/80-50/500 (without maternity)	30/80-50/1500 (without maternity)	30/70-50/2000 (without maternity)
Policy Maximum <i>The maximum amount of benefits payable per insured under the policy for all covered expenses incurred by a covered person while insured under the policy.</i>	\$2 million	\$2 million	\$2 million
Network Deductible (Ded.) <i>The amount of covered expenses a covered person must pay per calendar year before benefits become payable under the policy. Family deductible is twice the Individual amount.</i>	\$500	\$1,500	\$2,000
Network Coinsurance (Coins.) <i>The level of coverage for covered expenses provided by the insurance plan after the deductible is satisfied.</i>	80% coins.	80% coins.	70% coins.
Network Coinsurance Maximum (Out-of-Pocket) <i>The amount you pay per calendar year (after deductible; does not include copays) for covered expenses. Family coinsurance maximum is twice the Individual amount.</i>	\$2,000	\$4,000	\$4,000
Network Physician Office Visits	Office Visit \$20 copay, then 100%	Office Visit \$30 copay, then 100%, 4 visits per calendar year maximum	Office Visit \$30 copay, then 100%, 4 visits per calendar year maximum
Network Wellness Benefit (through age 18)	Office Visit Ded., then coins. Immunizations Ded., then coins. X-ray & Lab Tests* Ded., then coins.	Office Visit Ded., then coins. Immunizations Ded., then coins. X-ray & Lab Tests* Ded., then coins.	Office Visit Not covered Immunizations Not Covered X-ray & Lab Tests* Not covered
Network Wellness Benefit (age 19 and over)	Office Visit Ded., then coins., (limited to a \$300 combined maximum per calendar year) Mammogram Ded., then coins. Pap Smear Ded., then coins. Prostate Screening Ded., then coins. Other X-ray & Lab Tests* Ded., then coins., (limited to a \$300 combined maximum per calendar year)	Office Visit Ded., then coins., (limited to a \$300 combined maximum per calendar year) Mammogram Ded., then coins. Pap Smear Ded., then coins. Prostate Screening Ded., then coins. Other X-ray & Lab Tests* Ded., then coins., (limited to a \$300 combined maximum per calendar year)	Office Visit Not covered Mammogram Ded., then coins. Pap Smear \$30 copay, then 100% Prostate Screening Not covered Other X-ray & Lab Tests* Not covered
Network Radiology (X-ray) Test/Pathology (Lab*)	Ded., then coins.	Ded., then coins.	Ded., then coins.
Network Surgery and Anesthesiology <i>Surgical services and anesthesia services</i>	Ded., then coins.	Ded., then coins.	Ded., then coins.
Network Inpatient/Outpatient Facility Charges <i>Daily hospital room and board, miscellaneous hospital services, in-hospital medical services, out-of-hospital care</i>	Ded., then coins.	Ded., then coins.	Ded., then coins.
Network Inpatient Physician Hospital Visit	Ded., then coins.	Ded., then coins.	Ded., then coins.
Network Maternity Care <i>(Prenatal, postnatal, and childbirth expenses)</i>	Not covered	Not covered	Not covered
Emergency Room Charges <i>(Additional deductible waived if admitted)</i>	\$100 additional ded. per occurrence, then ded., then coins.	\$100 additional ded. per occurrence, then ded., then coins.	\$100 additional ded. per occurrence, then ded., then coins.
Ambulance <i>(air and/or ground)</i>	Ded., then 60% coins.	Ded., then 60% coins.	Ded., then 60% Coins.
Prescription Drug <i>The brand drug deductible is a combined mail order and retail deductible and is separate from the medical deductible. It applies to each covered person, per calendar year.</i>	Participating Pharmacy Generic Formulary: \$10 copay Brand-Name Formulary: \$30 copay Non-Formulary Brand: \$50 copay Mail Order (90-day supply): Generic Formulary: \$20 copay Brand-name Formulary: \$60 ccopyay Non-Formulary Brand: \$100 copay	Participating Pharmacy Generic Formulary: \$10 copay Brand-Name Formulary: \$100 ded., then \$35 Copay to a \$1000 calendar year maximum Non-Formulary Brand: Not covered Mail Order (90-day supply): Generic Formulary: \$20 copay Brand-name Formulary: \$100 ded., then \$70 copay to a \$1000 calendar year maximum Non-Formulary Brand: Not covered	Participating Pharmacy Generic Formulary: \$20 copay Brand-Name Formulary: \$100 ded., then \$35 copay to a \$1000 calendar year maximum Non-Formulary Brand: Not covered Mail Order (90-day supply): Generic Formulary: \$40 copay Brand-name Formulary: \$100 ded., then \$70 copay to a \$1000 calendar year maximum Non-Formulary Brand: Not covered

* If lab procedures are needed, network benefits will be available only when the lab work is done in a LabCorp facility or another UnitedHealthcare contracted lab. Visit www.uhc.com for a lab list.

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 coinsurance (which is 50%) and deductible (which is twice the individual network amount). Expenses incurred at network and non-network providers count toward satisfaction of the network/non-network deductible amount. Specific network and non-network benefits may be limited to maximum per day, per calendar year, per occurrence, or while insured. Certain non-network coinsurance amounts do not apply to the coinsurance maximum. To be considered for reimbursement, expenses must qualify as covered expenses.

Are you healthy? Do you believe in proactively managing your health? Do you seek preventive care to ensure you maintain a healthy lifestyle?

If the answer is “Yes,” then PacifiCare Personal SDHP may be the right plan for you.

PacifiCare Personal SDHP is a Preferred Network-based medical plan designed to provide coverage to individuals who lead a healthy, proactive lifestyle geared toward maintaining their health. With the PacifiCare Personal SDHP plan, you'll have access to a Self Directed Account (SDA) which covers physician visits and other preventive services to help keep you healthy, along with coverage for emergency and nonpreventive services. You also receive other value-added services to help you manage your day-to-day health.

What is the Self Directed Account (SDA)?

The SDA can be used to pay for specified eligible medical plan expenses and is available to satisfy part of the annual preferred network deductible.

The SDA offers you the flexibility you demand.

The SDA is like a “health-care checking account.” PacifiCare provides a quarterly allowance to use on preventive services including:

- Physician visits.
- Covered diagnostic X-ray and lab services.
- Covered immunizations.
- Mammography.
- Breast and pelvic exams.
- Prostate cancer screening.
- Periodic health evaluations.

You can access any physician for services covered by the SDA. If you choose to use a physician from a provider network, you will have access to negotiated rates. This will help you make the most of your SDA funds.

What is the SDA rollover feature?

The SDA's rollover feature allows the covered person to “save” the unused balance of the SDA by rolling it over to the next quarter. They can continue to roll over the remaining balance of the SDA quarter to quarter, year after year. The unused balance of the SDA is forfeited if the policy is terminated.

What services are not covered by the SDA?

Services not covered by the SDA include (but are not limited to) expenses such as hospitalization, outpatient surgery, emergency room services, and nontraditional medical expenses, such as acupuncture services.

PacifiCare Personal SDHP has a simple plan design and a variety of key features. The scenarios provided in the accompanying charts will give you an idea on how the plan works.

Jane's Individual Coverage

Self Directed Account \$ 250

Network Deductible \$3,000

- April 1, 2007 is Jane's effective date for the PacifiCare Personal SDHP plan.
- On April 15, 2007, Jane visits her doctor for her annual physical exam. Total cost of this visit is \$215.

SDA Balance	\$ 250
Annual Exam	-\$ 215
SDA Balance	\$ 35

- On Aug. 22, 2007, Jane visits the doctor with flu symptoms. The doctor prescribes a generic formulary antibiotic. Total cost of office visit = \$100. Prescription cost = \$35.

SDA Balance	\$ 35
SDA Credit for 3Q 2007	\$250
New SDA Balance	\$285
Office Visit (flu)	-\$100
SDA Balance as of Aug. 22, 2007	\$185

Prescription	\$ 35
Prescription Deductible	\$250
(Jane's responsibility)	\$ 35
No refunds will be deducted from SDA for balance of prescription cost.	

- Total out-of-pocket for Jane \$ 35
(Prescription applied to deductible).

Jack's Individual Coverage

Self Directed Account \$ 250

Network Deductible \$3,000

- April 1, 2007 is Jack's effective date for the PacifiCare Personal SDHP plan.
- On June 13, 2007, Jack breaks his leg in a bicycle accident. He has not used any of his SDA to date. The hospital bill for breaking his leg totals \$3,675.

Bicycle Accident Hospitalization	\$3,675
Amount Covered by SDA	\$0
Out-of-Pocket Cost for Jack \$3,000 deductible + \$202.50 (30% coinsurance)	
Total:	\$3,202.50

- On June 28, 2007, Jack visits a network provider with flu symptoms. The cost of the visit = \$140.

SDA Balance	\$250
Flu Symptoms Visit (30% coinsurance of \$140)	-\$ 42
SDA Balance	\$208

- Since Jack met his network deductible, his 30% responsibility for the flu visit will be deducted from the SDA funds. This is only done for eligible expenses and if funds are available.

- Total out-of-pocket for Jack \$3,202.50
(Bicycle accident hospitalization deductible + coinsurance).

PacifiCare Personal SDHP Plan

Features	70-50/3000
Policy Maximum	\$2 million
<i>The maximum amount of benefits payable per insured under the policy for all covered expenses incurred by a covered person while insured under the policy.</i>	
Network Self Directed Account (SDA)	\$250 per calendar quarter (Individual) \$500 per calendar quarter (Family)
Network Deductible (Ded.)	\$3,000
<i>The amount of covered expenses a covered person must pay before benefits become payable under the policy. Family deductible is twice the Individual amount.</i>	
Network Coinsurance (Coins.)	70% coins.
<i>The level of coverage for eligible expenses provided by the insurance plan after the deductible is satisfied.</i>	
Network Coinsurance Maximum (Out-of-Pocket)	\$3,000
<i>The amount you pay per calendar year (after deductible) for covered expenses. Family coinsurance maximum is twice the Individual amount.</i>	
Network Physician Office Visits	Office Visit Ded., then coins., (applicable to SDA)
Network Wellness Benefit (through age 18)	Office Visit Ded., then coins., (applicable to SDA) Immunizations Ded., then coins., (applicable to SDA) X-ray & Lab Tests* Ded., then coins., (applicable to SDA)
Network Wellness Benefit (age 19 and over)	Office Visit Ded., then coins., (applicable to SDA) Mammogram Ded., then coins., (applicable to SDA) Pap Smear & Prostate Screening Ded., then coins., (applicable to SDA) Other X-ray Tests Ded., then coins., (applicable to SDA) Other Lab Tests* Ded., then coins., (applicable to SDA)
Network Radiology (X-ray) Test/Pathology (Lab*)	Ded., then coins.
Network Surgery and Anesthesiology	Ded., then coins.
<i>Surgical services and anesthesia services</i>	
Network Inpatient/Outpatient Facility Charges	Ded., then coins.
<i>Daily hospital room and board, miscellaneous hospital services, in-hospital medical services, out-of-hospital care</i>	
Network Inpatient Physician Hospital Visit	Ded., then coins.
Network Maternity Care	Not covered
<i>(Prenatal, postnatal, and childbirth expenses)</i>	
Emergency Room Charges	\$100 additional ded. per occurrence, then ded., then coins.
<i>(Additional deductible waived if admitted)</i>	
Ambulance	Ded., then 60% coins.
<i>(Air and/or ground)</i>	
Prescription Drug	Participating Pharmacy
<i>The drug deductible is a combined mail order and retail deductible and is separate from the medical deductible. It applies to each covered person, per calendar year.</i>	
\$250 ded. then:	Generic Formulary: \$15 copay Brand-Name Formulary: \$40 copay Non-Formulary: \$60 copay Mail Order: Generic Formulary: \$30 copay Brand-name Formulary: \$80 copay Non-Formulary: \$120 copay

* If lab procedures are needed, network benefits will be available only when the lab work is done in a LabCorp facility or another UnitedHealthcare contracted lab. Visit www.uhc.com for a lab list.

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 coinsurance. Network/non-network coinsurance amounts are as follows: 70%/50%. Network/non-network coverage track toward the same deductible amount. Specific non-network benefits may be limited to maximums per day, per calendar year, per occurrence, or while insured. Certain non-network coinsurance amounts do not apply to the coinsurance maximum. To be considered for reimbursement, expenses must qualify as covered expenses.

Covered Expenses

This is not an all-inclusive list of covered expenses. Benefits are subject to any applicable copayment, deductible, coinsurance, usual and customary charges, and benefit maximums and limited fee schedules. All benefits for services are subject to policy provisions.

Benefits for services provided by non-network providers are limited, or excluded, and may be subject to additional deductibles.

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, speech, and occupational therapy. Physical, speech, and occupational therapy are subject to a \$1,000 combined calendar-year maximum.

Wellness Benefit

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

Other Covered Expenses

Covered services include radiology and pathology tests and prescription drug benefits (if Prescription Drug Coverage is included in your plan).

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.

Hospital* and Other Facility Charges

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

Newborn Care

Coverage is included for a newborn or sick baby for 31 days from birth. 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 physical, respiratory, occupational, and speech therapy, and skilled home care and health aide services. Covered to 100 visits per calendar year for *Personal Select* and covered to 60 visits per calendar year for *Personal SDHP*.

Skilled Nursing

Includes coverage for facility, room and board, and skilled nursing care for 90 days per calendar year for *Personal Select* and covered to 30 days per calendar year for *Personal SDHP*.

Organ Transplant and Transplant Services

Non-experimental and non-investigational organ transplants and transplant services are covered when the recipient is a covered person and the transplant is performed at a company-authorized transplant facility. Organ transplants are covered subject to deductible and coinsurance levels according to the policy maximum.

Transportation, food, and housing allowances are available to the transplant recipient, who is a covered person, to the maximums outlined in the policy, when the company-authorized transplant facility is greater than 100 miles from the recipient's primary residence. Transportation, food, and housing expenses of a living donor are excluded and are the responsibility of the covered person who is the recipient of the transplant.

* Hospital does not include a nursing home, convalescent home, or extended care facility.

** Separate Deductible may apply.

State Coverages—Nevada

Benefits are subject to any applicable copayment, deductible, coinsurance, usual and customary charges, and benefit maximums. All benefits for services are subject to policy provisions.

Benefits for services provided by non-network providers are limited, excluded, or may be subject to additional deductibles.

Mammograms

Coverage includes a baseline mammogram for women between the ages of 35 and 40, and an annual mammogram for women 40 years of age or older.

Pelvic examinations and pap smear examinations

Coverage is provided for pelvic examinations and Pap smear examinations annually.

Metabolic Disease Formulas

Coverage is provided for enteral formulas same as any other diagnosis.

Temporomandibular Joint Dysfunction

Benefits are covered the same as any other diagnosis.

Severe Mental Illness

Coverage is provided for severe mental illness. Inpatient services to a maximum of 40 days per calendar year. Outpatient services to a maximum of 40 visits per calendar year.

Chemical Dependency, Alcohol Treatment

Benefits of \$1,500 per calendar year maximum for detoxification, \$9,000 calendar year maximum for inpatient treatment, and \$2,500 maximum for outpatient treatment.

Billing Options

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

Usual and Customary Charge

We use a number of national standards to determine usual and customary amounts payable for medical services. If services are received from a non-network provider, the covered person will be responsible for any charges above these usual and customary amounts (not including copays and coinsurance), or the limited fee schedule.

Out-Of-Pocket Maximum Personal Select and Personal SDHP

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

Copays and/or additional medical deductibles do not apply toward out-of-pocket maximums. Please refer to the product features pages for out-of-pocket information for each plan design.

Insurance Plan Provisions

Pre-existing Condition Limitation

All medical insurance plans include a pre-existing condition limitation.

A pre-existing condition means a condition for which a person received medical care, treatment, services, medication, diagnosis, or consultation 6 months before the insured person's effective date of coverage. Pre-existing conditions are covered after a period of 12 months, during which time the person has been continuously covered under the policy.

The length of the exclusionary period for preexisting conditions will be reduced by the number of days of your creditable coverage and if you have not experienced a break in coverage of more than 63 days.

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, tobacco use, classes, gender, health status of you and your insured dependents, health status of the entire pool of insureds in which you are included, administrative costs, and other factors. 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 60 days prior to the effective date of a premium change, unless state law requires additional notice.

Premiums may also change with the next premium due date and the date when:

- A higher age is attained;
- 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 preceding reasons, 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.
- PacifiCare Life Assurance Company (PLAC) does not renew all insurance plans with the same type and level of benefits in the state.
- PLAC no longer sells similar health coverage in a given state.
- You or your dependents no longer reside in the network service area.
- You move to a state where, by law, PLAC is not licensed to do business.

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. on the termination date.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 guaranteed issue to an insurance plan.

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

- Has a total of 18 or more months of continuous creditable coverage.
- Most recent prior creditable coverage was under a group health plan, government plan, or church 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, Medicaid, or any successor program.
- 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, Individual short-term medical coverage, Medicaid, Medicare, public health plans, 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 apply for reinstatement of coverage. If your coverage lapses and you would like to apply for reinstatement, a written request along with a completed application is required. Depositing payment for reinstatement does not mean acceptance and does not guarantee approval of reinstatement. Reinstatement is not guaranteed.

Third Party Liability/Non-Duplication of Benefits

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.

Notification/Authorization

Certain non-formulary medications, and/or services require notification and/or preauthorization by the covered person. Failure to comply with notification and/or preauthorization requirements may result in a reduction of the benefits payable for covered services.

Limitations and Exclusions

Please read carefully.

Exclusions

Covered Expense does not include any of the following:

A charge for: • anything other than a Covered Service • services and supplies that do not meet generally accepted standards of medical practice • a Covered Service provided by a Covered Person's spouse, domestic partner, sibling, child, parent, in-law, aunt, uncle or grandparent • incurred for an employment or insurance purpose • outpatient disposable or consumable medical supplies, foods or nutritional supplements • psychosurgery • circumcision, unless performed within 6 months following birth • obesity treatment or weight reduction • visual therapy, including eye exercises, orthoptics, radial keratotomy (LASIK), keratimileusis, and keratophakai • acupuncture • orthotics, arch supports, orthopedic shoes, sneakers or support hose, or similar types of devices/applicances • a sex change • missed appointments or late charges • maternity services • reversal of sterilization • incidental items during a hospitalization • diagnosis or treatment of infertility.

A charge incurred as a result of: • employment related Sickness or Injury unless the Covered Person is exempt from Workers' Compensation coverage and is properly enrolled for such coverage under the terms of the policy • self-inflicted injury or an attempted suicide • participation in a riot or insurrection • participation in the commission of a felony or other unlawful act • declared or undeclared war • military duty • treatment for hearing disorders, including hearing aides and cochlear implants

A charge incurred unless specifically included in the Policy for: • eye examinations, routine eye fractions, frames and lenses for eyeglasses and contact lenses • cosmetic or reconstructive procedure • private duty nursing • drug administration • motor driven wheel chairs and beds or other durable medical equipment

A charge: • a Covered Person is not legally required to pay • incurred for a service or supply to eliminate or reduce a dependency or addiction to tobacco • incurred outside the United States when the Covered Person traveled to the location for purpose of obtaining drugs, services or supplies • for any medical care in connection with dental treatments unless required for repair or replacement of sound natural teeth damaged by injury while insured under this policy, within 12 months following injury or in connection with congenital defects, malformations or adnormalities present at birth.

Limitations on Benefits

• Acts beyond the Company's Control • Experimental and/or Investigational Procedures • Wellness • Physical, speech and occupational therapy • home health care • skilled nursing • organ transplant and transplant services • Severe Mental Illness • Chemical Dependency and Alcohol treatment • Durable Medical Equipment • Prosthetic devices • Orthotic devices • Hospice care.

Outpatient Prescription Drugs Exclusions and Limitations

No benefits are payable for any of the following:

- Drugs or medicines purchased and received prior to the Covered Person's effective date or subsequent to the Covered Person's termination
- Therapeutic devices or appliances
- All non-prescription contraceptive jellies, ointments, foams or devices
- Drugs dispensed by a Hospital, rest home, sanitarium, Skilled Nursing Facility, convalescent care Facility, nursing home or similar institution while confined as a patient
- Drugs or medicines delivered or administered to the Covered Person by the Provider or the Provider's staff
- Dietary supplements and dental-related products
- Medication which may be properly received without charge under local, state or federal programs or which is reimbursable under other insurance programs including workers' compensation
- Medications prescribed for experimental or non-FDA approved indications unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopeial Convention or in the American Hospital Formulary Services edition of Drug Information
- medications limited to investigational

use by law

- For patent Drugs or medications available without a prescription (over the counter) or for which there is a nonprescription equivalent available
- Drugs or medicines used or taken primarily to improve or otherwise modify the Covered Person's external appearance
- Nicotine gum or any other drug containing nicotine or other smoking deterrent medications
- Administration or injection of any drug
- Immunizing agents, injectables (except insulin), biological sera, blood plasma or medication prescribed for parenteral use
- Any applicable sales tax or surcharge
- Outpatient Prescription Drugs determined not to be effective for the specific diagnosis or which do not follow community practice standards
- Injectable infertility Drugs
- Prescription medication for the treatment of sexual dysfunction
- Elective or voluntary enhancement procedures, services, supplies and medications
- New prescription medications or supplies until they are reviewed for safety, efficacy and cost effectiveness, and approved by the Company
- Any benefit provided under the Outpatient Formulary Prescription Drug Benefit is not eligible as a Covered Expense under any other provision of the Policy.

Call (800) 232-5432

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 policy IHP-IPLAN-POLICY. Applicable law will apply with respect to eligibility, rating, and other terms of conditions and coverage.

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