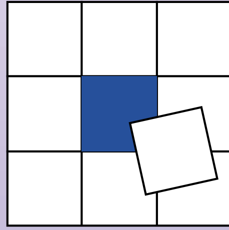
NEW



Health Logic

For logical consumers who want to take control of their healthcare costs.

- $5,000,000 Lifetime Maximum Benefit
- Prescription Generic Drug Copay Card Plus An Rx Discount (For Formulary and Brand Name Drugs)—Included For HL Plus, HL Standard and HL Traditional Indemnity Plans
- Prescription Drug Copay Card To Include Generic, Formulary And Brand Name Drugs—Included For HL Premium Plan
- Simplicity - Four Plans To Choose From
- Choice Of Multiple PPO Networks

Individual
Major Medical Plans - Colorado & Georgia

Health Insurance For Individuals And Their Families

Insured by:

Rated A (Excellent)
by A.M. Best Company
(A.M. Best is an independent analyst of the insurance industry; rating based on financial and operating performance)

INDIVIDUAL - CO/GA - 12/04

A Choice of 4 Major Medical Benefit Plans

BENEFIT	HL Premium PPO	HL Plus PPO (Best Buy!)	HL Standard PPO
Lifetime Maximum	$5,000,000	$5,000,000	$5,000,000
Calendar Year Deductible(s) (max 3 ind. PPO ded/family/cal. yr. Non-PPO ded. does not apply to the cal. yr. ded./family max.) (A separate Non-PPO cal. yr. deductible applies to ALL PPO Plans.)	PPO Deductible / Non-PPO Deductible $500 / $500 $750 / $750 **$1,250** / **$1,250** $2,000 / $2,000 $5,000 / $5,000	PPO Deductible / Non-PPO Deductible $500 / $1,000 $750 / $1,500 **$1,250** / **$2,500** $2,000 / $4,000 $5,000 / $10,000	PPO Deductible / Non-PPO Deductible $500 / $1,000 $750 / $1,500 **$1,250** / **$2,500** $2,000 / $4,000 $5,000 / $10,000
Calendar Year Coinsurance Choices (after applicable deductible(s) and copayments). The PPO and Non-PPO stop loss amounts accumulate separately. (All out-of-pocket deductibles, co-payments and coinsurance amounts must be met for each category of provider.)	**a) 80/20% to $5,000 PPO 60/40% to $10,000 Non-PPO** b) 80/20% to $10,000 PPO 60/40% to $10,000 Non-PPO c) 50/50% to $5,000 PPO (CO only) 50/50% to $10,000 Non-PPO (CO only) d) 70/30% to $7,500 PPO (GA only) 60/40% to $15,000 Non-PPO (GA only)	**a) 80/20% to $5,000 PPO 60/40% to $10,000 Non-PPO** b) 80/20% to $10,000 PPO 60/40% to $10,000 Non-PPO c) 50/50% to $5,000 PPO (CO only) 50/50% to $10,000 Non-PPO (CO only) d) 70/30% to $7,500 PPO (GA only) 60/40% to $15,000 Non-PPO (GA only)	**a) 80/20% to $5,000 PPO 60/40% to $10,000 Non-PPO** b) 80/20% to $10,000 PPO 60/40% to $10,000 Non-PPO c) 50/50% to $5,000 PPO (CO only) 50/50% to $10,000 Non-PPO (CO only) d) 70/30% to $7,500 PPO (GA only) 60/40% to $15,000 Non-PPO (GA only)
Calendar Year Coinsurance Maximum(s) (does not include calendar year deductible(s), copays, service deductible(s) or non-covered expenses.)	a) $1,000 PPO/$4,000 Non-PPO b) $2,000 PPO/$4,000 Non-PPO c) $2,500 PPO/$5,000 Non-PPO (CO only) d) $2,250 PPO/$6,000 Non-PPO (GA only)	a) $1,000 PPO/$4,000 Non-PPO b) $2,000 PPO/$4,000 Non-PPO c) $2,500 PPO/$5,000 Non-PPO (CO only) d) $2,250 PPO/$6,000 Non-PPO (GA only)	a) $1,000 PPO/$4,000 Non-PPO b) $2,000 PPO/$4,000 Non-PPO c) $2,500 PPO/$5,000 Non-PPO (CO only) d) $2,250 PPO/$6,000 Non-PPO (GA only)
Physician Office Visit Copay[1]	PPO $40[2] maximum of $200 for x-rays, lab exams and diagnostic tests in PPO physician office paid at 100%.[2] Non-PPO $40[3] Plus applicable Non-PPO deductible and Non-PPO coinsurance.	PPO $40[3] Copay applies to the physician office visit charge only. Non-PPO $40[3] Plus the Non-PPO deductible and Non-PPO coinsurance.	All Physician Office Visit charges are subject to applicable Calendar Year Deductible(s) and coinsurance.
Hospital Admission Service Deductible[1] (Per admission)	CO: $250 PPO, $500 NonPPO GA: $200 PPO, $300 NonPPO	CO: $350 PPO, $700 NonPPO GA: $300 PPO, $500 NonPPO	CO: $450 PPO, $900 NonPPO GA: $400 PPO, $700 NonPPO
Hospital Emergency Room Service Deductible[1] (Per occurrence) Waived if admitted as an inpatient following emergency room visit	CO $250, GA $200	CO $275, GA $225	CO $300, GA $250
Outpatient MRI, CAT Scan and Nuclear Imaging Service Deductible[1] (Per test, then subject to applicable calendar year deductibles and coinsurance.)	CO $350, GA $300	CO $400, GA $350	CO $450, GA $400
Outpatient Testing Service Deductible[1][4] (Per visit)	CO: $200 PPO, $400 NonPPO GA: $150 PPO, $200 NonPPO	CO: $225 PPO, $450 NonPPO GA: $175 PPO, $250 NonPPO	CO: $250 PPO, $500 NonPPO GA: $200 PPO, $300 NonPPO
Outpatient Ambulatory Surgical Facility Service Deductible[1] (Per visit)	CO: $200 PPO, $400 NonPPO GA: $150 PPO, $200 NonPPO	CO: $225 PPO, $450 NonPPO GA: $175 PPO, $250 NonPPO	CO: $250 PPO, $500 NonPPO GA: $200 PPO, $300 NonPPO
Routine Physical Exam	Maximum of $150 per exam per covered member/covered spouse every 24 months after 12 months of coverage.	Maximum of $150 per exam per covered member/covered spouse every 24 months after 12 months of coverage.	Maximum of $150 per exam per covered member/covered spouse every 24 months after 12 months of coverage.
Outpatient Rx Copay Drug Card [subject to a separate $100 (GA)/$200 (CO) Rx calendar year deductible per person]	$15 generic $40(CO)/$35(GA) formulary $60 brand name	$15 co-pay for generic drugs only[5]	$15 co-pay for generic drugs only[5]

(1) Copay/Service Deductible is in addition to the applicable calendar year deductible(s)/coinsurance and does not apply to the calendar year deductible(s).

(2) After your copay, the balance of the office visit charge paid at 100%. Additionally, after your copay, x-rays, lab exams and diagnostic tests up to $200 performed by and billed from a PPO physician paid at 100%. Covered expenses in excess of $200, expenses billed by an outside lab, and all other covered services performed during the office visit are subject to calendar year deductible and coinsurance.

(3) Copay applies to the physician office visit charge only, all other covered charges incurred in the physician's office are subject to the calendar year deductible(s) and applicable coinsurance.

(4) Applies to outpatient x-rays, laboratory and diagnostic testing not performed in a physician's office. Additionally, this Service Deductible does not apply to charges subject to the Outpatient MRI, CAT Scan, Nuclear Imaging Tests Service Deductible.

(5) **There is no coverage for formulary and brand name drugs on the HL Plus PPO and/or the HL Standard PPO Plans.**

Use the Physicians, Hospitals or Other Providers of Your Choice

BENEFIT	Traditional Indemnity NonPPO
Choose Your Calendar Year Deductible (maximum 3 individual deductibles per family per calendar year)	❑ $500 ❑ $750 ❑ $1250 ❑ $2000 ❑ $5000
Then Choose Your Coinsurance. Coinsurance Maximum does not include calendar year deductibles, service deductibles or non-covered expenses. (*Example:* Choose 80/20 coinsurance with $5000 stop loss, your coinsurance maximum is $1000)	*Coinsurance* / *Coinsurance Maximum* ❑ 80/20%—$5,000....$1,000 ❑ 50/50%—$5,000....$2,500 *Coinsurance* / *Coinsurance Maximum* ❑ 80/20%—$10,000....$2,000 ❑ 50/50%—$10,000....$5,000
Physician Office Visit	Subject to calendar year deductible and coinsurance
Inpatient Hospital Service Deductible(1) (per admission)	CO $400, GA $350
Outpatient Ambulatory Surgical Facility Service Deductible(1) (per visit)	CO $275, GA $225
Outpatient Testing Service Deductible(1)(2) (per visit)	CO $200, GA $150
Hospital Emergency Room Service Deductible(1) (per occurrence)	CO $250/GA $200 (waived if admitted as an inpatient following emergency room visit)
Outpatient MRI, CAT Scan and Nuclear Imaging Service Deductible(1) (per test)	CO $350, GA $300
Outpatient Rx Generic Drug Copay Card	$15 Copay for Generic Drugs only(3)

(1) Service deductible is in addition to the chosen calendar year deductible/coinsurance and does not apply to the calendar year deductible.

(2) Applies to outpatient x-rays, laboratory and diagnostic testing. This Service Deductible does not apply to the charges subject to the Outpatient MRI, CAT Scan, Nuclear Imaging Tests Service Deductible.

(3) There is no coverage for formulary and brand name drugs on the Traditional Indemnity NonPPO plan.

For all four major medical benefit plans, the policy will pay 100% of covered expenses up to the $5,000,000 Lifetime Maximum after you have met your out-of-pocket expenses. Out-of-pocket expenses include any applicable deductibles, coinsurance, copays, amounts in excess of usual, reasonable and customary charges and non-covered expenses.

Rx Discount On

Plus, Standard & Traditional Indemnity Plans

Jane Doe
1425 Oak Lane
Johsonville, TX 99901

An Express Scripts® discount is provided for formulary and brand name drugs at no additional charge. Simply present your ID card at an affiliated network pharmacy when you purchase your prescription to receive your Rx discount. While the cost of the Rx formulary or brand name drug is your responsibility you can enjoy the valuable discount provided when you utilize the affiliated Express Scripts pharmacy(ies). The Rx discount is not an insurance benefit. The Rx discount in not available to drugs purchased at pharmacies not affiliated with Express Scripts.

Description Of Outpatient Prescription Drug Card Benefits

1. HL Premium Plan:
Outpatient covered prescription drugs are subject to a separate $200 (CO)/$100 (GA) Rx calendar year deductible per person then subject to the following copays: $15 generic, $35(GA)/$40(CO) formulary, $60 brand name. After applicable copay, the balance of the cost of the drug paid at 100% at participating pharmacies. Mail order (most states) included with 2x applicable copay for 90-day supply. A reduced benefit may be offered to all proposed insureds or the benefit eliminated if any proposed insured is on maintenance medications.

2. HL Plus, HL Standard and Traditional Indemnity Plans:
Subject to a separate $200 (CO)/$100 (GA) Rx calendar year deductible per person. $15 copay for generic drugs only. **There is no benefit for formulary or brand name drugs.** After copay, the balance of the cost of the generic drug paid at 100% at participating pharmacies. Mail order (most states) included for generic drugs with 2x copay for 90-day supply.

APPLIES TO ALL PLANS:
To determine an affiliated participating network pharmacy, call Express Scripts at 800-234-7345. Express Scripts has over 50,000 affiliated pharmacies nationwide. Simply present your Rx card and pay the applicable copay. Charges for covered Rx drugs purchased from non-affiliated pharmacies will be paid to the insured up to the amount that would be paid if purchased through an affiliated participating pharmacy, less the covered person's drug copayment.

Prescription Drug Card benefits are not payable for drugs purchased without a prescription; contraceptive drugs, devices or supplies (contraceptive drugs and devices covered in GA); immunization agents or therapeutic devices. A complete listing of the Rx exclusions is listed in the Prescription Drug Card Benefit Rider.

Optional Benefits

Initial Premium Rate Guarantee—Initial premium rates, excluding fees, will be guaranteed for either 6 or 12 months. Initial premium rates may change if you move.

Supplemental Accident—Paid at 100% up to a $500 maximum per occurrence with NO calendar year deductible. Charges for the covered injury must be incurred within 90 days of the date of the injury provided initial treatment was received within 72 hours of the injury. Covered expenses in excess of $500 will be payable as any other covered expense.

24 Hr. Occupational Coverage—To be eligible for this optional Rider, the applicant and/or spouse must be: (1) a sole proprietor, partner, owner or other individual gainfully employed in an occupation eligible for the Rider; and (2) eligible to opt out of Workers' Compensation by their state law and have done so. This optional Rider provides benefits for injuries or sicknesses, that arise out of or in the course of employment, on the same basis as any other covered illness. Benefits are payable provided the covered person is not insured or required to be covered under any Workers' Compensation or similar law, and the expenses are incurred while the Rider is inforce. The Rider will terminate on the date the covered person changes occupation, or on the date the covered person becomes covered or is required to be covered by Workers' Compensation. If the covered person's occupation changes, the covered person is required to provide notification within 30 days of the date of the change in occupation. If the Rider terminates because the covered person's occupation changes, the individual can request to the plan administrator to add this Rider to their policy under their new occupation if gainfully employed in an eligible occupation and is eligible to opt out of Workers' Compensation and has done so. If this Rider is not elected, there is no on the job coverage.

Mental Illness and Nervous Disorders (GA only)—Paid on same basis as any other illness up to maximum of 30 days inpatient treatment per calendar year and 48 outpatient treatments per calendar year. If this option is not elected, benefits for inpatient and outpatient psychiatric care are payable in accordance with the policy's provision.

Outline Of Plan Benefits and Features

(Subject to applicable calendar year deductible(s), coinsurance, copay and/or service deductible(s).)

- **Ambulance Service ($1000 for ground or water, $5000 for air maximum per occurrence)**
- **Ambulatory Surgical Centers**
- **Anesthetics and their Administration**
- **Chemotherapy and Radiation Therapy**
- **Common Accident Deductible**
- **Dental Treatment required as a result of a covered injury to sound natural teeth**
- **Dressings, Sutures, Casts, Splints, Trusses, Crutches**
- **Emergency Treatment received outside the U.S.**
- **Home Health Care - up to 40 visits per calendar year (up to 60 visits in CO)**
- **Homeopathic Benefit - up to $50 per visit, $500 calendar year maximum**
- **Hospice Care - up to $5,000 lifetime maximum benefit (in CO, up to $100 per day per 6-month benefit period)**
- **Hospital Daily Room and Board (semi-private rate)**
- **Hospital Inpatient miscellaneous medical services and supplies**
- **Hospital Outpatient Services**
- **Intensive Care**
- **Major Medical Calendar Year PPO Deductible Carryover**
- **Medically necessary services for Premium, Plus and Standard PPO Plans not available from a PPO provider and referred to a NonPPO provider considered for payment at a PPO level**
- **Medical Benefits for Premium, Plus and Standard PPO Plans for Emergency Services, as defined in the policy, considered for payment at a PPO level**
- **Organ Transplants or replacements**
- **Oxygen and other Gases**
- **Physical, Respiratory and Speech Therapy for Rehabilitative Treatment**
- **Physician Charges**
- **Private Duty Nursing ($2000 maximum benefit per calendar year)**
- **Psychiatric Care (per calendar year) – Inpatient up to 55 days of active treatment or $2,000, whichever occurs first. Outpatient payable at 50% up to $20 per visit, 55 visits.**
- **Rental of durable medical equipment**
- **Skilled Nursing Facility for Convalescent Care**
- **Spinal Manipulation and Other Manipulative Therapy – 15 visits per calendar year maximum**
- **X-rays, Laboratory Tests, and Other Diagnostic Tests**

Preventive Care Benefits

Preventive Care Benefits are subject to applicable calendar year deductible(s), coinsurance, copay or service deductible unless stated or mandated otherwise.

Routine Physical Examinations—After the first 12 months of coverage under this policy, benefits are payable up to a maximum of $150 per examination per covered member or covered spouse per benefit period (every 2 years). Benefits are not subject to the calendar year deductible, service deductibles or copayments.

Child Health Supervision Services—For children through age 6. Includes physical exams, developmental assessment, immunizations and lab exams at defined intervals. Not subject to calendar year deductible. (In CO, covered at defined age intervals for children through age 12.)

Pap Smear—One screening per calendar year including the physician's office visit.

Routine Mammograms—Females: One baseline ages 35-39 and one every year for ages 40 and older. (In CO, one baseline ages 35-39; one every two years for ages 40-49 and one every year for ages 50 and older. In CO, routine mammogram is not subject to any copays, calendar year deductibles, coinsurance or service deductibles.)

Prostate Exams—Males: ages 40 and over. One per calendar year including the office visit and PSA test. (In CO, Males: Age 50 and over [40 if high risk]; and not subject to any copays, calendar year deductibles, coinsurance or service deductibles.)

Plan benefits, including Preventive Care Benefits, may be subject to exclusions, limitations and maximum benefits and may vary by state. Complete description of benefits is contained in the Policy.

Benefit Definitions

The following is a sampling of the benefits and definitions applicable to The Health Logic Plans. Benefits are subject to exclusions, limitations and maximum benefits and may vary by state. Complete provisions are outlined in the Policy. All covered expenses are subject to any applicable calendar year deductible(s), service deductibles, copayments, coinsurance and policy maximums, unless otherwise specified. PPO and NonPPO deductible(s) and coinsurance maximums accumulate separately.

Calendar Year Deductible Carryover—Covered expenses incurred during the last three months of a calendar year that are applied to the medical plan's calendar year deductible (PPO deductible if PPO plan selected) will also apply toward the following year's calendar year deductible. This does not apply to the NonPPO calendar year deductible or the separate Rx drug card deductible.

Calendar Year Deductible Family Maximum—The calendar year deductible (PPO deductible if PPO plan selected) is considered satisfied for all family members if three members of a family meet their individual calendar year deductible in a calendar year. This does not apply to the NonPPO calendar year deductible or the separate Rx drug card deductible.

Common Accident Deductible—If two or more covered persons sustain an injury in the same accident, only one calendar year deductible will be applied to all covered medical expenses arising out of that accident.

Coverage Outside the U.S.—Emergency (as defined in the policy) treatment only is covered outside the U.S.

Home Health Care Benefits—Benefits paid for care at home, in lieu of a covered hospital confinement. There is a maximum of 40 visits per calendar year (maximum 60 visits in CO).

Homeopathic Benefit—Homeopathic treatment rendered by a licensed homeopathist is covered to a maximum of $50 (after the calendar year deductible), per visit and a maximum of $500 per calendar year. (Supplies dispensed, distributed or used by the homeopathic provider are not covered.)

Hospice Care—Benefits for up to six months, to a lifetime maximum of $5,000. If an insured is receiving hospice benefits, bereavement counseling services for an immediate family member are covered. Bereavement benefits are payable up to a maximum of $500 and end three months after the insured's death. Bereavement counseling services are not subject to the calendar year deductible, service deductible, copayments or coinsurance. (In CO, Hospice Care benefits limited to $100 per day per benefit period; maximum 2 benefit periods [benefit period is 6 months]. Bereavement counseling maximum is $1,500 and end 12 months after the insured's death.)

Medical Emergencies—Medical benefits for emergency (as defined in the policy) services will be considered for payment at participating provider benefit level under the PPO plans. Emergency services must be provided within 72 hours following the onset of the injury or illness.

Organ Transplants—Charges for the specific transplants or replacements are covered as any other illness.

Pap Smear Test/Prostate Cancer Screening (PSA) Test - Covered on the same basis as other Physician Office Visits and tests performed in the physician's office during the Physician Office Visit. **Health Logic Premium Plan** - PPO: After the copay, balance of physician office visit charge is paid at 100%; physical exam is subject to deductible and coinsurance; laboratory and diagnostic tests performed by and billed from the PPO provider are paid at 100% up to $200 maximum, then balance is subject to deductible and coinsurance. Laboratory and diagnostic tests billed by an outside lab are subject to applicable deductible and applicable coinsurance. NonPPO: After copay, balance of office visit charge, physical exam and laboratory and diagnostic tests subject to NonPPO deductible and NonPPO coinsurance. **Health Logic Plus Plan** - PPO: After copay, balance of PPO physician office visit charge paid at 100%; physical exam and laboratory and diagnostic tests subject to deductible and coinsurance; NonPPO: After copay, balance of office visit charge, physical exam and laboratory and diagnostic tests subject to NonPPO deductible and NonPPO coinsurance. **Health Logic Standard and Traditional Indemnity Plans** - All covered expenses subject to applicable deductibles and coinsurance. (In CO, PSA tests are not subject to any copay, calendar year deductibles, coinsurance or service deductibles.)

Premium—The periodic payment necessary to keep coverage under the policy in force. Premium does not include any fees or dues.

Psychiatric Care–Inpatient *(including chemical dependency, substance abuse, alcohol and drug rehabilitation)*—Treatment as an inpatient in

Benefit Definitions (continued)

a mental health facility or hospital for psychiatric care (or in a licensed alcohol or drug rehabilitation facility). Benefits are limited to a calendar year maximum of 55 days of active treatment or $2,000, whichever occurs first.

Psychiatric Care–Outpatient—Treatment as an outpatient in an outpatient mental treatment center subject to a 50% coinsurance and a maximum benefit of $20 per visit; maximum of 55 visits per calendar year.

Referral—Under a PPO plan, if a medically necessary service is not available from a participating provider in the covered person's selected network, the network provider may refer a covered person to a nonparticipating provider and covered expenses will be considered for payment at the participating provider benefit level.

Service Deductible—A payment that must be made by the covered person for certain services. Service deductibles do not apply toward the covered person's calendar year deductible, calendar year maximums, copayments or coinsurance.

Skilled Nursing Facility—Following a covered hospital confinement of three days, and begins within 14 days after release from such hospital confinement.

Spinal Manipulation and Other Manipulative Therapy—Up to a maximum of 15 visits in each calendar year for spinal manipulation, manual or electrical muscle stimulation, and other manipulative or ultra sound therapy when performed by a physician.

Exclusions & Limitations

Exclusions & Limitations (may vary by state)

Except as specifically provided for in the policy, the policy does not cover:

• preexisting conditions; • **GA only: charges incurred prior to the date the covered person has been covered under the policy for six consecutive calendar months for the care or treatment of: hernia; tonsils; adenoiditis; any disease or disorder of the reproductive system; any rectal disease or disorder; gall bladder; varicose veins; or laminectomy, discectomy or spinal fusion. Any such condition may also be excluded as a preexisting condition. This limitation shall not apply to services provided for an emergency where such condition is not excluded as a preexisting condition. This exclusion will not apply to a covered person receiving treatment due to a malignancy, provided such treatment is not being rendered to a preexisting condition;** • expenses incurred before the effective date; • expenses incurred after coverage under the policy terminates, regardless of when the condition originated; • any conditions specifically excluded by riders or exclusions attached to the policy; • expenses incurred to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the policy; • experimental, investigational, or unproven services; • expenses determined to be educational; • amounts in excess of the usual, reasonable and customary charges; • expenses the covered person is not required to pay, or which would not have been billed if no insurance existed; • care in government institutions unless the covered person is obligated to pay for such care; • charges incurred for illness or injury that arises out of, as a result of, or in the course of employment; • non-emergency treatment received outside of the United States; • charges incurred by a covered person while on active duty in the Armed Services; • expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection; • expenses incurred or expense related thereto, while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony; • pregnancy or childbirth, except for complications of pregnancy; • charges incurred for voluntary termination of pregnancy; • any drug (including birth control pills), implants or injections, supply, treatment, device or procedure that prevents or terminates conception and/or childbirth; • treatment of infertility, including but not limited to any attempt to induce fertilization by any method other than by natural means; in vitro fertilization, artificial insemination or similar procedures whether the covered person is the donor, recipient or surrogate (In CO, diagnosis of infertility also not covered.); • any drugs, supplies, treatments, devices or procedures related to sex transformation or reversal thereof, sexual dysfunctions, penile implants or sexual inadequacies; • sterilization or reversal of sterilization; • physical exams or other services or supplies not needed for medical treatment; • prophylactic treatment, including surgery or diagnostic testing; • outpatient treatment of alcoholism; • outpatient treatment of chemical dependency, substance abuse and/or drug addiction; • programs, treatment, supplies, or procedures for tobacco use cessation; • expenses resulting from intentional self-inflicted injury, suicide or attempted suicide, whether sane or insane; • charges incurred which result from: (a) the voluntary taking of drugs, except those taken as prescribed by a physician, (b) the voluntary taking of poison, (c) the voluntary inhaling of gas, (d) in GA, being intoxicated or under the influence of any narcotic unless administered on the advice of a physician, or (d) in CO, being under the influence of alcohol; • dental treatment or care; • orthodontia or other treatment involving the teeth and supporting structures; • in CO: treatment by any method for jaw joint problems, including temporomandibular joint dysfunction (TMJ); • surgical or non-surgical correction of refractive error; vision therapy; routine vision exams to assess the initial need for or changes to prescription eyeglasses or contact lenses; the purchase, fitting or adjustment of eyeglasses or contact lenses; eyeglasses or contact lenses for the treatment of aphakia; • routine hearing exams to assess the need for or change to hearing aids; the purchase, fittings or adjustments of hearing aids; • cosmetic or reconstructive procedures, services or supplies; • charges for breast reduction unless medically necessary; • charges for breast augmentation; • removal of breast implants; • **outpatient formulary (non-generic) or brand name prescription medications (unless the Health Logic Premium PPO Plan is elected)**; • medications and drugs, including vitamins and vitamin– mineral supplements, available over-the-counter (OTC) whether or not by a physician's prescription

order; • any expense related to the treatment of hair loss; • treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions or the removal of one or more corns, calluses or toenails; • charges for blood or blood plasma that has been replaced; • treatment of autism (CO only), developmental delays and learning disabilities, testing and training for education or vocation; • treatment of acne; • weight loss programs, diets, or treatment of obesity, extreme obesity or morbid obesity, including surgery for reconstruction, repair or reversal of a gastric bypass; • transportation charges; • rest and/or recuperation cures or care in a skilled nursing facility, convalescent nursing home or facility, extended care facility, or home for the aged, whether or not part of a hospital; • services or supplies for personal comfort or convenience, including custodial care or homemaker services; • services and/or supplies furnished and/or provided by an immediate family member or a person who ordinarily resides in the home of the covered person or by the employer of an immediate family member, except for covered expenses rendered while hospital confined; • any charges incurred in connection with a hospital admission on Friday or Saturday unless the attending physician states in writing that the admission was an emergency; • immunizations not necessary for the treatment of an illness or injury; • expenses incurred for occupational therapy; • acupuncture unless the charges incurred are in lieu of anesthesia; • marriage or family counseling; • sex therapy.

Pre-Existing Conditions–Definition and Limitation - Colorado

An illness, injury or pregnancy of a covered person for which the covered person has incurred charges, received medical advice, treatment, services, diagnostic tests, consultation from a physician or taken prescription medication during the 12 months prior to the covered person's effective date of coverage under the policy. Benefits will be payable for a pre-existing condition, unless the condition is specifically excluded under the policy or excluded by endorsement or rider attached to the policy, if at the end of a continuous period of 12 months commencing on or after the effective date of the covered person's coverage, the person has been covered under the policy. This period is reduced by the time covered under prior creditable coverage where there is not a break in coverage greater than 90 days immediately prior to the covered person's effective date.

Pre-Existing Conditions–Definition and Limitation - Georgia

An illness or injury of a covered person for which the covered person has received medical advice, treatment, services, diagnostic tests, consultation or medication during the twelve (12) months prior to the covered person's effective date of coverage under the policy. Benefits will be payable for a pre-existing condition, unless the condition is specifically excluded under the policy or excluded by endorsement or rider attached to the policy, if at the end of a continuous 12-month period commencing on or after the effective date of the covered person's coverage, the person has not received medical advice, treatment, services, diagnostic tests, consultation or medication in connection with such illness or injury; or, at the end of the two (2) year period commencing on the effective date of the covered person's coverage, the person has been covered under the policy.

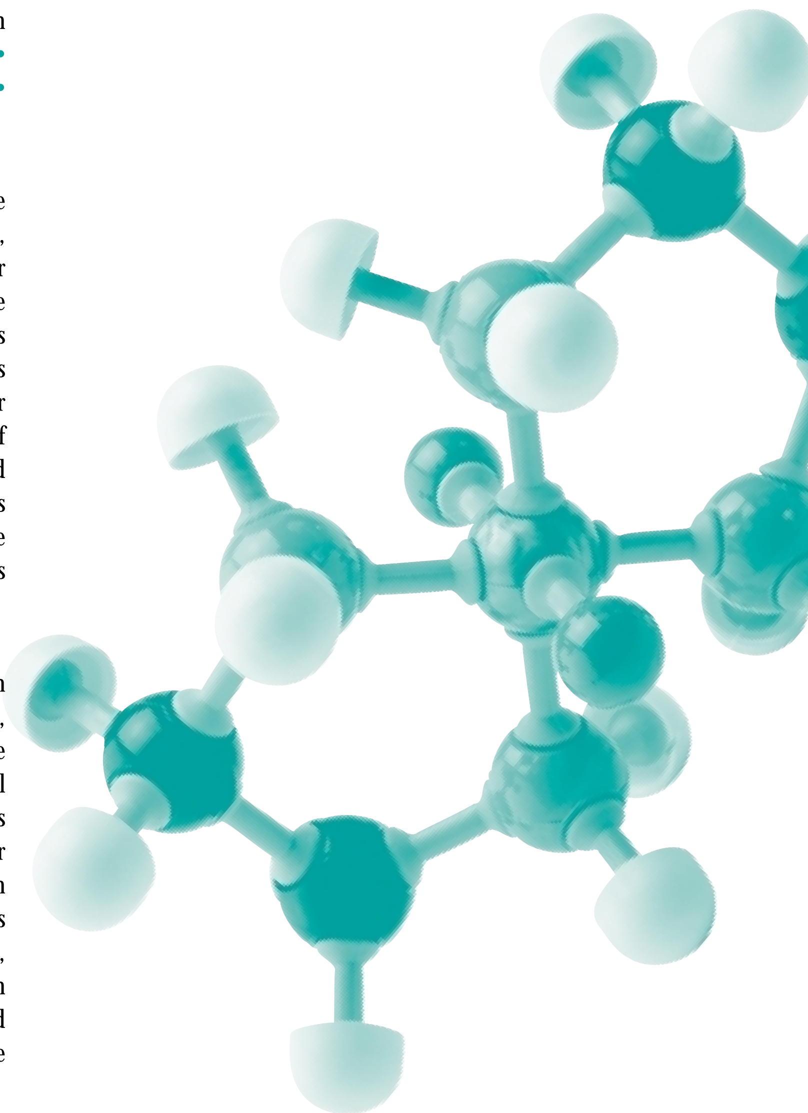
Health conditions duly disclosed in the application for coverage of the covered person and otherwise covered by this policy, unless the condition is specifically excluded by endorsement or rider attached to the policy, are covered from the effective date of coverage under the policy.

Failure to fully disclose information can result in rescission (voiding) or reformation of coverage and the denial of a claim. Please refer to the Application and the Policy for further details.

Coverage under the plan may be uniformly modified prospectively subject to HIPAA and state law.

This brochure is a brief description of the important features of the Policy. It is not a contract.

Applicants should not cancel any existing medical insurance plan until they have been notified in writing by the insurance company or its designated plan administrator that their new insurance is in effect.



General Information

Family premium discount applies when a certificate is issued with two or more family members applying together.

Available Effective Dates are the 1st or 15th of any month, subject to underwriting approval.

10 Day Free Look Provision.

Eligibility:

* Individuals can apply for coverage if they are between the ages 18 through 64 .
* Individual's dependents can apply for coverage if they are a legally married spouse, thru age 64, and unmarried dependent children under age 19 (20 in GA) (under age 25 if enrolled full time in an accredited two-year or four-year college or university).
* Children only coverage available for infant through 18 (19 in GA) (24 if full-time student). Parent must be enrolled as applicant.

Termination of Insurance

Insurance will remain in force until:

* The date there is fraud or material misrepresentation with regard to the policy or its benefits.
* The date the insured's premium is due if not received by the end of the grace period.
* The date of death of the insured.
* The premium due date following the date the insurer terminates all policies in the insured's state of residence.
* Dependent child's coverage terminates on the premium due date following: the date of the covered dependent's marriage; the date the covered dependent reaches age 19 (20 in GA) (or 25 if a full-time student). (Termination of insured's insurance will also result in dependent termination.)

In the absence of fraud or misrepresentation, **insureds cannot be singled out for a rate increase nor can their policy be cancelled due to claims on an individual basis.**

Underwritten By

Omaha, NE

In CO:
Policy Form #EM 28 18 (04-01)-P-CO
Plan #HL 08/01-001-CO

In GA:
Policy Form # EM 28 18 (04-01)-P-GA
Plan #HL 08/01-001-GA

Insurance premiums vary by effective date, age, sex, state, zip code, plan, deductibles and coinsurance selected and underwriting decision. Premiums may also vary based on PPO network and occupation. The plans described in this brochure are intended for distribution to Colorado and Georgia residents only.

Notice to Colorado Residents

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 or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must 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.

If a covered person obtains services from a non-PPO provider, the covered person may be billed by the non-PPO provider for any calendar year deductibles, coinsurance, co-payments or service deductibles and any amount that exceeds the usual, reasonable and customary charge. Reimbursement rates to non-PPO providers for specific health care services and the access plan may be obtained by sending a written request to the plan administrator. Depending upon the PPO network you choose, there may not be providers in the following counties: Dolores, Hinsdale, Jackson, San Juan, and San Miguel.