SALVASEN LIMITED MED PREFERRED

CERTIFICATE OF COVERAGE

COVERAGE TYPE: SALVASEN LIMITED MEDICAL

PLAN ADMINISTRATOR

SALVASEN HEALTH
PO BOX 691247
HOUSTON, TX 77269
PHONE: 877-707-1442
FAX: 877-585-8842
EMAIL: INFO@SALVASEN.COM

MONTHLY PREMIUMS

SALVASEN BASIC LIMITED MEDICAL			
Member	**Member + Spouse**	**Member + Children**	**Member + Family**

SALVASEN LIMITED MEDICAL © IS A LIMITED BENEFIT INSURANCE CERTIFICATE.

Fixed Indemnity Limited Benefit Medical is administered by SALVASEN HEALTH, Houston, TX. This insurance is not basic health insurance or major medical coverage; it is not designed as a substitute for basic health insurance or major medical coverage. This policy meets the Minimum Essential Coverage (MEC) requirements of the Affordable Care Act (ACA).

Fixed Indemnity Limited Benefit Medical Insurance is subject to provisions, benefits, exclusions or limitations of the Certificate which may vary by state. Coverage becomes effective on the date provided in the membership material. The insurer has the right to increase premium rates and has the option to cancel coverage. Spouse includes Domestic Partner if legally recognized in the governing jurisdiction. Your coverage will continue as long as the Certificate remains in force and the premiums are paid. Any dependents covered under the Certificate will remain covered as long as they remain eligible, the Member's coverage remains in force, and the required premium is paid. All coverage will end on the date any insured person submits a fraudulent claim. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Not available in all states. Please refer to your "Certificate of Coverage – General Provisions" for your exact terms and conditions.

CERTIFICATE BENEFITS

Inpatient Hospital Benefits[1]	Hospital Room & Board Benefits	Room & Board Benefit per Day for covered conditions, except as noted in Specified Conditions	$250
		Number of Daily Benefits per Coverage Year	30
		Mental and Nervous Benefit per Day	$100
		Number of Daily Benefits per Coverage Year	10
		Alcohol and Substance Abuse Benefits per Day	$100
		Number of Daily Benefits per Coverage Year	10
	Hospital Admission Benefit for Specified Conditions[2]	Cancer (Malignant Neoplasm) Benefit per Day	$2,500
		Number of Daily Benefits per Coverage Year	1
		Heart Attack (Myocardial infarction) Benefit per Day	$2,500
		OR Heart Disease[1] Benefit per Day	$1,500
		Number of Daily Benefits per Coverage Year	1
		Accidental Injury Benefit per Day	$1,500
		Number of Daily Benefits per Coverage Year	1
		Stroke (Cerebrovascular Accident – CVA) Benefit per Day	$2,500
		Number of Daily Benefits per Coverage Year	1
		Childbirth Benefit per Day	$1,500
		Number of Daily Benefits per Coverage Year	1
	Surgery	Maximum Daily Surgery Benefit per Procedure[4]	$500
		Maximum Daily Anesthesia Benefit[5]	1
Outpatient Benefits	Radiology Benefit	Daily Benefit for Magnetic Resonance Imaging (MRI)	$100
		Number of Daily Benefits per Coverage Year	1
		Daily Benefit for Computerized Tomography (CT) Scan	$50
		Number of Daily Benefits per Coverage Year	1
		Daily Benefit for All Other Radiology Services	$40
		Number of Daily Benefits per Coverage Year	3
	Pathology (Lab) Benefits	Daily Benefit for all Pathology Services	$40
		Number of Daily Benefits per Coverage Year	3
	Emergency Room Visit Benefits	Daily Benefit for the Treatment of an Accidental Injury	$500
		Number of Daily Benefits per Coverage Year	2
		Daily Benefit for the Treatment of a Sickness	$50
		Number of Daily Benefits per Coverage Year	3
	Surgery	Maximum Daily Surgery Benefit per Procedure[4]	$500
		Maximum Daily Anesthesia Benefit[5]	$100

1 There is 12-month Pre-existing Condition Limitation for all Fixed Indemnity Inpatient Hospital Benefits.

2. The Hospital Admission Benefit for Specified Conditions has a 30-day waiting period. No benefits are payable for any Specified Condition where the date of diagnosis is during 30-day waiting period.

3 The daily Hospital Admission Benefit is payable for either Heart Attack or Heart Disease during a coverage year, but not both.

4 Daily benefits for covered surgery are scheduled and vary based on the specific surgical procedure performed.

5 Daily benefits for covered anesthesia vary and are equal to 20% of the applicable surgery benefit.

MEDICAL BENEFITS (PREVENTIVE CARE ONLY)

A Participant is entitled to the Covered Expenses described in this Certificate of Coverage. For coverage under this Plan, Covered Expenses must be ordered by a Physician or Provider. Services that are not listed here-in or are listed in the General Limitations and Exclusions are not Covered Expenses.

The Plan covers preventive and wellness services for eligible adults and Children and women's preventive services.

Unless otherwise noted, frequency will be presumed to be annual. Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

Subject to the Plan's provisions, limitations and Exclusions, the following are covered benefits when received at an In-Network Provider with no cost-sharing. Note, however, that if it is verified by the Third-Party Administrator that the eligible service is not available In-Network, benefits will be paid at the In-Network benefit level (i.e. no cost-sharing) so long as there is no In-Network provider for the eligible service within 50 miles from the Participant's residence.

Summary of Preventive Care Only Benefits	
Copays	$0 (unless otherwise indicated)
Deductible	$0
Benefit % Payable by Plan	100%
Plan Annual Maximum	Unlimited
Plan Lifetime Maximum	Unlimited
Network Provider	PHCS
Physician Office Visits	2 (two) per covered member per year
Specialist Office Visits	1 (one) per covered member per year
Urgent Care Visits	1 (one) per covered member per year

Physician Office Visits

Maximum fee per visit - $150.00 / $25 Copay

Specialist Office Visits

Maximum fee per visit - $150.00 / $50 Copay

Urgent Care Visits

Maximum fee per visit - $150.00 / $25 Copay

Covered Services for Children & Adolescents

Well child exams

1. History
2. Physical exam
3. Measurements (Height, Weight & Body Mass Index)
4. Vision acuity test
5. Developmental & behavioral assessments
6. Oral health assessment
7. Anticipatory guidance

Immunizations

1. Diphtheria, Tetanus, Pertussis
2. Hemophilus influenza type B
3. Hepatitis A & B
4. Human Papillomavirus (HPV)
5. Influenza (Flu)
6. Measles, Mumps, Rubella
7. Meningococcal
8. Pneumococcal (Pneumonia)
9. Inactivated Poliovirus
10. Rotavirus
11. Varicella (Chickenpox)

Screenings

1. Hearing loss, hypothyroidism, sickle cell disease
2. Phenylketonuria (PKU) in newborns
3. Hematocrit or hemoglobin screening
4. Obesity screening
5. Lead screening
6. Dyslipidemia screening for children at higher risk of lipid disorder
7. Tuberculin testing
8. Depression screening
9. Screening for sexually transmitted infections (STIs)
10. HIV screening
11. Cervical dysplasia screening

Preventive treatments

Gonorrhea preventive medication for eyes of all newborns

<u>Covered Services for Adults</u>

Annual preventive care visit

1. History
2. Physical exam
3. Measurements (Height, Weight & Body Mass Index)

Immunizations

1. Diphtheria, Tetanus, Pertussis
2. Hepatitis A & B
3. Human Papillomavirus (HPV)
4. Influenza (Flu)
5. Measles, Mumps, Rubella
6. Meningococcal
7. Pneumococcal (Pneumonia)
8. Varicella (Chickenpox)
9. Zoster

General Health Screenings

1. Blood pressure
2. Cholesterol screening based on age and individual risk factors
3. Depression screening
4. Diabetes screening for adults with high blood pressure
5. HIV screening
6. Obesity screening
7. Sexually transmitted infection (STI) screenings (Chlamydia,
8. Gonorrhea, Syphilis)

Cancer Screening

1. Colorectal cancer screenings using fecal occult blood testing,
2. sigmoidoscopy or colonoscopy

Health Counseling

1. Alcohol misuse
2. Healthy diet
3. Obesity
4. Prevention of sexually transmitted infections (STIs)
5. Tobacco use
6. Use of aspirin to prevent cardiovascular disease
7. Use of folic acid

Men Only

Abdominal Aortic Aneurysm screening

Women Only

1. Annual well woman visits
2. Screening mammography
3. Cervical cancer screening including pap smear
4. Osteoporosis screening
5. Genetic counseling and evaluation for BRCA testing where family
6. history is associated with an increased risk
7. Human Papillomavirus (HPV) DNA test
8. Chemoprevention of Breast cancer
9. Domestic violence counseling
10. Female sterilization: Tubal ligation
11. Contraception
    a. Generic prescription contraceptives approved by FDA and covered under the plan.
    b. Branded prescription contraceptives approved by FDA and covered under the plan ($50 Copay per prescription)
    c. Over-the-counter contraceptives approved by the FDA (i.e. foam, sponge, female condoms) when prescribed by a physician

Pregnant Women

1. Alcohol misuse screening and counseling
2. Anemia screening
3. Bacteriuria screening
4. Blood test screening for Rh incompatibility
5. Gestational Diabetes screening
6. Hepatitis B screening
7. Screening for Sexually Transmitted Infections (STIs), including
8. Chlamydia, Gonorrhea and Syphilis
9. Tobacco cessation counseling

Breastfeeding Women

1. Breastfeeding specialist/nurse practitioner with state recognized certification who is in provider network
2. Breastfeeding support and counseling by a trained in-network provider while you are pregnant and/or after you've given birth
3. Manual breast pump

Prescription Drug Schedule of Benefits

Provider: Broadreach Medical Resources, Inc. (BMR)
1350 Broadway, Suite 410
New York, NY 10018
www.bmr-inc.com
1-866-718-2375

Limitations: 1. FDA approved generic contraceptives will be paid at 100% after copay.
2. Smoking Cessation Drugs and Devices: FDA approved generic smoking deterrents will be paid at 100% after copay.
3. Some medications are limited to a 30-day supply by the Federal Drug Administration and require a new prescription for each 30-day supply.

Drug Type	Participant Pays	Limitations / Notes
Generic Drugs – only FDA approved preventative medications and supplements (as required by ACA).	$0 Copay	Limited to a 30-day supply
Brand Name W/O Generic	Not Covered	Not Covered
Brand Name	Not Covered	Not Covered
Specialty Drugs	Not Covered	Not Covered

Preventive Care Drugs

Charges for any preventive care drugs as required by the ACA. The Plan may use reasonable medical management techniques to control costs and promote efficient delivery of care, such as covering a generic drug without cost sharing and imposing cost sharing for equivalent branded drugs. However, in accordance with ACA guidelines, the Plan will accommodate any individual for whom a drug (generic or brand name) would be medically inappropriate, as determined by the individual's health care Provider, by waiving the otherwise applicable cost sharing for the brand or non-preferred brand version.

Routine Patient Costs for Participation in an Approved Clinical Trial

Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided:

1. The clinical trial is approved by any of the following:
    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.

f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

2. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

Medical (Preventive Care Only) Limitations

Covered Preventive Services for Adults (Ages 18 and Older)	
Test	**Limitations**
Abdominal Aortic Aneurysm Screening	One-time screening for age 65-75
Aspirin use for men	Ages 65-79 to prevent CVD when prescribed by a physician
Aspirin use for women	Ages 55-79 to prevent CVD when prescribed by a physician
Colorectal Cancer screening	Starting at age 50, limited to 1 every 5 years
Hepatitis B screening	For adults at high risk, and one time for anyone born prior to 1966.
Hepatitis C screening	For adults at high risk, and one time for anyone born prior to 1966.
Immunization vaccines	Hepatitis A&B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis and Varicella
Lung Cancer Screening	Low dose computed tomography (LDCT) for adults age 55-80 who have a 30-pack year smoking history and currently smoke or have quit within the past 15 years.
Covered Preventive Services for Women, Including Pregnant Women	
Test	**Limitations**
Anemia screening	Routine basis for pregnant women

Bacteriuria urinary tract or other infection screening	Pregnant women
BRCA counseling and genetic testing	Women at higher risk
Breast Cancer Mammography Screenings	Every year for women age 40 and over
Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies	Pregnant and nursing women
Contraception	FDA approved contraceptive methods, sterilization procedures and patient education and counseling. Does not include abortifacient drugs.
Folic Acid Supplements	When prescribed by a Physician for women who may become pregnant
Gonorrhea screening	Pregnant women
Human Papillomavirus (HPV) DNA test	Every 3 years for women with normal cytology who are 30 or older
Osteoporosis screening	Over age 60
Rh Incompatibility screening and follow up testing	Pregnant women
Tobacco Use screening and interventions	Expanded counseling for pregnant tobacco users
Well-woman visits	To obtain recommended preventive services
Covered Preventive Services for Children	
Autism screening	Limited to 2 screenings up to age 26 months
Behavioral assessments	Limited to 5 assessments up to age 17
Congenital Hypothyroidism screening	For Newborns
Depression screening	Adolescents age 12 and older
Phenylketonuria (PKU) screening	Newborns
Sexually Transmitted Infection (STI) prevention counseling & screening	Adolescents
Vision screening	Under Age 5

LIMITATIONS & EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for

providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Involving a Participant who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons. That are for services, supplies, and/or treatment of any Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal institution with said confinement exceeding 24 consecutive hours.

Cosmetic Surgery. That are Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. That do not restore health, unless specifically mentioned otherwise.

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Family Member. That are performed by a person who is related to the Participant as a spouse / domestic partner, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "inlaw".

Foreign Travel. That are received outside of the United States if travel is for the purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities. That meet the following requirements:

1. That are furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
2. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: *This Exclusion does not apply to treatment of non-service-related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This Exclusion does not apply where otherwise prohibited bylaw.*

Illegal Acts. That are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. This Exclusion will apply even if the Participant has a prescription for the drug and the drug is legal in the state where the Participant lives. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Incurred by Other Persons. That are expenses Incurred by other persons.

Long Term Care. That are related to long term care.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service. That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, considering applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs. That are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over the counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Covered Provider. That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Not Specified as Covered. That are not specified as covered under any provision of this Plan.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease and performed by an appropriate Provider.

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether the Participant had such mandatory coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur

in the transmittal of information to the Third-Party Administrator, including interest or financing charges.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law.

Provider Error. That are required as a result of unreasonable Provider error.

Self-Inflicted. That are Incurred due to an intentionally self-inflicted Injury or Illness not definitively (a) resulting from being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions).

Subrogation, Reimbursement, and/or Third-Party Responsibility. That are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

Unreasonable. That are not reasonable in nature or in charge (see definition of Maximum Allowable Charge) or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vehicle Accident. That are for treatment of any Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt (or car seat), even if the cause of the Illness or Injury is not related to the failure of the Participant to wear a helmet or seatbelt (or car seat). This Exclusion does not apply: (a) to Participants who were passengers on public transportation, ride for hire or livery services or (b) when a seatbelt or helmet is not required by law.

War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a

documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide benefits other than those provided under the terms of the Plan.

BALANCE BILLING

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many situations, and the Plan has no control over Non-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CHOICE OF PROVIDERS – PREVENTIVE CARE

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third-Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Choice of Providers – Physician Office Benefit

Physician Office Visits are provided through the PHCS Network. For a list of providers, please visit:

https://www.multiplan.com/webcenter/portal/ProviderSearch

Physician Office Visits specified in your coverage type are per covered member per year up to 3 (three) covered members.

CLAIMS INFORMATION

For complete details on the claims process please review the "GENERAL PROVISIONS CERTIFICATE" related to your plan.

THIRD PARTY ADMINISTRATOR

TrinityHealth Plan Administrators, LLC

PO Box 79

Arnold, MD 21012

EDI PAYOR ID: CB122

Pre-certification / authorization

No pre-authorization or certification is required for benefits provided under this plan.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third-Party Administrator within 180 days of the date charges for the service(s) and/or supplies were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is filed when the request for approval of treatment or services is made and received by the Third-Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is filed when the following information is received by the Third-Party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Certificate Holder.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third-Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third-Party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

BENEFIT DETAILS

PREVENTATIVE & WELLNESS

You and your family are eligible for some important preventive services at no additional cost to you. You may not have to pay a copayment, co-insurance, or deductible to receive recommended preventive health services, such as screenings, vaccinations, and counseling.

1. Network provider: PHCS

   This plan provides these preventive services only through an in-network provider. You may receive these services from an out-of-network provider, but out-of-network providers may charge you an additional fee.
2. Office visit fees: Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.
3. Talk to your health care provider: To know which covered preventive services are right for you — based on your age, gender, and health status.

Medical (Preventive Care Only) Exclusions:

1. Injury or self-inflicted bodily harm
2. Sickness or disease
3. Preventive health services not included under ACA
4. Preventive health services rendered outside of the United States
5. Preventive health services that are performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of “blood” or “in law.”