

# HealthBasic

A limited medical plan solution for small business



ace usa

“The insurance industry has never understood my needs as a small business owner.”

## HealthBasic changes that with one plan offering three levels of coverage and cost

### OWNER LEVEL

A mid-level medical plan at a lower cost than major medical.

### SALARIED EMPLOYEE OR MANAGER LEVEL

A limited medical plan that covers a majority of needs at a reasonable cost.

### HOURLY EMPLOYEE LEVEL

A basic limited medical plan at minimal cost.

The HealthBasic limited medical plan proposed in this document is not basic health insurance or major medical coverage. It provides limited coverage for accidents, illness and specific disease. The HealthBasic plan is comprised of a package of group insurance policies which are issued on a separate and non-coordinating basis and include: fixed-indemnity, accident-only, and limited-scope prescription drugs.

*A minimum of five enrolled employees is required to initiate the plan.*

Marketed By:



**Wise  
Benefits.com**

*Your One Source for Limited Medical Plans!*



TRN-ACEHB032011

# We understand the realities of being a small business owner.

## The HealthBasic plan offers:

### Hassle-free administration

Takes no more than 30 minutes to get everyone enrolled and doesn't require a census or health histories.

### A no-cost solution

Offers different levels of cost and coverage for different classes of employees and can be 100% paid for by employees.

### Usable benefits to recruit and retain valuable employees

HealthBasic isn't a high-deductible plan that requires you to pay thousands out of pocket before the insurance starts paying the bills. HealthBasic provides first-dollar coverage for day-to-day commonly occurring medical expenses.

## HealthBasic

A limited medical plan solution for small business



Contact Us at:

Learn More



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IMPORTANT NOTICE: Insurance policies providing certain health insurance coverage issued or renewed on or after September 23, 2010 are required to comply with all applicable requirements of the Patient Protection and Affordable Care Act (PPACA). However, there are a number of insurance coverages that are specifically exempt from the requirements of PPACA (See § 2791 of the Public Health Services Act). ACE maintains that the Limited Accident and Sickness Plan presented in this brochure is "fixed indemnity insurance" and is therefore, exempt from the requirements of PPACA.

WiseBenefits.com, 5233 Shasta Way, Suite 100-A, Marietta, GA 30062  
(800) 825-7605, (770) 643-4800, (770) 643-4870 fax

# HealthBasic Medical Plan

## IMPORTANT INFORMATION

Each insured member and each insured family member receives the following benefits each coverage year:

MONTHLY RATES – 100% EMPLOYEE PAID	HOURLY	SALARIED/MANAGER	OWNER
Employee Only	\$89.00	\$196.00	\$298.00
Employee + 1 Dependent	\$196.00	\$434.00	\$667.00
Employee + Family	\$279.00	\$600.00	\$917.00
MONTHLY RATES – 50% EMPLOYER PAID	HOURLY	SALARIED/MANAGER	
Employee Only	\$79.00	\$176.00	
Employee +1 Dependent	\$177.00	\$390.00	
Employee + Family	\$252.00	\$539.00	
	HOURLY	SALARIED/MANAGER	OWNER
<b>INPATIENT BENEFIT</b>			
Hospital Confinement			
Day 1 benefit amount	\$1,000	\$2,500	\$5,000
Days 2+ benefit amount per day	\$500 x 5 days	\$1,000 x 10 days	\$2,500 x 20 days
Days 1+ additional ICU benefit amount per day	N/A	\$750 x 5 days	\$2,000 x 5 days
Surgery benefit amount (incl. maternity) per surgery	\$1,000 x 1 surgery	\$2,500 x 1 surgery	\$5,000 x 2 surgeries
Anesthesia benefit amount - per surgery	\$250 x 1 surgery	\$625 x 1 surgery	\$1,250 x 2 surgeries
<b>Total of all potential inpatient benefits</b>	<b>\$4,750</b>	<b>\$19,375</b>	<b>\$77,500</b>
<b>OUTPATIENT ILLNESS BENEFIT</b>			
Physician Office Visit Pre-pay <sup>(1,2)</sup>	\$10	\$10	\$10
Benefit amount per visit	\$65 x 10 visits	\$85 x 10 visits	\$100 x 20 visits
Wellness benefit amount per visit	N/A	\$150 x 1 visit	\$250 x 1 visit
Well child care (up to age 4) benefit amount per visit	N/A	\$100 x 4 visits	\$150 x 4 visits
Emergency Room (sickness) benefit amount per visit	\$200 x 2 visits	\$750 x 2 visits	\$1,000 x 2 visits
Surgery benefit amount per surgery	N/A	\$1,250 x 1 surgery	\$2,500 x 1 surgery
Anesthesia benefit amount - per surgery	N/A	\$313 x 1 surgery	\$625 x 1 surgery
Diagnostic, x-ray, lab - benefit amount per test			
Class I: Laboratory - blood work, CMP, lipid panel	\$35 x 4 tests	\$50 x 4 tests	\$75 x 6 tests
Class II: X-rays, ECG, all other diagnostic	\$75 x 2 tests	\$125 x 2 tests	\$150 x 4 tests
Class III: Ultrasound, mammogram	\$150 x 1 test	\$200 x 1 test	\$250 x 2 tests
Class IV: CT, PET, MRI	\$500 x 1 test	\$750 x 1 test	\$1,250 x 1 test
<b>Total of potential outpatient illness benefits</b>	<b>\$1,990</b>	<b>\$5,863</b>	<b>\$10,775</b>
<b>OUTPATIENT ACCIDENT BENEFIT</b>			
Deductible per Accident	\$0	\$0	\$0
Benefit % payable	80%	80%	80%
<b>Maximum outpatient accident benefit per year</b>	<b>\$1,000 per year</b>	<b>\$5,000 per year</b>	<b>\$25,000 per year</b>
<b>PRESCRIPTION BENEFIT</b>			
Retail - Generic RX co-pay		\$10	\$10
Retail - Preferred Brand RX co-pay	Discount Only <sup>(2)</sup>	\$20	\$20
Mail Order - Generic RX co-pay		\$25	\$25
Mail Order - Preferred Brand RX co-pay		\$50	\$50
<b>Maximum benefit per year</b>		<b>\$600</b>	<b>\$1,500</b>
<b>ACCIDENTAL DEATH BENEFIT</b>			
<b>Accidental Death &amp; Dismemberment benefit amount *</b>	<b>\$10,000/5,000/1,000</b>	<b>\$25,000/5,000/1,000</b>	<b>\$25,000/10,000/1,000</b>
<b>TERM LIFE INSURANCE BENEFIT</b>			
<b>Term Life Insurance benefit amount * <sup>(3)</sup></b>	<b>\$5,000/2,000/1,000</b>	<b>\$5,000/2,000/1,000</b>	<b>\$5,000/2,000/1,000</b>

<sup>(1)</sup> The office visit pre-pay is a service through the PHCS PPO Health Network. <sup>(2)</sup> Term Life is underwritten by Combined Insurance Company of America, part of ACE Group of Companies. Pays in addition to plans Basic+ and Max+.

\* Benefit amounts listed are for: Employee/Spouse/Child(ren)

The limited medical plans proposed in this document are not basic health insurance or major medical coverages. They provide limited coverage for accidents, illness, and specific disease. The HealthSelect plan is comprised of a package of group insurance policies which are issued on a separate and non-coordinating basis and include: fixed-indemnity, accident-only, and limited-scope prescription drugs.

# HealthBasic Dental Plan

MONTHLY RATES			
Employee Only			\$20.00
Employee +1			\$43.00
Family			\$59.00
Dental Benefits		Type 5: Periodontics	
Maximum Plan Year Limit	\$1,000	Lifetime maximum	\$500
Periodontics	\$500 maximum	Tissue grafts or bone surgery	\$96
Orthodontics	\$500 maximum	Gingivectomy (per quadrant)	\$60
Type 1: Preventive & Diagnostic		Periodontal scaling, periodontal splinting, root planning, gingival curettage (per quadrant)	\$36
Oral exams, including prophylaxis	\$36	Gingivectomy (per tooth)	\$24
Bitewings, per film	\$5	Type 6: Oral Surgery	
X-Ray, panoramic or cephalometric	\$36	Surgeries Level 1	\$120
Sealants / topical fluoride	\$11	(Ex. Removal of exostosis)	
Space maintainers	\$108	Surgeries Level 2	\$66
Type 2: Major Restorative		(Ex. Removal of impacted tooth)	
Crowns, bridges & dentures	\$180	Surgeries Level 3 (ex. Simple Extraction)	\$36
Pre-fabricated crowns	\$60		
Crown build-up procedures	\$48	Type 7: General Anesthesia and IV	
Type 3: Minor Restorative		IV, first half hour general, each	\$72
Fillings	\$42	Additional 1/4 hour general	
Crowns, bridges & denture repair	\$24	Type 8: Orthodontia	\$500
Relining or rebasing dentures	\$60	Per course of treatment	
Type 4: Endodontics		Types 1 through 7 subject to annual maximum of \$ 1,000	
Root canals, apicoectomies	\$192	Types 2, 5, 6a, and 8 are subject to 12 month waiting period.	
Root amputation	\$96	No waiting periods for Preventive, Diagnostic, Minor Restorative, and General Anesthesia. 12 month waiting period on Major Restorative, Periodontics, Oral Surgery, and Orthodontia.	
Therapeutic pulpotomy, retrograde fillings, apexification, hemisection	\$48		

## Value Added Services



### Medical PPO Network Office Visit Pre-pay

Access to Network discounts at over 568,000 participating PHCS Network physicians and hospitals. Service provides members affordable access to physicians by allowing them to pay a \$10 Office Visit Pre-pay before insurance benefits are applied.



### Prescription Drug Card

With ScriptSave® members enjoy instant savings for their entire household on brand name and generic medications. Savings average 22%, with potential savings of up to 50% on brand name and generic prescription drugs at over 50,000 participating pharmacies. With Medco, members can use their card for prescription fills and refills at over 60,000 participating pharmacies for co-pay benefits that will be processed in real-time at the point-of-purchase at the pharmacy.



### Telemedicine

With Teladoc: For only a \$38 consult fee, members can receive 24/7 access to affordable healthcare via phone consultations to diagnose, recommend treatment, and write short-term, non-narcotic prescriptions.



### Nurseline and EAP

OptumHealth Care24 provides a toll-free, 24/7/365 Nurseline which provides an immediate and reliable source for non-emergency health information and confidential medical counseling. Includes three face-to-face counseling visits per condition.



### Dental PPO Network

With Careington Dental PPO Network, members have access to over 65,000 general dentists and specialties that have lowered their prices for members by 10 - 60% off of their usual charges.

These services are not insurance and are not provided by ACE American Insurance Company.

## What Else Do I Need to Know?

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### Group Participation Requirement:

Minimum of five enrolled employees needed to initiate coverage.

### Employee Eligibility:

All employees' eligibility is defined by the employer.

### Individual Underwriting:

None. Guarantee issue with no medical evidence or questions required.

### Coverage Availability:

Not available in all 50 states.

### Continuation of Coverage When Employment Ends:

Included in the coverage provision of the policy.

### Issue Ages:

Employee/spouse – ages 18 through 64

Dependent child – to age 26

### AD&D Benefit Reductions:

At age 70-74, benefit reduces to 65% of original face amount. At age 75-79, benefit reduces to 40% of original face amount. At age 80+, benefit reduces to 20% of original face amount.

### Pre-existing Condition Limitation

6/12 pre-ex on inpatient & surgery only.

See exclusions on page 11 for details.

## How Do I Get Started? *Minimum of five enrolled employees needed to initiate coverage.*

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1. Complete & sign the Request for Coverage form. Ensure you keep a copy for yourself.
2. Make copies of the enrollment form and give one to each eligible employee to complete and sign. Ensure you keep the Master Copy of the enrollment form on file in order to duplicate for new hires. You can also download new forms at [www.healthbasicplan.com](http://www.healthbasicplan.com).
3. Fax or email your Request for Coverage form and all completed enrollment forms along with a voided check if ACH payment is chosen to the fax number or email address on the Request for Coverage form. Employers with fewer than 50 employees may be required to include a copy of their Employer Quarterly Wage Report.
4. You will be contacted within two business days to confirm your acceptance. Please check the box indicating if you want to receive a call or an email.
5. Each enrolled employee will receive an ID Card and plan information at the home address listed on his or her enrollment form.
6. Ongoing, give every eligible new employee a copy of the enrollment form. Fax/email completed forms to Ternian.

## Billing and Other Information:

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1. We will contact you within two business days after receipt of the Request for Coverage Form to confirm your acceptance.
2. Initial coverage begins the first of the month following setup – new employees are effective the first of the month following our receipt and approval of their Enrollment Form.
3. You will receive a bill by the 25th of the month prior to the effective date listing all enrollee information.
4. You will have until the 1st of the month to make changes to the enrollee list.
5. On the 5th of each month, either your checking account or credit card will be debited for the month's premium.

Fixed indemnity medical, accident-only, accidental death and dismemberment, and prescription drug coverages are underwritten by ACE American Insurance Company. Term life insurance is underwritten by Combined Insurance Company of America, part of the ACE Group of Companies. These plans are not major medical insurance and are NOT designed to replace, provide or modify major medical insurance. This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit from providing insurance, including, but not limited to, the payment of claims. Administered by Ternian Insurance Group LLC. [www.ternian.com](http://www.ternian.com)

# Employer Request For Coverage Form

ACE American Insurance Company

## **PARTICIPATING EMPLOYER (POLICYHOLDER) INFORMATION**

1. Business Name: \_\_\_\_\_
2. Contact Name and Title: \_\_\_\_\_
3. Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. Check preferred contact method:  Phone: \_\_\_\_\_  E-mail: \_\_\_\_\_
6. Number of Eligible Employees: \_\_\_\_\_
- |   |  |
|---|--|
| # Eligible Hourly Employees: _____          | # Enrolled Hourly Employees _____          |
| # Eligible Salaried/Managers: _____         | # Enrolled Salaried/Managers _____         |
| # Eligible Owners and Family Members: _____ | # Enrolled Owners and Family Members _____ |
7. Requested Plan Effective Date: \_\_\_\_\_ (Must be the first of the month.)
8. Employer Contribution:  Yes If Yes, describe: \_\_\_\_\_  No

## **BROKER/AGENT INFORMATION**

Agent Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## **METHOD OF PAYMENT (CHOOSE ONE OPTION.)**

- Debit my Checking Account** (You must include a copy of a voided check with this form.)

Bank: \_\_\_\_\_

Branch Name/Address: \_\_\_\_\_

- Debit my Credit Card**

Card Type:  Visa  MasterCard  American Express  Discover

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_(\_\_\_\_)

Billing Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

I hereby authorize Ternian Insurance Group on behalf of ACE American Insurance Company to initiate debit entries to the Checking Account or Credit Card listed above. I acknowledge that the origination of debit transactions to my account must comply with the provisions of U.S. law.

## **ACKNOWLEDGMENT AND AGREEMENT**

**BY SIGNING BELOW:** The employer ("Group") understands and agrees that the requested insurance coverage will not become effective on the proposed effective date until this completed Request for Coverage form is reviewed, approved, and signed by Ternian. The group insurance policy will serve as the contractual agreement between the Group and the insurance company with respect to the terms of the insurance coverage and the cost thereafter. Group acknowledges that the information on this form is complete and accurate to the best of its knowledge. Group understands that the medical plans to be offered (if any) are fixed indemnity sickness and accident policies and are not considered creditable coverage under HIPAA, are not ERISA qualified plans, and are not intended to be a substitute or replacement for comprehensive or major medical health insurance plans or workers compensation plans. Group agrees that it is solely responsible for any applicable obligations under employer legislation and that Ternian and the insurance carrier assume no liability.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

If needed, Request for Coverage forms are available at [www.healthbasicplan.com](http://www.healthbasicplan.com)



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FAX OR EMAIL COMPLETED FOR TO: 770.643-4870,  
memberservices@WiseBenefits.com, Questions? Call 1-800-825-7605



Marketed By:  
**Wise Benefits.com**

Your One Source for Limited Medical Plans!

# Employee Enrollment Form

ACE American Insurance Company

Master Copy  
Retain for new hires

Step 1: Select the medical plan you are eligible for:  Hourly  Salaried/Manager  Owner

Step 2: Dental  Yes  No  I want dental only

Step 3: Select who you want to cover: CHECK ONLY ONE.

I want to cover myself only  I want to cover myself and one dependent (spouse or child)  I want to cover myself and my family

Step 4: Provide the information that we need in order to enroll you and/or your family members.

First Name	M.I.	Last Name	Gender (MF)	Date of Birth
Social Security Number			Hire Date	
Street Address	City		State	Zip Code
Email Address	Primary Phone #		<input type="checkbox"/> Home	<input type="checkbox"/> Work <input type="checkbox"/> Cell

**DEPENDENT INFORMATION (IF ANY):** For more than three dependents attach additional sheet.

Spouse/Child	First Name	M.I.	Last Name	Gender (MF)	Birth Date (mm/dd/yyyy)

**BENEFICIARY INFORMATION:** Person who will receive benefits in the case of your death. You will be the beneficiary for dependents.

First Name	M.I.	Last Name	Gender (MF)	Relationship to You
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WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Employee's Signature	Date Signed
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I have read the ACE American Insurance Company enrollment brochure, including the exclusions and limitations, and accept the terms and conditions of the coverages outlined in it. I understand the fixed indemnity insurance plans are not considered creditable coverage under HIPAA and do not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment brochure and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the brochure only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date. I authorize my employer to deduct the required premium for the plan I have elected from my pay. To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclose information about me.



FAX OR EMAIL COMPLETED FOR TO: 770.643-4870,  
memberservices@WiseBenefits.com, Questions? Call 1-800-825-7605



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# What's Not Covered

## We will not pay benefits for any loss, injury or sickness that is caused by, or results from:

- Pre-existing Conditions occurring within the first 12 months of coverage (applies to Hospital Confinement and Surgery and Anesthesia benefits only). "Pre-existing Condition" means an illness, disease, or other condition of the Covered Person, that was treated, diagnosed or required medications in the 6 month period before the Covered Person's coverage became effective under this Policy.
- Intentionally self-inflicted injury, suicide or attempted suicide.
- War or any act of war, whether declared or not.
- Service in the military, naval or air service of any country or international organization.
- Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
- Commission of, or attempt to commit, a felony.
- Commission of or active participation in a riot, or insurrection.
- Bungee cord jumping, parachuting, skydiving, parasailing, hang-gliding.
- flight in, boarding or alighting from any aircraft except as a fare-paying passenger on a regularly scheduled commercial airline.
- An accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, except while participating in Driver's Education Program.
- Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice. (This exclusion applies to the Accidental Death and Dismemberment benefit only.)
- Travel or activity outside the United States, Canada or Mexico, except for a Medical Emergency.
- Travel in any aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year.
- Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Doctor unless specifically provided herein.
- Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration.
- While the covered person is legally intoxicated (as determined by that state's laws) or while under the influence of any drug unless administered under the advice and consent of a Doctor.
- Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
- Mental and Nervous Disorders.
- Cosmetic surgery, except for reconstructive surgery needed as the result of an injury or sickness.
- Experimental or Investigational drugs, services, supplies or any procedure held to be experimental or investigatory by Us at the time the procedure is done.
- treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
- sexual reassignment surgery, sexual transformation surgery, sexual transgendering surgery.
- services related to sterilization, reversal of a vasectomy or tubal ligation; in vitro fertilization and diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered Injury or Sickness.
- treatment or services provided by a private duty nurse, unless provided for in the Policy.
- organ or tissue transplants and related services.
- personal comfort or convenience items.
- rest or custodial cures.
- hearing aids.
- radial keratotomy.
- treatment by a family member or member of the Covered Person's household.

- routine dental care and treatment, except for treatment of Injury as specified in the Policy.

## We will not pay benefits for any loss, injury or sickness that is caused by, or results from:

1. Suicide or attempted suicide, intentionally self-inflicted injury.
2. War or any act of war, whether declared or not.
3. A Covered Accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
4. Sickness, disease, or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. Injury that occurs while the Covered Person is legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered under the advice and consent of a Doctor.
7. Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice.
8. Commission of, or attempt to commit, a felony.
9. Aggravation or re-injury of a prior Injury the Covered Person suffered prior to his or her coverage effective date, unless We receive a written medical release from the Covered Person's Doctor.

## In addition to the above Exclusions, We will not pay Accident Medical Expense Benefits for any loss, treatment or services resulting from or contributed to by:

- treatment by persons employed or retained by the Policyholder, or by any Immediate Family or member of the Covered Person's household.
- treatment of sickness, disease or infections except pyogenic infections or bacterial infections that result from the accidental ingestion of contaminated substances.
- treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, detached retina unless caused by an Injury, or mental disorder or psychological or psychiatric care or treatment (except as provided in the Policy), whether or not caused by a Covered Accident.
- pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
- mental and nervous disorders (except as provided in the Policy).
- damage to or loss of dentures or bridges, or damage to existing orthodontic equipment (except as specifically covered by the Policy).
- expenses incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofascial pain (except as provided by the Policy).
- Injury covered by Workers' Compensation, Employer's Liability Laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
- cosmetic surgery, except for reconstructive surgery needed as the result of an Injury.
- any elective treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed by us to be experimental; and (b) are not recognized and generally accepted medical practices in the United States.
- eyeglasses, contact lenses, hearing aids, examinations or prescriptions for them, or repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
- expenses payable by any automobile insurance Policy without regard to fault. (This exclusion does not apply in any state where prohibited.)
- conditions that are not caused by a Covered Accident.
- participation in any activity or hazard not specifically covered by the Policy.
- any treatment, service or supply not specifically covered by the Policy.

## No Prescription Drug Benefits will be paid for:

- All over-the-counter products and medications unless shown in the

definition of Prescription Drug. This includes, but is not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements, and all other over-the-counter products and medications.

- Blood glucose meters and insulin injecting devices.
- Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs.
- Biologicals (including allergy tests); blood products; growth hormones; hemophilic factors; MS injectables; immunizations; and all other injectables unless shown in the definition of Prescription Drug.
- Medical supplies and durable medical equipment.
- Liquid nutritional supplements; pediatric Legend Drug vitamins; prescribed versions of Vitamins A, D, K, B12, Folic Acid, and Niacin – used in treatment verses as a dietary supplement; and all other Legend Drug vitamins and nutritional supplements.
- Anorexiant; any cosmetic drugs including, but not limited to, Renova and skin pigmentation preps; any drugs or products used for the treatment of baldness; and topical dental fluorides.
- Refills in excess of that specified by the prescribing Doctor, or refills dispensed after one year from the original date of the prescription.
- Any drug labeled "Caution – limited by Federal Law for Investigational Use" or experimental drugs.
- Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
- Drugs needed due to conditions caused, directly or indirectly, by a covered person taking part in a riot or other civil disorder; or the covered person taking part in the commission of a felony.
- Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or any act of war; or drugs dispensed to a covered person while on active duty service in any armed forces.
- Any expenses related to the administration of any drug.
- Drugs or medicines taken while in or administered by a Hospital or any other health care facility or office.
- Drugs covered under Worker's Compensation, Medicare, Medicaid or other governmental program.
- Drugs, medicines or products which are not medically necessary.
- Diaphragms; erectile dysfunction Legend Drugs; and infertility Legend Drugs.
- Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard; Glucagon-auto injection; and Imitrex-auto injection.
- Smoking deterrents, Legend or over-the-counter drugs.
- Replacement of stolen medication (except under circumstances approved by us), or lost, spilled, broken or dropped Prescription Drugs.
- Vacation supplies of Prescription Drugs (except under circumstances approved by us).
- All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of one year from such FDA approval for its intended indication.

#### **No Dental indemnity Benefits will be paid for expenses incurred:**

- For services and supplies not listed in the Coverage Schedule, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
- For cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
- For services related to, performed in conjunction with, or resulting from a non-covered procedure.
- For charges in excess of the Usual and Customary rate.
- For any treatment program which began prior to the date the Insured is covered under the Policy.
- For crowns, inlays and onlays on teeth that can be restored by direct placement materials.
- For the replacement of crowns, bridges, dentures, inlays or onlays that can be restored to normal function.
- For the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
- For any unmarried child age 19 and over unless he is dependent upon you for support and you claim as an exemption on your federal income tax and/or while a full-time student. A full-time student is one who is enrolled for 12 semester hours of credit in an accredited junior college,

college, or university. Any exemption will end at age 26.

- For service or supplies payable under any medical expense, auto or no-fault plan.
- For any condition covered under any Worker's Compensation Act or similar law.
- For services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
- During any waiting period we require. When you voluntarily end your insurance without a qualifying event and re-enroll at a later date, your waiting period is 2 years and begins on the date your coverage first ended.
- For services that are applied toward the satisfaction of a Deductible, if any.
- For services subject to a waiting period that were incurred during the waiting period.
- For charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
- For hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
- For drugs or the dispensing of drugs.
- For oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes), unless included within the Coverage Schedule.
- For implants; myofunctional therapy; athletic mouth guards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
- For orthodontia, unless included within the Coverage Schedule.
- For services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits.
- For composite, resin, or white fillings on posterior primary teeth. Benefits will be reduced to that of an amalgam or silver filling.
- For the replacement of a filling within 24 months of placement, unless for specific health reasons.
- For the replacement of retainers.
- For sealants not applied to permanent bicuspid or molar; applied at age 15 or older; applied 3 years from a previous sealant application; applied to a decayed tooth.
- For lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays, unless included within the Coverage Schedule.

#### **The following applies to the Group Term Life Insurance benefit:**

- **SUICIDE EXCLUSION:** We will not pay a death benefit if an insured person dies by suicide, while sane or insane, within two years of the date his/her insurance starts. If You or Your spouse dies by suicide, We will refund the premiums paid for Your insurance (if a dependent child dies by suicide, We will refund the premiums paid for the dependent children's insurance only if You have no surviving insured dependent children). If any death benefit is increased, this suicide exclusion starts anew, but will apply only to the amount of the increase.

#### **Claims Administered by:**

Administrative Concepts, Inc. (ACI)  
994 Old Eagle School Road, Ste. 1005  
Wayne, PA 19087  
1-800-964-7096



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