OUTLINE OF COVERAGE

Individual Engage Comprehensive Health Insurance Policy

Policy Number: [123456]

Policyowner: [John Doe]

Issue Age: [35]

Type of Coverage: [Family]

Benefit Period: Calendar Year

Policy Effective Date: [January 1, 2016]

Policy Anniversary Date: [January 1 of each Year]

Initial Premium: [$615.82]

Mode of Payment: [Monthly]

Premium Due Date: [The first day of each month]

Benefit Plan: Engage Silver PPO -- Standard Plan

THE POLICY PROVIDES A PREFERRED PROVIDER NETWORK BY WHICH INSUREDS CAN RECEIVE SERVICES FROM PREFERRED PROVIDERS. IT IS THE INSURED'S RESPONSIBILITY FOR PAYMENT OF BILLED CHARGES BEYOND THOSE CHARGES REIMBURSED BY US WHEN THE INSURED USES THE SERVICES OF A PROVIDER (NON-PREFERRED PROVIDER) WHO IS OUTSIDE OF THE PREFERRED PROVIDER NETWORK.

(1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) **Comprehensive Health Insurance Coverage** — Policies of this category are designed to provide to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. *Basic* hospital or *basic* medical insurance coverage is not provided.

(3) **Description of Benefits** – The policy provides Comprehensive Health Preferred Provider Organization (PPO) Insurance coverage. You have the option to receive services from a Preferred Provider or a Non-Preferred Provider. Generally, benefits are paid at a higher level when a Preferred Provider is used. The Outline of Coverage reflects the benefits payable when services for Covered Benefits are provided by a Preferred Provider or a Non-Preferred Provider. The Outline of Coverage and the Covered Benefits provided under the Policy are indicated below in this section.

Out-of-Network Maximum – Be aware that your actual costs for services provided by an <u>out-of-network</u> provider may exceed this policy's maximum out-of-pocket for out-of-network services. Your costs for the following covered services do not accumulate toward the maximum out-of-pocket amount if delivered by an out-of-network provider: Dental Services, Vision Services and Prescription Drug Services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and that amount is not counted toward the out-of-network maximum out-of-pocket.

BENEFIT INFORMATION	TIER 1 NETWORK	TIER 2 NETWORK	OUT OF NETWORK
Maximum Lifetime Benefit			
• Per Insured	Unlimited	Unlimited	Unlimited
Deductible			
• Individual Deductible (*per Insured per Calendar Year)*	$2,500	$3,000	$9,000
• Family Deductible *(per family per Calendar Year)*	$5,000	$6,000	$18,000
Annual Out-of-Pocket Maximum			
• Individual Annual Out-of-Pocket Maximum *(per Insured per Calendar Year)*	$6,500	$6,500	$19,500
• Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	$13,000	$13,000	$39,000
Coinsurance	40%	40%	60%

Any Deductible and Out of Pocket Maximum dollars from Tier 1 will be applied to Tier 2 Deductible and Out of Pocket Maximum respectively.

COVERED BENEFITS

This Policy will pay Covered Medical Expenses incurred for Covered Benefits provided in *Section 5, Covered Benefits*: (1) based on the Allowable Fee; and (2) unless otherwise indicated below, subject to the Deductible, Coinsurance, and Annual Out-of-Pocket Maximum amounts shown under the *Benefit Information* section of this Outline of Coverage. If a Copayment applies to a Covered Benefit, it will be indicated below in this Covered Benefits section.

COVERED BENEFIT	YOUR COST for TIER 1 NETWORK	YOUR COST for TIER 2 NETWORK	YOUR COST OUT OF NETWORK
All Covered Benefits shown in Section 5, unless otherwise specified below in this Outline of Coverage	40% after Deductible	40% after Deductible	60% after Deductible
Daily Hospital Room and Board	40% after Deductible	40% after Deductible	60% after Deductible
Miscellaneous Hospital Services	40% after Deductible	40% after Deductible	60% after Deductible
Surgical Services	40% after Deductible	40% after Deductible	60% after Deductible
Anesthesia Services	40% after Deductible	40% after Deductible	60% after Deductible
In-Hospital Medical Services	40% after Deductible	40% after Deductible	60% after Deductible
Out-of-Hospital Care	40% after Deductible	40% after Deductible	60% after Deductible
Chemical Dependency • Inpatient/Outpatient Facility	40% after Deductible	40% after Deductible	60% after Deductible
• Office Visit	$35 Copay per visit	$35 Copay after Deductible	60% after Deductible
Chiropractic Services • Limit of 20 Office Visits per Calendar Year	$65 Copay per visit	$65 after Deductible	60% after Deductible
Convalescent Home Services • Limit of 60 days per Calendar Year	40% after Deductible	40% after Deductible	60% after Deductible
Durable Medical Equipment (DME) • Rental (up to the purchase price), Purchase and Repair and Replacement of DME *Preauthorization is required for original purchase or replacement of DME over $500.*	40% after Deductible	40% after Deductible	60% after Deductible

COVERED BENEFIT	YOUR COST for TIER 1 NETWORK	YOUR COST for TIER 2 NETWORK	YOUR COST OUT OF NETWORK
Emergency Services	$200 Copay per visit	$200 Copay per visit	$200 Copay per visit
Home Health Care Services • Limit of 180 days of Home Visits per Calendar Year	40% after Deductible	40% after Deductible	60% after Deductible
Laboratory Services	40% after Deductible	40% after Deductible	60% after Deductible
Mental Health Services			
• Inpatient/Outpatient Facility	40% after Deductible	40% after Deductible	60% after Deductible
• Office Visit	$35 Copay per visit	$35 Copay after Deductible	60% after Deductible
Physician Medical Services			
• Physician Office Visits (Non-Specialist)	$35 Copay per visit	$35 Copay after Deductible	60% after Deductible
• Physician Specialist Visits	$65 Copay per visit	$65 Copay after deductible	60% after Deductible
(See below for office visit benefit for Preventive Health Care Services.)			
Prescription Drugs Benefit			
• **Retail Pharmacy Prescriptions** (31-day supply)			
• Tier 0 – Preventive Drugs, including contraceptives	$0 Copay	$0 Copay	$0 Copay
• Tier 1 -- Generic Drugs	$15 Copay	$15 Copay	$15 Copay
• Tier 2 - Preferred Brand Drugs	$40 Copay	$40 Copay	$40 Copay
• Tier 3 - Non-Preferred Brand and Generic Drugs	$65 Copay	$65 Copay	$65 Copay
• Tier 4 -- Specialty Drugs	$90 Copay	$90 Copay	$90 Copay
• **Mail Order Maintenance** (90-day supply)			
• Tier 0 – Preventive Drugs, including contraceptives	$0 Copay	$0 Copay	$0 Copay
• Tier 1 -- Generic Drugs	$30 Copay	$30 Copay	$30 Copay
• Tier 2 - Preferred Brand Drugs	$80 Copay	$80 Copay	$80 Copay
• Tier 3 - Non-Preferred Brand and Non Preferred Generic Drugs	$130 Copay	$130 Copay	$130 Copay
• Tier 4 -- Specialty Drugs	N/A	N/A	N/A
If You choose a Brand-Name drug when a Tier 1 Generic drug is available, you must pay an Ancillary Charge in addition to the Deductible and/or Copayment, as applicable, except for medically			

COVERED BENEFIT	YOUR COST for TIER 1 NETWORK	YOUR COST for TIER 2 NETWORK	YOUR COST OUT OF NETWORK
necessary Tier 0 contraceptives, for which substitution may require a written statement from your attending physician. If you use an out of network pharmacy, you are responsible for any amounts owed that are more than the allowed amount			
Preventive Health Care Services • Includes well baby, child and adult preventive services • Includes covered immunizations	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	40% after Deductible	60% after Deductible
Prostheses Benefit (Non-Dental) • Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics • Preauthorization required for the original purchase or replacement of prosthetics over $500	40% after Deductible	40% after Deductible	60% after Deductible
Therapeutic Services – Outpatient • Habilitative: Limit of 20 visits per year for PT, OT, and ST combined • Rehabilitative: Limit of 20 visits per year PT, OT, and ST combined	40% after Deductible	40% after Deductible	60% after Deductible
Transplant Services	40% after Deductible	40% after Deductible	60% after Deductible

COVERED BENEFIT	YOUR COST TIER 1 NETWORK	YOUR COST TIER 2 NETWORK	YOUR COST OUT OF NETWORK
Vision Care Benefit – Pediatric Vision Care Services *This Vision Care Benefit only applies to Insured Dependent Children under age 19.*			
• **Vision Care Services** • **Vision Examination** *Frequency of Services:* One Vision Examination per Insured Dependent Child per Calendar Year	None, 100% Covered	25%	25%

• **Vision Care Materials**
  • **Lenses**
  • Single Vision
  • Bifocal
  • Trifocal
  • Lenticular
 	
**Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.*
 	
Frequency of Services: One set of lenses per Insured Dependent Child per Calendar Year
	
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
	None, 100% Covered*
		
		25%
		25%
		25%
		25%
			
			25%
			25%
			25%
			25%

• **Vision Care Materials** • **Frames** *Frequency of Services:* One frame per Insured Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.	None, 100% Covered	25%	25%

• **Contact Lenses**
  • Necessary Professional Fees and Materials
  • Elective Professional Fees** and Materials
	
	None, 100% Covered***
	None, 100% Covered***
		
		25%***
		25%***
			
			25%
			25%

***15% discount applies to the Provider's usual and customary professional fees for contact lens evaluation and fitting*

****The following service limitations apply to In-Network benefits for Contact Lenses: (1) Standard (one pair annually) = 1 contact lens per eye (total 2 lenses); (2) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses); (3) Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses); and (4) Dailies (one month supply) = 30 lenses per eye (total 60 lenses).*

EXCLUSIONS AND LIMITATIONS

All benefits provided under this Policy are subject to the exclusions and limitations in this Section and as stated under Section 5, Covered Benefits. No benefits will be paid under this Policy that are incurred by or results from any of the following:

1. Inpatient or outpatient custodial care, rest cures, or transportation if not medically necessary;

2. Any condition, disease, illness or accidental injury to the extent that the Insured is entitled to benefits under occupational coverage provided through an employer, or under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries, conditions, or occupational disease. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party;

3. War, or act of war, whether declared or not, rebellion, armed invasion, or insurrection;

4. Service in the Armed Forces or any auxiliary units of the Armed Forces;

5. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;

6. Vision services, including, but not limited to, (a) eye examinations for the prescription or fitting of eyeglasses or contact lenses; (b) purchase of eyeglasses and contact lenses; (c) Lasik surgery; or (d) radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism). This exclusion does not apply to the Pediatric Vision Care benefit provided under this Policy;

7. Hearing aids and examinations for the prescription or fitting of hearing aids;

8. Cosmetic Surgery - Surgery primarily for the purpose of improving appearance, except for reconstructive surgery. Such reconstructive surgery must be: (a) incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; or (b) because of congenital disease or anomaly of a Insured Dependent Child;

9. For cosmetic foot care, and other foot care including but not limited to, treatment of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain and toenails (except for surgical care of ingrown or diseased toenails);

10. Foot orthotic appliance provided for the treatment of any medical condition;

11. Treatment for infertility and fertilization procedures, including, but not limited to, ovulation induction procedure and pharmaceuticals, artificial insemination, invitro fertilization, embryo transfer or similar procedures, including but not limited to laboratory services, radiology services or similar services, drugs or devices related to treatment for fertility or fertilization procedures;

12. Any injury incurred while committing an illegal act;

13. The Insured being intoxicated or under the influence of any narcotic unless administered on the advice of Physician;

14. Treatment provided in a government hospital, except Idaho residents who are confined in state medical institutions; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law;

15. Services performed by You or a member of Your Immediate Family;

16. Services for which there is no legal obligation for the Insured to pay or for which no charge would be made if insurance did not exist, unless such charge is regularly and customarily made in similar amount by the provider of such to other non-indigent patients, or unless, in either case, We are required by law to pay to the Government of the United States;

17. Nonsurgical Treatment for malocclusion of the jaw, including services for anterior or internal dislocation, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances;

18. Unless otherwise included under this Policy as a Covered Benefit, dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;

19. Private duty nursing;

20. Reversal of an elective sterilization;

21. Outpatient prescription drugs for which benefits are provided under the Prescription Drug Benefit in this Policy;

22. Transplants of a non-human organ or artificial organ transplant;

23. Any services, supplies, drugs and devices which are: (a) investigational/Experimental Service; (b) not accepted medical practice; and (c) not a Covered Medical Expense. We may consult with Physicians or national medical specialty organizations for advice determining whether the service or supply is accepted medical practice;

24. For travel by the Insured or a provider;

25. Orthodontics;

26. Services, supplies and devices relating to any of the following treatments or related procedures: (a) acupuncture; (b) acupressure; (c) homeotherapy; (d) rolfing; (e) holistic medicine; (f) marriage counseling; (g) religious counseling; (h) self-help programs; or (i) stress management;

27. Vitamins. NOTE: Certain vitamins may be covered for specific conditions in accordance with published Medical Policy;

28. Food supplements and/or medical foods, except when used for Inborn Errors of Metabolism or Enteral Nutrition services as defined in the Medial Policy;

29. For weight control or treatment of obesity or morbid obesity, including but not limited to Surgery for obesity, except when Surgery for obesity is Medically Necessary to control other medical conditions that are eligible for Covered Services under the Policy, and nonsurgical methods have been unsuccessful in treating the obesity. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition;

30. Education services, unless otherwise specified as a Covered Benefit, or tutoring services;

31. Any services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature;

32. Non-medically necessary durable medical equipment, communication devices and prosthetic limbs;

33. Services, supplies, drugs and devices which are not listed as a Covered Benefit as provided in this Policy unless medically necessary;

34. Charges for any procedures, services, supplies, care or treatment, including gender-reassignment drug therapies in a pre-surgery situation, related to a sex reassignment, including transgender reassignment surgery.

35. Elective abortions except if recommended by a consulting physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape, as defined in section 18-6101, Idaho Code, or incest as determined by the courts; or

36. Non Emergent Medical Service outside the United States are not covered.

37. For any of the following:

    a. Appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Policy;
    b. Orthognathic surgery, including services and supplies to augment or reduce the upper or lower jaw;
    c. Implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
    d. Alveolectomy or alveoloplasty when related to tooth extraction.

NONRENEWAL OR DISCONTINUANCE OF THIS POLICY BY THE COMPANY

This Policy will be renewed or continued at Your option. However, We may non-renew or discontinue this Policy only if:

1. You fail to pay premiums in accordance with the terms of this Policy, or if We do not receive timely premium payments;
2. You have: (a) performed an act or practice that constitutes fraud; or (b) made an intentional misrepresentation of a material fact under the terms of this Policy;
3. We cease to offer coverage in the individual market in accordance with applicable Idaho State law or federal law, if applicable; or
4. You no longer live, reside, or work in:
   a. The service area of the Preferred Provider Network used under this Policy; or
   b. An area for where We are authorized to do business;
   but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.