MedOne HSAvings℠

American Medical Security®

A HIGH-DEDUCTIBLE HEALTH PLAN

COLORADO

United Wisconsin Life Insurance Company

It goes without saying that your health is important, and it's also important to choose a health insurance company you can rely on. For many years, individuals and their families have relied on the health insurance products designed, administered, and marketed by American Medical Security, Inc. (AMS) and underwritten by United Wisconsin Life Insurance Company.

We realize that one health insurance plan doesn't suit everybody's needs, so we've designed a portfolio of insurance plan designs to choose from. We're confident you'll find the insurance plan and options that fit your needs and budget.

But that's not all. We offer unparalleled service with our insurance plans. For example, a helpful customer service representative will answer the phone when you call our home office—24 hours a day, 365 days a year. You won't find any electronic phone menus to work your way through.

We also provide you with a toll-free number you can call to speak to a registered nurse. Nurses are available to give you medical information 24 hours a day, 365 days a year.

When you add our service to the products we market, you have a company you can rely on for your health insurance needs—a company that incorporates the small-town values of its hometown of Green Bay, Wis., into its everyday business practices.

As you discuss the benefits, features, and services described in this brochure with your professional agent and learn more about our company, we're confident you'll be reassured that your health insurance needs will be in competent hands. We invite you to join the AMS family of satisfied customers.

AN ALTERNATIVE APPROACH TO FUNDING HEALTH-CARE COSTS FOR INDIVIDUALS

The cost for health care and health insurance has risen in recent years. As a result, individuals are looking for solutions. And American Medical Security, Inc. (AMS) and United Wisconsin Life Insurance Company have a health insurance solution that can help individuals and families.

Many individuals may prefer a health insurance plan with lower premiums. They want protection from financial losses that may result from a hospitalization or other catastrophic event but are willing to pay expenses for less serious medical services. Combining a tax-preferred federal health savings account (HSA)* with a qualified high-deductible health plan (HDHP) may be the answer.

What is an HSA?

An HSA is a federal tax-exempt savings account set up at a financial institution to save money exclusively for payment of qualified medical expenses.

Anyone who has an HDHP that meets government requirements may open an HSA. MedOne HSAvings is designed to meet these requirements.**

What is an HDHP?

HDHPs must meet federal guidelines. Both deductible and out-of-pocket maximum amounts are determined by the federal government. These amounts follow the Department of Labor's Consumer Price Index and may change annually.

Those with family coverage meet a family deductible, and eligible expenses for all family members contribute to the deductible. When the family calendar-year deductible is met by any combination of family members, the insurance plan pays eligible benefits for the entire family.

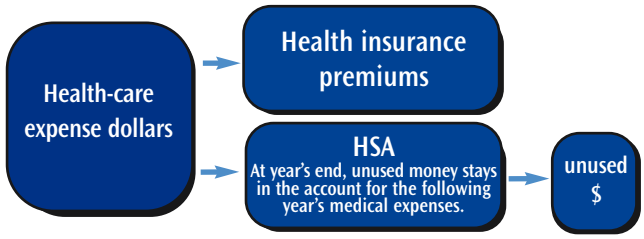
HDHPs also have maximum limits on the annual out-of-pocket amounts for covered expenses. The amounts paid to meet the deductible are applied to the maximum out-of-pocket amounts.

How An HSA Works

The following diagram illustrates the benefits of an HSA.

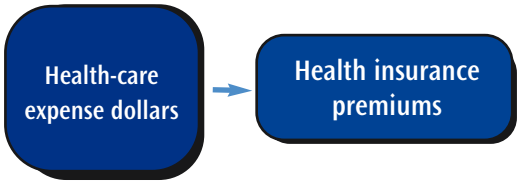
Health Plan with an HSA

When an HSA is used together with an HDHP, health-care expense dollars are split between health insurance and the HSA. The HSA owner decides the amount to deposit in the HSA. At the end of the year, any money that hasn't been used can remain in the HSA for the following year's medical expenses.



Health Plan without an HSA

Without an HSA, health-care expense dollars go entirely to health insurance.



Some Advantages for Customers

HSA contributions are tax deductible up to allowable limits. The amount of HSA money spent on qualified medical expenses can be excluded on tax returns.

Any unused money at the end of the plan year can be retained in the HSA for the following year.

MEDONE HSAvings ELIGIBILITY

Eligible applicants must be age 18 or over and under age 65. All applicants must meet the insurer's underwriting requirements and be U.S. citizens or be in the U.S. by a valid permanent visa or green card. A copy of the visa or green card is required.

Eligible 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 to age 25.

** HSAs are not insurance.*

*** Both the family and individual deductible plans have been designed to meet the HSA high deductible health plan requirements of Federal Law (26 U.S.C. Sec 223). This law contains several requirements regarding the tax deductibility of HSAs. Please consult with your tax and legal advisors to determine whether your HSA will qualify as tax deductible.*

MedOne HSAvings

FAMILY DEDUCTIBLE PLAN

Your lifetime maximum per covered person is $5 million.

100% Option

DEDUCTIBLE AMOUNTS		COINSURANCE AMOUNTS	
Network	Non-network	Network	Non-network
❑ $2,000	$4,000		
❑ $2,500	$5,000		
❑ $3,000	$6,000		
❑ $4,000	$8,000	❑ 100%	70% of $10,000
❑ $5,150	$10,300		
❑ $7,500	$15,000		
❑ $10,000	$20,000		

80% Option

Network	Non-network	Network	Non-network
		80% of	*60% of*
❑ $2,000	$4,000	❑ $10,000	$10,000
		❑ $20,000	$20,000
		❑ $30,000	$30,000
		❑ $40,000	$40,000
❑ $2,500	$5,000	❑ $10,000	$10,000
		❑ $20,000	$20,000
		❑ $30,000	$30,000
❑ $3,000	$6,000	❑ $10,000	$10,000
		❑ $20,000	$20,000
		❑ $30,000	$30,000
❑ $4,000	$8,000	❑ $10,000	$10,000
		❑ $20,000	$20,000
		❑ $30,000	$30,000
❑ $5,150	$10,300	❑ $10,000	$10,000
		❑ $24,200	$24,200
❑ $7,500	$15,000	❑ $10,000	$10,000

50% Option

Network	Non-network	Network	Non-network
		50% of	*50% of*
❑ $2,000	$4,000	❑ $6,000	$12,000
		❑ $8,000	$16,000
		❑ $10,000	$20,000
		❑ $16,000	$32,000
❑ $2,500	$5,000	❑ $5,000	$10,000
		❑ $10,000	$20,000
		❑ $15,000	$30,000
❑ $3,000	$6,000	❑ $8,000	$16,000
		❑ $14,000	$28,000
❑ $4,000	$8,000	❑ $6,000	$12,000
		❑ $12,000	$24,000
❑ $5,150	$10,300	❑ $5,700	$11,400
		❑ $7,700	$15,400
		❑ $9,700	$19,400
❑ $7,500	$15,000	❑ $5,000	$10,000

Eligible expenses for all family members contribute to meeting the family deductible. When the family deductible is met by any combination of family members, the insurance plan pays benefits for the entire family.

To determine your Out-of-Pocket Maximum, add your deductible to your coinsurance portion.

Insurance plans provide only limited benefits for services provided by non-network providers. The Classic MedOne HSAvings insurance plan (non-network) is available. Please see your agent for details.

MedOne HSAvings

INDIVIDUAL DEDUCTIBLE PLAN

Your lifetime maximum per covered person is $5 million.

100% Option

DEDUCTIBLE AMOUNTS		COINSURANCE AMOUNTS	
Network	Non-network	Network	Non-network
❑ $1,500	$3,000	❑ 100%	70% of $10,000
❑ $2,000	$4,000		
❑ $2,600	$5,200		
❑ $3,500	$7,000		
❑ $5,000	$10,000		

80% Option

Network	Non-network	Network	Non-network
		80% of	*60% of*
❑ $1,000	$2,000	❑ $10,000 ❑ $20,000	$10,000 $20,000
❑ $1,500	$3,000	❑ $10,000	$10,000
❑ $2,000	$4,000	❑ $10,000	$10,000
❑ $2,600	$5,200	❑ $10,000	$10,000
❑ $3,000	$6,000	❑ $5,000	$5,000

50% Option

Network	Non-network	Network	Non-network
		50% of	*50% of*
❑ $1,000	$2,000	❑ $4,000 ❑ $6,000	$8,000 $12,000
❑ $1,500	$3,000	❑ $5,000	$10,000
❑ $2,000	$4,000	❑ $4,000	$8,000
❑ $2,600	$5,200	❑ $2,800 ❑ $4,800	$5,600 $9,600
❑ $3,000	$6,000	❑ $2,000 ❑ $4,000	$4,000 $8,000

To determine your Out-of-Pocket Maximum, add your deductible to your coinsurance portion.

COVERED EXPENSES APPLY TO BOTH FAMILY AND INDIVIDUAL DEDUCTIBLE PLANS

Physician Services
- Professional fees
- Inpatient and outpatient services
- Emergency room services

Wellness (Routine) Benefit
(Eligible only when received from a network provider unless otherwise mandated)
- Physical exams
- Pap smears
- Prostate screening
- Mammograms
- Lab and X-ray

Pathology (lab) and Radiology (X-ray) Tests
- Diagnostic
- MRI and CAT scans

Surgery and Anesthesiology Fee
- Inpatient and outpatient

Hospital and Facility Services
- Inpatient and outpatient care
- Diagnostic tests, lab, and X-ray
- Emergency room and urgent care

Complications of Pregnancy

Transplants

Ambulance
- Ground and air transportation

Skilled Nursing Care
- 30 days per calendar year

Home Health Care
- 20 visits per calendar year

All eligible services are subject to deductible, then coinsurance up to the out-of-pocket maximum, then 100%.

Insurance plans provide only limited benefits for services provided by non-network providers. The Classic MedOne HSAvings insurance plan (non-network) is available. Please see your agent for details.

DEDUCTIBLE*

The deductible is the amount of covered expenses you pay each calendar year before benefits are paid under the Policy.

COINSURANCE

The coinsurance is 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 covered expenses for the remainder of the calendar year.

OUT-OF-POCKET MAXIMUM*

The out-of-pocket maximum is a specific limit on the amount of covered expenses you pay per calendar year. When an individual out-of-pocket maximum level has been reached, that individual no longer pays deductible or coinsurance for the remainder of that calendar year. Out-of-pocket expenses for all family members contribute to meeting the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, none of the family members pay deductible or coinsurance for the remainder of that calendar year.

Non-network deductibles and coinsurance amounts credit toward both the network and non-network out-of-pocket maximums. The network deductible and coinsurance apply only to the network out-of-pocket maximum.

* This insurance plan's deductible and out-of-pocket levels are intended to satisfy government rules applicable to HDHPs. The rules may change annually. Deductible and out-of-pocket levels may be adjusted at the beginning of each year to stay within these rules. We'll notify you of any changes as soon as reasonably possible.

COVERED EXPENSES

Benefits are subject to applicable deductible, coinsurance, and maximum allowable charges. All services are subject to Policy provisions.

Transplants

When using the Transplant Provider Network, eligible services are covered at 100% after your deductible to a $1 million lifetime maximum. Outside the Transplant Provider Network, eligible services are covered at 70% after a deductible to a lifetime maximum of $250,000. Transplant benefits are combined to a total maximum of $1,000,000 per lifetime, per insured.

Services include the transplant of kidney, liver, pancreas, heart, lung, kidney/pancreas, heart/lung, allogenic bone marrow, autologous bone marrow, stem cell, and donor expenses as defined in the Policy. Subject to prior approval. Artificial organs are not covered.

Note: The transplant provider network is separate from the medical network if a network insurance plan is chosen.

Hospice Care

Part-time nursing care and home health aide services are included up to eight hours a day. Physical therapy, services, supplies, prescription drugs, and case management are also included.

Skilled Nursing Care

Includes coverage for room, board, routine services, and skilled nursing care for 30 days per calendar year.

Complications of Pregnancy

Complications of pregnancy are covered the same as any sickness for any insured female. Complications do not include expenses for normal pregnancy and childbirth.

Newborn†

Coverage is included for a newborn for 31 days from birth. It includes surgery and treatment of injury, sickness, birth defects, and medically necessary treatment for cleft lip and cleft palate. 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 part-time physical, respiratory, occupational, and speech therapy and part-time or intermittent skilled home care and health aide services. Covered to 20 visits per calendar year.

Vision Exam

Coverage includes one comprehensive eye exam every 12 months including refraction. Benefits are payable at 100% after a $10 copay when services are received from a vision benefit network provider.

Benefits are payable to a maximum of $38 when services are rendered by a vision benefit non-network provider.

Note: The vision benefit network is separate from the medical network if a PPO insurance plan is chosen.

† See other covered expenses.

OTHER COVERED EXPENSES

Home Health Care

Home care is extended from 20 visits to 60 visits per calendar year.

Mammography Screening

Benefits are payable in accordance with increases and decreases in the national Consumer Price Index-Urban (CPI-U) published by the U. S. Bureau of Labor and Statistics. On September 1st of each year, the CPI-U amount will be updated to reflect the most recent CPI-U for the preceding 12-month period.

Prostate Screening

Benefits are included for covered males age 50 and over or age 40-50 subject to physician's recommendation. Network and non-network benefits are covered at 100% for the first $65 per screening, balance will be paid according to the plan.

Well Child Care

Covered services for covered dependent children include physical exams, immunizations, and other limited services, from birth to age 13. Covered services are subject to coinsurance or copays, but are not subject to deductible or lifetime maximums.

Diabetes Treatment

Coverage also includes prescribed equipment, supplies and outpatient self-management training and education, including medical nutrition therapy. Covered services are subject to applicable copay, deductible, and coinsurance.

Sick Baby (Congenital Defects and Birth Abnormalities)

Sick baby coverage also includes physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for 20 visits per year, up to 5 years of age.

INSURANCE PLAN FEATURES

TravelCare®

The TravelCare benefit allows insureds who are traveling outside their networks' primary service areas to receive care from providers affiliated with Private Healthcare Systems, Inc. (PHCS), a nationwide PPO network. Receive care from a PHCS provider and get network-level coverage—that may mean less out-of-pocket expense for you. To receive this insurance benefit, select an insurance plan design using a PPO.

On-the-Job Protection

On-the-Job Protection offers 24-hour coverage for eligible medical expenses due to work-related injury or sickness. Some occupations are ineligible. Ask your agent about On-the-Job Protection.

Non-Tobacco Use Discount

If you don't use tobacco, you may receive premium savings!

Get the most from your insurance plan!

When you precertify treatment, our health-care management professionals can advise you and your physician of the coverage available for your treatment. By offering sensible, cost-effective solutions, we encourage you to manage your health care and get the most from your insurance plan.

Preferred Provider Organization (PPO)

A network of credentialed doctors, clinics, hospitals, and other health-care providers that are contracted to provide medical services at negotiated fees. AMS may replace the network at any time. Advance notice will be given.

Non-Network Providers are providers, including physicians, clinics, and hospitals, that are not contracted with the network.

Network Adequacy

There are no participating providers located in Hinsdale and San Juan County. The list of participating providers is subject to change; therefore, we recommend that you contact us at (800) 232-5432 extension 15201 to verify whether or not your provider is a participating provider prior to services being rendered.

Receive up to $1,000 Cash

If you find an overcharge on a hospital or medical bill, we may pay you up to 50% of the savings, up to $1,000 cash per calendar year.

VALUE-ADDED SERVICES AND DISCOUNTS

Note: The features listed below are not insurance benefits.

Customer Service

Whenever you call our home office, a customer service representative will answer the phone—24 hours a day, 365 days a year. You can expect prompt, friendly service and accurate information about claims, benefits, and general coverage around the clock.

Nurse Healthline, Inc.*

Registered nurses provide free medical and provider information toll free 24 hours a day, 365 days a year. Approximately one-third of Nurse Healthline, Inc. calls provide information for home self-care. Consider the savings of time and money.

* Services are provided through a contractual agreement with our affiliate, Nurse Healthline, Inc.

PPO Plan Options

With all our insurance plans, you have the freedom to visit the doctor you feel most comfortable with—the doctor you trust. You can save money by selecting an insurance plan that uses a PPO and visiting network providers when you need treatment.

Prescription Discount

Although this is not an insurance benefit, you may realize savings when you purchase your prescription drugs at a member pharmacy. You pay the entire cost of your prescription drug but at the discounted cost. (See page 8 for buy-up option.)

Dental Discounts

AMS and **CARE**INGTON International have an agreement to provide MedOne HSAvings insureds with a dental discount card program. Thousands of participating dentists nationwide present discounts on a variety of common dental services—from cleanings and exams to crowns and prosthetics. A dental insurance plan with broad coverage is available to replace the **CARE**INGTON discount program. (See page 8 for more information.)

VSP Discounts

Laser Vision Discounts: VSP has made arrangements with laser surgery facilities and doctors to offer its members discounts that average 20% to 25%. Eyewear Discounts: VSP doctors offer valuable savings, including a 20% discount on pairs of prescription glasses (lenses and frame) not covered by an eyewear benefit. You can also save 15% on the cost of your contact lens exam when you receive contact lens services from VSP.

OPTIONAL BENEFITS

Optional Benefits are available at an additional cost.

Prescription Drug Coverage Option

When you purchase the Prescription Drug Coverage Option, your prescription drug expenses apply to your medical deductible and coinsurance. In addition, you receive prescription drugs at a reduced cost when you purchase them from a member pharmacy. You can save as much as 14% on brand-name drugs and as much as 50% on generic drugs at more than 52,000 member pharmacies nationwide.* You pay the reduced cost at the member pharmacy and they will either submit the information to us electronically or give you a receipt so you can submit it to us. Eligible charges then will be applied to your network deductible and coinsurance. Prescriptions purchased at a non-member pharmacy are not eligible for a reduced cost. However, eligible charges will apply to your non-network medical deductible and coinsurance when you submit your receipt to us.

** Savings subject to change.*

MedOne Dental Insurance Plan Benefits

Combining MedOne Dental insurance with your MedOne HSAvings health insurance plan gives you a more comprehensive coverage package. When elected, MedOne Dental replaces the **CARE**INGTON International Discount Dental Program. (See page 7.)

MedOne Dental delivers some of the same coverages as employer-based dental programs.

Product Details

Coverage Information: MedOne Dental coverage is available only at the time a MedOne HSAvings health insurance plan is applied for or up to 45 days after the application is signed.

Waiting Period Information: Waiting periods apply from the original effective date of MedOne Dental coverage. (See chart.) Credit for coverage with a prior carrier is not applicable to the waiting periods. A waiting period is the period of time before the insured is eligible for benefits under the Policy.

Wellness (Routine) Option

The Wellness (Routine) Option pays 100% up to $150 per covered person, per calendar year for network routine physical exams, X-rays and laboratory tests, mammograms, Pap smears, and prostate screenings. Eligible charges in excess of the the Wellness (Routine) Option benefit are subject to normal insurance plan benefits. This benefit does not apply to services received in a hospital setting.

This Wellness (Routine) Option is not available with the Classic MedOne HSAvings Plans.

MedOne DENTAL SERVICES	BENEFITS	WAITING PERIOD
Calendar-Year Deductible	$50 per person (3 per family maximum)	N/A
Calendar-Year Maximum	$750 per person	N/A
Preventive *Oral evaluations and cleanings (twice per calendar year)* *Topical fluoride treatments (for dependent children up to age 16)*	80% of eligible expenses (after deductible)	No waiting period
Basic Services *X-rays; sealants for dependent children (up to age 16); nonsurgical extractions; simple restorative services; stainless steel crowns on primary teeth; repair of crowns, inlays, bridgework, or dentures*	60% of eligible expenses (after deductible)	6-month waiting period
Major Services *Endodontics; periodontics; crowns, inlays, onlays, and veneers; oral surgery; dentures, bridges, and partials*	50% of eligible expenses (after deductible)	18-month waiting period

BILLING OPTIONS

When you choose a MedOne HSAvings insurance plan design, you have the option to have annual, semiannual, or quarterly direct billing. Monthly and other mode of payments can be made by automatic bank draft withdrawals. Credit Cards (VISA®, Discover®, or MasterCard®) will also be accepted for the first month premium only.

MAXIMUM ALLOWABLE CHARGE

We use a number of national standards to determine maximum amounts payable for medical services. If charges from a non-network provider are above these maximum amounts, the insured person may be subject to additional charges (above coinsurance).

Maximum Allowable Amount for Non-Preferred Provider Organization

If you would like to obtain the maximum allowable amount for a specific covered health care service, which will be rendered by a non-preferred provider organization, you can contact us at 1-800-232-5432, extension 15201.

INSURANCE PLAN PROVISIONS

Pre-existing Condition Limitation

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

A pre-existing condition means (1) a condition for which a person received medical care, treatment, services, medication, diagnosis, or consultation 12 months before the insured person's effective date of coverage or (2) a condition that produced symptoms that are distinct and significant enough to establish the onset of a condition or that the condition manifested itself, where a person learned in medicine would be able to diagnose the condition because of those symptoms, or where the symptoms would cause an ordinarily prudent person to seek diagnosis or treatment. Pre-existing conditions are covered after a period of 12 months, during which time the person has been continuously covered under the Policy.

We will waive the pre-existing limitation for conditions that are fully and completely disclosed on the application; however, we may place an exclusion or impairment rider on a certain condition(s).

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, gender, tobacco use, classes, health status of you and your insured dependents, the length of time you are insured under the insurance plan, health status of the entire pool of insureds in which you are included, administrative costs, and other factors. Your initial premium rates are guaranteed for the first 12 months of coverage providing you maintain residence in the same geographic location. Thereafter, 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 30 days prior to the effective date of a premium change, unless state law requires additional notice.

Premiums may also change on the next premium due after the date when:

- You or your insured dependent attain a higher age;
- 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 reasons stated above, 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.
- We do not renew all insurance plans with the same type and level of benefits in the state.
- We no longer sell similar health coverage in a given state.
- You or your dependents no longer reside in the network service area, if covered by a network insurance plan.
- You move to a state where, by law, we are 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. Central Standard Time on the termination date.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act (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 guarantee issue to the CoverColorado plan.

An eligible person 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 insurance plan.
- Is not eligible for coverage under Medicare or Medicaid.
- Was not terminated for nonpayment of premiums, fraud, or intentional misrepresentation of material fact.
- 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 insurance plan.

Creditable coverage includes health insurance coverage and other health coverage, such as coverage under other group health insurance plans, short-term medical coverage, Medicaid, Medicare, CHAMPUS, other 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.

SUBROGATION/RIGHT OF REIMBURSEMENT

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.

LIMITATIONS AND EXCLUSIONS

Please read carefully.

Medical

No medical insurance coverage is provided for any of the following unless specified elsewhere as a covered benefit for:

Alcoholism, drug abuse, mental or nervous disorders • Any treatment or supply for hair loss or growth • Any weight loss method • Attempted suicide or intentional self-inflicted injury or sickness while sane or insane • Blood products replaced by donation or blood storage except for scheduled surgery • Bony protuberances or misalignment of forefoot and toes including bunions, spurs, and hammertoe • Care provided by a family member or by a person residing with you • Cesarean-section delivery • Civil or criminal battery or felony • Cost of brand-name drugs in excess of the cost of generic drugs • Cost to rent durable medical equipment that exceeds the cost to purchase the item • Custodial care • Dental surgery except as defined under the Policy • Dental treatment from chewing injury or dental implants • Drugs obtainable without a written prescription • Emergency room treatment if no emergency exists • Exams, x-rays, and tests for routine physicals when using a non-network provider or if exams, x-rays, and tests are being done for employment, school, travel, buying insurance, marriage, or family planning • Expense for which no benefit is described • Experimental or investigative procedures, devices, or drugs • Eye exams, eyeglasses, contact lenses, or surgery to improve eyesight • Hearing aids or exams • Hospital costs for admission from 8 a.m. Friday to midnight Sunday except for an emergency or scheduled surgery • Immunizations • Items used only for comfort such as a humidifier • Learning disabilities or developmental disorders, testing or training for education or vocation, vision therapy, or speech therapy except for injury or functional defect • Marriage, family, or sex counseling • Multiple surgeries done at the same time; secondary procedures are covered up to one-half the cost of each additional procedure • Normal pregnancy • On-the-job injury or sickness for you and your spouse unless enrolled and approved by us for the On-the-Job Protection Benefit • Orthognathic reconstructive surgery • Plastic or cosmetic surgery unless for reconstruction caused by a covered injury, sickness, or mastectomy • Pre-admission testing in a hospital not done within seven days before scheduled admission • Pre-existing conditions • Prescription drug charges except in hospital or hospice, unless the prescription drug coverage option is purchased • Private duty nursing • Riot • Routine injection of drugs • Sclerotherapy for varicose veins • Services and supplies furnished by a government plan, hospital, or institution unless by law you must pay • Services and supplies not medically necessary, not recommended/approved by a doctor, or not provided within the scope of a doctor's license • Services or supplies charged in excess of the maximum allowable charge • Services or supplies provided by your employer or provided after insurance terminates • Services or supplies provided free of charge • Sex change operations and complications; testing and treatment for

impotency or infertility; any treatment, procedure, drug, or device to prevent or promote conception • Skilled nursing facility confinement beyond 30 days per calendar year • Sterilization • Strained or flat feet; instability or imbalance of feet or ankles; orthopedic shoes or supplies; cutting or removal of corns, calluses, or toenails except for diabetes or similar disease • Therapeutic restoration of nerve system and body structures by manipulation and treatment of human body structures including the spine • TMJ and related disorders • Treatment of the following conditions during the first six months you are insured by the Policy: hemorrhoids, hernia, tonsillectomy or adenoidectomy (except covered for an emergency), and varicose veins • Treatment outside of the U.S. except for an emergency • War or military service • Well baby care.

Dental

The following dental expenses are not covered:

Any dental supplies including, but not limited to, take-home fluoride, prescription drugs and nonprescription drugs • Any dental procedures for which benefits are payable under the medical insurance provision of the certificate • Athletic mouth guards • Attempted suicide or intentionally self-inflicted injury while sane or insane • Broken appointments • Changing vertical dimension, restoring occlusion, bite registration, or bite analysis • Charges for dental services that are not documented in the dentist's records • Correcting congenital malformation • Cosmetic procedures • Cost to complete claim forms • Dental implants and related services • Dental treatment, appliance, or device related to periodontal splinting, correction of abrasion, erosion, attrition, abfraction, bruxism, or desensitizing of teeth that can be restored by other means • Diagnostic casts • Due to your participation in a riot or committing a felony • Duplicate dentures • Engaging in an illegal occupation • Expenses incurred during a waiting period • For services incurred prior to you and your covered dependent's effective date under the Policy • Gold foil restorations • Harmful habit appliances • Hospital and related anesthesia charges • Initial placement of full or partial dentures or bridges to replace natural teeth lost before the effective date of insurance • Lab procedures • Local anesthesia • Myofunctional therapy • Occurring during or arising from your course of occupation or employment • Occlusal guards • Oral hygiene instruction • Orthodontia • Orthognathic surgery • Participating in a professional or semiprofessional contest for compensation, wage, or salary • Photographs • Physical therapy • Plaque control • Precision or semi-precision attachments • Procedures not included in the classes of eligible dental expenses, not dentally necessary, not rendered or not rendered within the scope of the dentist's license • Procedures that cost in excess of the maximum allowable charge • Provided by a government plan or educational institution as allowed by law • Removal of sound functional restorations; temporary crowns and temporary prosthetics • Replacement of bridges, crowns, inlays, onlays, or veneers within seven years of the last replacement except for loss of natural tooth • Replacement of bridges, crowns, dentures, inlays, onlays, or veneers if they can be repaired or restored • Replacement of full or partial dentures within five years of the last replacement except for loss of natural tooth • Replacement of lost or stolen appliances or retainers • Services not incurred by the insurance termination date • Services payable by workers' compensation, whether you are eligible or are covered • Services received outside the U.S. except for emergency treatment for pain • Services rendered by a family member or someone who lives with you or provided free without insurance • Sterilization fees • Teeth that are not periodontally sound or have a questionable prognosis as determined by us • Thermonuclear or atomic explosion or resulting exposure to radiation • Treatment of fractures, cysts, TMJ or related conditions • Treatment of halitosis and any related procedures • War or military service.

Vision

The following vision expenses are not covered:

Any eye examination, or any corrective eyewear, required by an employer as a condition of employment • Corrective surgical procedures such as, but not limited to, Radial Keratotomy, Photo-refractive Keratectomy and corneal modulation • Corrective vision treatment of an experimental or investigative nature • Medical or surgical treatment of the eyes • Orthoptics or vision therapy training and any associated supplemental testing.

Colorado Access Plan

The Colorado Access Plan which provides information regarding hospitals, providers, referral procedures, grievance procedures and emergency provisions is available upon request.

You may be eligible for participation in CoverColorado if a licensed physician has diagnosed you with a medical condition that is on the list of presumptive medical conditions established by the CoverColorado Board of Directors. To verify if you are eligible for participation in CoverColorado, please visit their website at www.covercolorado.org or contact them by telephone at (800) 672-8447.

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier must also provide the form, upon oral or written request within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

This is an outline only and not intended to serve as 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 PO-0003 or PO-1003.

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