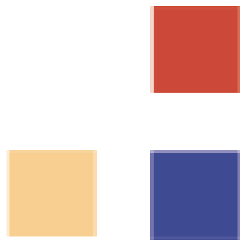

CompleteCare
Personal Health Plans

Affordable health and supplemental benefit choices for individuals and families

Underwritten by Fidelity Security Life Insurance Company

the

CompleteCare

Personal Health Plans

Empower yourself with the **CompleteCare Personal Plans**...a health insurance portfolio that is more than just insurance. Our exclusive **Personal Satisfaction Program™** complements our health plans and offers a more intelligent way to purchase and use health insurance. It's automatically included with any plan you choose!

Personal Satisfaction Program™

My Health Compass™ - Allows you to "shop" for pricing and evaluate the quality of hospitals in your area. A must have for individuals with a high deductible.

Optum® NurseLine - Provides you with 24-hour telephone access to registered nurses and assistance with understanding alternatives for treating various health conditions.

Medex Plus Traveler's Emergency - Provides for free emergency air transport and healthcare coordination when you are are 100 miles or more away from home.

Discount Drug Card - Saves money on prescription items if you elect not to have outpatient prescription coverage.

7 great benefit programs to choose from

Copay Choice Plan

Our most comprehensive plan.
- Comprehensive benefits
- Convenience of copays
- Customized coverage to meet personal needs

Copay Advantage Plan

Copay Choice benefits, lower premium.
- Comprehensive benefits at an attractive price
- Premium savings are reached by having separate out-of-pocket maximums for "medical services & supplies" and "inpatient facility confinement & surgical services"

50-50 Share Plan

The no-deductible plan!
- No up-front deductible for in-network services
- Significant premium savings
- Physician office visit copay

Health Security Plan

Higher deductibles, lower premiums.
- 100% coverage of eligible expenses incurred that day up to the plan limits after the calendar year deductible is met

Daily Deductible Plan

One low network deductible to meet daily.
- 100% coverage of eligible expenses incurred that day up to the plan limits after the Daily Deductible is met
- Designed specifically for individuals and families who want to maximize their premium savings without having to satisfy a large calendar year deductible

Single Deductible Plan

HSA Qualified You pick your HSA custodian

One deductible for eligible expenses, in- or out-of-network.
- Health Savings Account (HSA) qualified
- A simple, cost-effective and intelligent way to finance healthcare
- For family coverage, you and your dependents share one common deductible amount

New!

CompleteCare HSA Plan

HSA Included Use our HSA custodian

Seamlessly integrated qualified health plan and Health Savings Account (HSA).
- Automatic, hassle-free set-up of your Health Savings Account (HSA) with our industry leading HSA custodian
- Always qualified - the CompleteCare HSA plan stays HSA qualified
- Telephone and internet customer service support answers your questions about your CompleteCare HSA Plan

For complete details about the *CompleteCare Plans*, consult the Certificate of Insurance underwritten by Fidelity Security Life Insurance Company.

key features

- **“A-rated” carrier.** Fidelity Security Life Insurance Company is rated A- **(Excellent)** based on an analysis of financial position and operating performance by A.M. Best Company, an independent analyst of the insurance industry.

- **$5,000,000 per person medical benefit** while insured, $1,000,000 per calendar year. Mental & Nervous / Chemical Dependency per person combined $10,000 maximum benefit while insured.

- **Lower rates for non-tobacco users.**

- **No ineligible occupations or employment requirements.**

- **Flexible billing options** including monthly bank draft, credit card, direct bill and list bill (where available)

- **Initial 12-month rate guarantee and an 18-month initial rate guarantee option.**

- **10% family discount.**

- **Common Accident Deductible Provision, Health Security Plan only.** If two or more insured persons in a family are in the same accident, only one deductible will apply to covered charges for all such persons due to that accident for that calendar year.

- **Health Savings Account (HSA) qualified plans.** These plans offer a more intelligent means of financing health care expenses. Funds can be used to pay medical expenses tax-free or can be allowed to accumulate interest and grow, tax-free, year after year until retirement.

Underwritten by
Fidelity Security life Insurance Company

Your CompleteCare Personal Health Plan covers these medically-necessary expenses:*

- Hospital room and board
- Medical supplies/hospital services
- Physician services
- Licensed emergency ambulance services when medically necessary
- X-ray, laboratory and diagnostic tests
- Radiation therapy
- Chemotherapy, antibiotic therapy and infusion therapy
- Blood and its administration, but not the cost of blood or blood components if replaced by donation
- Initial supply but not replacement of casts, splints, trusses, crutches and braces (excluding dental braces and orthodontics)
- Initial supply of artificial limbs, larynx and eyes due to loss of limbs, larynx and eyes as the result of bodily injury sustained or sickness that begins while you are insured under the plan
- Rental (or at our option, lease or purchase) of a wheelchair, hospital bed, crutches, canes and other durable medical equipment
- Anesthetics, oxygen and their administration
- Ambulatory surgical center services.

Other covered services and benefits are outlined in this brochure; for complete details, please refer to the Certificate of Coverage (C-5028 or C-5031).

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*Note: Benefit limits may apply - see Certificate of Coverage for details.
Benefits are subject to applicable copayment, deductible and coinsurance

In-Network	Copay Choice Plan	Copay Advantage Plan	50-50 Share Plan
Outpatient Physician Office Visit Copay, Free-Standing Urgent Care Facilities	$35 or $70 copay, then **100% coverage**	$35 copay, then **100% coverage**	$50 copay, then **100% coverage**
Mammography	$35 or $70 copay, then **100% coverage**	$35 copay, then **100% coverage**	$50 copay, then **100% coverage**
Outpatient Diagnostic Lab, X-ray, MRI, CT, Nuclear Imaging and other tests Copay Options	Deductible and coinsurance apply	Deductible and coinsurance apply	50% coinsurance
Calendar Year Deductible Options[1]	$1,000 • $1,500 $2,500 • $3,500 • $5,000 *Per person. Max. 3 per family.*	$1,000 • $1,500 $2,500 • $3,500 • $5,000 *Per person. Max. 3 per family.*	**None**
Coinsurance Options	80% or 70%	80% or 70%	50%
Additional Individual Out-of-pocket Maximum[1]	$2,000 or $6,000 *Per person. Max. 2 per family.*	80%: Outpatient Medical Services and Supplies: $2,000[3]; Inpatient Facility Confinement and Surgical Services: $4,000[3] 70%: Outpatient Medical Services and Supplies: $3,000[3]; Inpatient Facility Confinement and Surgical Services: $6,000[3] *Per person. Max. 2 per family.*	$4,000 • $6,000 • $8,000 *Per person. Max. 2 per family.*
Inpatient Confinement Copay Per confinement	$250	$250	$250
Emergency Room Additional Copay *Copays waived if admitted as inpatient. Deductible and/or coinsurance apply afterward*	$100	$100	$100
General Outpatient Medical Services and Supplies, Ambulance, Non-Surgical Back Treatment[2]	Deductible and coinsurance apply	Deductible and coinsurance apply	50% coinsurance
Outpatient Mental, Nervous and Chemical Dependency[5]	Deductible and 50% coinsurance apply	Deductible and 50% coinsurance apply	50% coinsurance applies
Out-of-Network			
Calendar Year Deductible[1]	2x the network deductible *Per person. Max. 3 per family.*	2x the network deductible *Per person. Max. 3 per family.*	$3,000 *Per person. Max. 3 per family.*
Coinsurance	50%	50%	50%
Individual Out-of-pocket Maximum[1]	$5,000 or $10,000 *Per person. Max. 3 per family.*	$5,000 or $10,000 *Per person. Max. 3 per family.*	$4,000, $6,000, or $8,000 *Per person. Max. 3 per family.*

[1] Amount excludes copays and/or Rx deductibles. Out-of-pocket maximum also excludes calendar year deductible, except on Single Deductible and CompleteCare HSA Plans. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network maximum out-of-pocket has been satisfied, the in-network deductible and maximum out-of-pocket are deemed satisfied.

[2] Non-surgical back treatment subject to $500 maximum benefit per calendar year.

[3] In- and out-of-network maximums for **each type of service accumulate separately,** however, once the out-of-network maximum out-of-pocket for a category of services has been satisfied, the in-network maximum out-of-pocket for that category of services is deemed satisfied.

Health Security Plan	Daily Deductible Plan	HSA Qualified Plans: Single Deductible Plan	HSA Qualified Plans: CompleteCare HSA Plan
Deductible applies	Daily Deductible applies	Deductible applies	Deductible applies
Deductible applies	**100% coverage with no daily deductible**	100% coverage after deductible	100% coverage after deductible
Deductible applies	Daily Deductible applies	Deductible applies	Deductible applies
$2,000 • $5,000 $7,500 • $10,000 *Per person. Max. 3 per family.*	Daily Deductible: $250 or $500 *Per person up to maximum out-of-pocket stated below.*	In- and out-of-network expenses all accumulate to a common individual or family deductible **Individual**: $1,000, $1,700, $2,600 **Family**: $2,000, $3,350, $5,150	In- and out-of-network expenses all accumulate to a common individual or family deductible **Individual**: $1,000, $1,700, $2,600 **Family**: $2,000, $3,350, $5,150
100%	100%	100%	100%
$0	$6,000 *Includes all eligible insured's expenses paid towards Daily Deductibles*	$0	$0
$250	None	None	None
$100	None	None	None
Deductible and coinsurance apply	Daily Deductible applies	Deductible applies	Deductible applies
Deductible and 50% coinsurance apply	Daily Deductible applies	Deductible and 50% coinsurance apply	Deductible and 50% coinsurance apply
$5,000 • $10,000 $12,000 • $14,000 *Per person. Max. 3 per family.*	2x the network Daily Deductible	Single Deductible for in- and out-of-network expenses (see above)	Single Deductible for in- and out-of-network expenses (see above)
80%	100%	70%	70%
$1,500 *Per person. Max. 3 per family.*	$12,000 Includes all *eligible expenses paid towards Daily Deductibles*	Individual $3,350 Family $6,150	**Individual** $3,350 **Family** $6,150
		Health Savings Account (HSA) *Qualified!* The plan for you to use when setting up a Health Savings Account (HSA) with an HSA custodian.	**Health Savings Account (HSA)** ***Included!*** Selecting this plan automatically sets-up a Health Savings Account (HSA) in your name with our trusted HSA custodian.

[4]Maximum out-of-pocket corresponds to the selected deductible.

[5]Mental & Nervous and Chemical Dependency are subject to limits. See page 9 for limitations.

optional benefits[1]

Outpatient Prescription Drug Options[2]

Rx coverage up to plan limits - no separate Rx coverage limit! Includes oral contraceptives.

Options	Generic	Brand Deductible	Preferred Brand	Non-Preferred Brand
Option 2: **Rx Insurance** *Most Comprehensive*	$25	None	$100	$150
Option 3: **Rx Deductible 250**	$15	$250	$30 + 20%	$45 + 20%
Option 4: **Rx Deductible 500**	$15	$500	$30 + 20%	$45 + 20%
Option 5: **Deductible 1000**	$15	$1,000	$30 + 20%	$45 + 20%

Option 1: **Rx Discount Only** — If no other Rx option is selected, the plan automatically includes the discount-only drug feature, which provides discounts of up to 25% at Express Scripts pharmacies.

*Available only on the Single Deductible **and** CompleteCare HSA plans:*

Option 6: **Rx HSA** — Covered prescription drugs are paid the same as any other illness under the health plan and are subject to the calendar year deductible and coinsurance.

Prescription Drug Formulary[2]

When an optional prescription drug benefit is selected, a prescription drug formulary applies. The prescription drug formulary is a tool used to improve quality assurance and effective cost management within the outpatient prescription drug benefit. The formulary is a list of quality generic and brand name medications offering the potential for cost savings. Formularies are quite common in health care plans today. There are often two or more medications used to accomplish the same therapeutic effect. When your physician prescribes one of the listed medications, if medically appropriate, you will have a lower out-of-pocket cost for that prescription.

Most physicians are aware of the need for cost effective drug therapy and work with formulary programs. In the event you or your physician are reluctant to choose a particular medication from the formulary list, you are not required to do so. The formulary system is voluntary and intended to be a participating effort by all involved parties to help contain the ever-rising costs of health care through effective drug therapy management. When non-formulary brand name prescription drugs are used, a higher copay applies.

Maximum Allowable Cost (MAC)

When a brand-name medication is dispensed because of an insured person's preference and a less expensive FDA-approved generic medication could have been dispensed, the insured person's out-of-pocket costs may be increased. The out-of-pocket costs will be increased by the difference in the price of the insured's preferred brand medication and the established Maximum Allowable Cost (MAC) price for the generic equivalent.

MAC pricing is a statistically derived maximum allowable base price that will be paid for prescription drugs for which a less expensive, FDA-approved generic equivalent is available. This method assures that the cost to the plan does not increase when an insured person makes a decision to use a more expensive product. MAC pricing increases generic utilization and helps to equitably control the cost of outpatient prescription drugs dispensed.

Mail Order and Internet Purchases

Enjoy the convenience of mail order and/or Internet purchases by ordering up to a 3-month supply of your prescription drugs and items at a time. You can use your discount feature or your optional drug coverage benefit to purchase prescription drugs and items. When using your optional drug coverage benefit, **only 2 months' payment applies to each 3-month supply**!

Supplemental Accident Coverage

Plan pays 100% of each accident's covered charges up to the selected benefit amount per person, then the plan's deductible and coinsurance apply. Benefit applies to both in- and out-of-network providers.

Choose per accident: ❑ $500 ❑ $1,000

Dependent Life Insurance

Available for spouse and/or children.

Spouse: ❑ $2000	**Children:**		
	❑	**$100**	**14 days to 6 months**
	❑	**$1,000**	**6 months to less than 19 years**
	❑	**$1,000**	**19 to less than 25 years, if full-time student**

Additional Life Insurance

$10,000 included for primary insured except in FL, OH, OK, and TX, where life insurance is offered as an optional benefit. Additional optional life insurance coverage is available up to $100,000.

Wellness (Preventative Care) Benefit

❑ Covered charges are paid at 100% up to $250 per person, per calendar year, with no waiting period.
Includes: · Routine physical exams · Well-child care, including immunizations · Routine PAP smears & related lab charges · Prostate cancer screening services

Benefit applies to in-network providers only.

Vision Benefit

Your CompleteCare Personal Health Plan includes an optional vision benefit offered through EyeMed. Through this program, you can enjoy immediate savings on eye care needs, including frames, bifocals, non-disposable contact lenses and many other items and services at more than 800 LensCrafters stores nationwide and thousands of independent providers affiliated with EyeMed.

There are two coverage options, with different copays for eye exams and prescription lenses.

❑ Option 1 - $10 exam/$25 lenses/$100 frame allowance

❑ Option 2 - $20 exam/$20 lenses/$100 frame allowance

Refer to the IAC Vision Plan Overviews for additional details. Check for state availability.

Optum Personal Assistance Program

Includes in-person counselor appointments, networks for childcare and eldercare problems, legal concerns and financial issues, referrals to national and community services and an audio health information library.

24-Hour Occupational Coverage

Qualified sole proprietors, partners, or business owners who are not covered by Workers' Compensation are eligible for 24-hour Occupational Coverage under their CompleteCare Personal Health Plan. Benefits may be payable for covered charges incurred by these insured persons for work-related injuries or sickness.

18-month Rate Guarantee

Your plan includes an initial 12-month rate guarantee. Select this option to extend the plan's rate guarantee period for an additional six months.

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[1] - See Certificate of Coverage and Schedule of Benefits for additional details.

[2] -See Express Scripts Formulary for current list of preferred prescription drugs. Rx options 1-5 not available on the CompleteCare HSA Plan.

Emergency Care at Out-of-network Hospitals

If you are taken to an out-of-network hospital for a medical emergency, we will pay for covered services at network benefit levels. However, you must arrange for transfer to a network hospital within 48 hours or as soon as this transfer can take place without detriment to your health. Otherwise, covered services will be paid at out-of-network benefit levels.

Hospital Room and Board

Your CompleteCare Personal Health Plan covers hospital room and board charges according to the plan you selected, on the basis of the average semi-private room rate. If the hospital does not have semi-private rooms, the plan will pay the base amount of 90% of that hospital's lowest-priced private room.

Intensive Care

Intensive care room and board provided through network hospitals will be paid at the most common rate for intensive care units. If provided through out-of-network facilities, they will be paid at up to 3 times the most common semi-private room rate. Observation room and intermediate care unit services will be paid at a rate of up to 2 times the most common semi-private room rate.

Non-Surgical Back Treatment (Chiropractic Care)

Covered expenses for non-surgical back treatment are payable up to $500 per person per calendar year, on an outpatient basis. Applicable deductible and coinsurance apply.

Home Health Care

After applicable deductible has been satisfied, covered medical expenses will be paid at the coinsurance level you have selected, up to 21 visits per calendar year, per insured person.

Mammography and Breast Screening

Subject to schedule and/or state mandates. See certificate of coverage for details.

<u>Copay Choice, Copay Advantage & 50-50 Share Plan:</u>
In-network, after applicable copay, mammography and breast screening services are covered at 100%.
Out-of-network, deductible and coinsurance apply.

<u>Health Security Plan:</u>
In-network, after applicable deductible, mammography and breast screening services are covered at 100%.
Out-of-network, deductible and coinsurance apply.

<u>Daily Deductible Plan:</u>
In-network, mammography and breast screening paid at 100% with no daily deductible.
Out-of-network, daily deductible applies.

<u>Single Deductible & CompleteCare HSA Plan:</u>
In-network, deductible applies to mammography and breast screening.
Out-of-network, deductible and coinsurance apply to mammography and breast screening.

Mental & Nervous Conditions, Substance Abuse & Chemical Dependency Treatment

The maximum benefit for mental & nervous and chemical dependency treatment is $10,000 combined per person, while insured. Covered charges **do not** accumulate towards the plan's maximum out-of-pocket amounts.

Outpatient Mental & Nervous & Chemical Dependency

Applicable deductible & coinsurance apply. Up to $25 per visit, maximum of 50 visits or $1,250 per calendar year.

Inpatient Mental & Nervous

Applicable copay, deductible & coinsurance apply. Maximum of 10 inpatient days, up to $2,500 per calendar year.

Inpatient Chemical Dependency

Benefits are not provided for inpatient chemical dependency treatment, unless otherwise mandated by state law.

Complications of Pregnancy

Complications of pregnancy are covered the same as any other illness. Normal pregnancy is not a covered benefit. See Major Medical Exclusions and Limitations and Pre-certification Requirements for details.

Skilled Nursing Facility Care

After your applicable copay and/or deductible has been satisfied, covered medical expenses will be paid at the coinsurance level you have selected, up to $100 daily benefit, limited to 50 days per calendar year, per insured person.

Hospice Care

The plan will pay covered medical expenses for hospice care for up to 6 months. Pre-certification is required. The plan will also cover bereavement support services for the insured person's family during the 3-month period after death, up to $250.

Organ Transplant Benefit

The plan includes access to the **United Resource Networks** (URN) for organ transplants. In addition to contracting with providers and *Centers of Excellence*, this specialized network offers expertise, patient advocacy and case management services. URN helps to ensure that you receive the highest levels of care for these complex services. When you use one of the URN *Centers of Excellence,* an allowance of up to $5,000 is available for necessary travel and room and board expenses for a companion, or, two companions, if the insured is a minor.

When you use URN providers for transplant services, covered medical expenses will be paid up to the plan maximum benefit of $5,000,000 while insured, up to $1,000,000 in a calendar year. If services are received from a provider in your selected PPO network, the maximum benefit allowed is $250,000. If these services are received from out-of-network providers, then the maximum benefit allowed is $100,000 while insured. See the certificate of coverage for details.

Covered Charges

Covered charges include provider network contracted charges or necessary, reasonable and customary charges for out-of-network providers for expenses that are necessary for the treatment of injury or sickness that is not excluded from your coverage.

"Necessary, reasonable and customary" means the usual charge made for necessary medical services and supplies generally furnished for sickness or injuries of comparable severity and nature in the geographic area in which the services or supplies are furnished.

In determining what should be considered necessary, reasonable and customary for services and supplies, we use and subscribe to a standard industry reference source that collects data and makes it available to member companies. The database used reflects the amounts charged by providers for health care services based on the smallest geographic zip code areas generating a statistically credible charge distribution. This data is updated and published twice per year. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers who are not included in the database. We then use a specific representative percentile of that range of charges to determine the necessary, reasonable and customary charge for all people who are insured under this policy.

Eligibility

If you are under age 65, you and your eligible dependents may be eligible to purchase a CompleteCare Personal Health Insurance Plan. You can apply by completing an application for participation and by qualifying for coverage according to the plan's medical underwriting guidelines.

Eligible dependents include:

- Your legally recognized spouse (under age 65)
- Your unmarried child(ren) under age 19
- Your unmarried child(ren) ages 19 to 25*

*Unmarried children ages 19 to 25 will be considered eligible dependents if they are dependent upon you for maintenance and support and are enrolled on a full-time basis in an accredited school or college. We define "full-time basis" in this instance as being enrolled in and attending the accredited school or college in each and every semester (or quarter) for a minimum of 12 credit hours.

Rate Guarantee

Your initial monthly premiums are based on several factors, including, but not limited to, your age, your spouse's age (if applicable), the number of children you have covered under the plan, and your home address.

We guarantee that your rates will not change for the initial 12 months (18-months, if the optional 18-month initial rate guarantee is elected) of coverage from your effective date unless one or more of the following events occur during that time:

- You move to a new residence
- Provider access fees change
- Administrative fees change

Accidental Death & Dismemberment

Your CompleteCare Personal Health Plan life insurance benefit includes accidental death and dismemberment coverage. Upon receipt of notice and due proof that an insured person sustained any of the losses listed in the table below, the plan will pay the sums indicated. These losses must be the direct result of accidental bodily injury that occurred not more than 90 days prior to the date that the loss was sustained.

Table of Losses

In the event of the loss of:	The plan will pay:
Life	The Principle Sum
Both hands or both feet	The Principle Sum
Sight of both eyes	The Principle Sum
One hand & one foot	The Principle Sum
One hand & sight of one eye	The Principle Sum
One foot & sight of one eye	The Principle Sum
One hand	1/2 Principle Sum
One foot	1/2 Principle Sum
Sight of one eye	1/2 Principle Sum

With respect to hands or feet, "loss" means severance at or above the joint. Eyes "loss" means entire, irrevocable loss of sight.

Effective Date of Coverage

You may request that your coverage under your CompleteCare Personal Health Plan become effective on either the 1st or the 15th of the month. We must receive your application before the effective date you have requested. If your application is approved, your coverage will become effective on the monthly premium due date that coincides with or on the next following date on which the application is approved. Your applicable premium must be paid before your policy goes into effect. If the company is unable to approve your application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

Any dependent(s) whom you want to include under the plan must not be hospitalized and must be able to perform the same activities that they were able to perform at the time that you submitted your application. If these requirements are not met, your application will be disapproved and a new application will be required if you wish to be considered for coverage at a future date.

Child(ren) Only Coverage

Child(ren) only coverage is available for applicants 2-17 years of age. When covered children attain age 18, they can be issued coverage under their own individual plan and charged an adult rate if they reside in a state where the coverage is available. Premium is based on the rates applicable to the state in which the child resides. Children of foreign nationals with legal residency in the United States are not eligible for coverage.

Applications for child(ren) only coverage will be declined if either parent or legal guardian of the child(ren) to be included under the coverage is currently an expectant parent or has undergone infertility testing within one (1) year of the date of application for the child(ren) only coverage.

Accidental Death & Dismemberment Exclusions

Benefits are not payable under the Accidental Death and Dismemberment coverage for any loss caused by, contributed to, or resulting directly from:
• any act of war, whether declared or undeclared, riot or insurrection, or resulting from service in the military, naval or air forces of any country or in any auxiliary or civilian noncombatant unit auxiliary to or serving with such forces • travel or flight in, or descent from, any aircraft except as a fare-paying passenger on a licensed commercial aircraft operating on a regular schedule between established airports • suicide, attempt at suicide or by intentionally self-inflicted injuries while sane or insane • sickness, disease, or mental infirmity, or medical or surgical treatment or diagnosis thereof, or bacterial or other infection (except infection which occurs through and as a result of a visible wound caused by accidental bodily injury) • participating in or commission of, or attempting to commit an assault or felony, or a loss to which a contributing cause was the insured person's being engaged in an illegal occupation • bodily injury sustained as a consequence of intoxication or influence of any narcotic unless administered on the advice of a legally qualified physician • the voluntary ingestion of poison, inhaling of gas, or asphyxiation • the ingestion of any drug, sedative or narcotic, unless prescribed by a physician.

Guarantee of Renewability

This health plan renews annually on a common renewal date after the initial 12-month rate guarantee. With a common renewal date, all health plans renew on the same date. Common renewal dates allow for more stability in premium rates and more accurate rate pooling.

Coverage under your CompleteCare Personal Health Plan will be renewed each month unless we notify you that we will not renew your coverage for any of the following reasons:

- Your premium is not paid according to the terms of the policy
- You or your insured dependent(s) have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the policy
- You or your insured dependent(s) enter into full-time military service
- You no longer reside, live or work in the service area for which we are authorized to do business
- We decline to renew all health insurance in the individual market (subject to our giving you at least 180 days' advance written notice.)

Pre-existing Conditions and Admitted Health History

Health conditions that are fully disclosed in writing on a CompleteCare Personal Health Plans application are covered from the effective date of coverage under the policy unless the condition is specifically excluded by endorsement or health condition rider attached to the certificate of coverage.

Pre-existing Condition Limitation

Your CompleteCare Personal Health Plan includes limitations on coverage for pre-existing conditions. No benefits will be payable for any charges in connection with a bodily injury or sickness for which you or your covered dependent:

- received medical treatment, including the taking of medication prescribed by your doctor;
- received medical advice or consulted with a doctor; or
- experienced distinct symptoms which would have caused an ordinarily prudent person to seek medical diagnosis or treatment during the 12 months immediately preceding the effective date of coverage under your CompleteCare Personal Health Plan.

This pre-existing condition limitation will not apply to charges incurred in connection with that bodily injury or sickness after the first of the following events occur:

- you have been continuously covered under your CompleteCare Personal Health Plan for 12 months and you have not received any medical care or treatment for that pre-existing bodily injury or sickness during those 12 months; or
- you have been continuously covered under your CompleteCare Personal Health Plan for 24 months.

Reduced Benefits Due to Medicare Eligibility

If you or your insured dependent incur covered expenses for services or supplies for which benefits are payable under both Medicare and your CompleteCare Personal Health Plan, Medicare will always be your primary coverage and this plan will pay as a secondary plan. That means that your CompleteCare Personal Health Plan will pay the balance of covered expenses that remain after Medicare benefits are paid.

The maximum amount payable under your CompleteCare Personal Health Plan will be the lesser of either the amount that we would have paid in the absence of Medicare's payment or the amount of those covered expenses, minus Medicare's payment. We must receive verification of Medicare's payment or refusal of payment for those expenses incurred under Medicare Part A or Part B before we will consider paying benefits.

Termination Provisions

We can refuse to renew coverage for a certificate holder:

- when a premium is not paid in accordance with the terms of the group policy, or we have not received timely premium payments;
- when a certificate holder or his or her insured dependent has committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the group policy;
- when a certificate holder or his or her insured dependent enters full-time service in the military, naval or air forces, or any branch thereof;
- in the case of coverage through a network plan, the certificate holder no longer resides, lives, or works in the service area for which we are authorized to do business;
- subject to our giving each certificate holder at least 90 days advance written notice, if we are refusing to renew the group policy; or
- subject to our giving each certificate holder at least 180 days advance written notice, if we are refusing to renew all health insurance in the individual market.

Major Medical Exclusions & Limitations

Expenses for any of the following are excluded from coverage under your CompleteCare Personal Health Plan:

• expenses incurred in connection with a pre-existing condition l any confinement, treatment, service, supply or prescription which is (a) not the result of bodily injury or sickness, (b) not recommended by a physician; or (c)not medically necessary l normal pregnancy or voluntary abortion, except that complications of pregnancy will be treated the same as any other illness
• experimental or investigational medical treatment
• bodily injury or sickness arising from an occupation, except for owners, proprietors or partners who are not covered under Workers' Compensation or occupational disease law and who have selected the 24-hour occupational coverage option
• confinement, treatment, services or supplies provided by a government owned or operated facility, unless the covered person is legally required to pay for those services
• bodily injury or sickness resulting from war or any act of war, declared or undeclared, or while on active duty with any military, naval or air force of any country or international organization
• newborn nursery care
• dental care, except for treatment of injury to sound, natural teeth within 90 days of the date of an injury
• treatment or surgery for prognathism, retrognathism, microtrognathism, or to reposition the maxilla, mandible, or both, unless due to an injury incurred while covered under the policy
• treatment for temporomandibular joint dysfunction (TMJ)
• cosmetic surgery
• routine eye exams, glasses, visual therapy, or contact lenses
• radial keratotomy and keratectomy
• hearing aids or fitting thereof
• contraceptive devices
• charges incurred as the result of participating in a riot or insurrection or commission of a felony or while imprisoned
• acupuncture, except when used in lieu of anesthetic
• routine physical exams, except as provided under the Wellness benefit
• routine removal of corns, calluses or toenails
• charges for treatment for obesity or weight reduction
• charges for provider services if that provider is: (a) a close relative; (b) lives in the same household; or (c) is your employer (except for charges rendered during a hospital stay)
• charges incurred due to an attempted suicide or intentionally self-inflicted injury or sickness while sane or insane
• treatment for mental, nervous or chemical dependency disorders, except as provided for in the certificate of coverage
• Charges related to: (a) procedures to restore or enhance fertility; (b) reversal of sterilization; (c) penile implants; or (d) fertility and sterility studies
• impregnation techniques, including but not limited to artificial insemination, invitro fertilization, intra-fallopian transfers or genetic counseling
• sexual reassignments or sexual dysfunctions or inadequacies
• hospital and physician charges for weekend admissions occurring between noon on Friday and noon the following Sunday for non-emergency procedures, unless medically necessary or surgery is scheduled for the following day
• congenital conditions, except with respect to children covered from birth under the policy
• custodial care
• services or supplies for which no charge is made or the Insured Person is not required to pay
• charges for services received or supplies purchased outside of United States unless incurred while traveling and approved for use in the United States
• any service or supply related to the implant of an artificial organ
• education or training materials
• equipment, other than durable medical equipment, including but not limited to: modifications to motor vehicles or homes such as wheelchair ramps or lifts, water therapy devices, exercise equipment, etc.
• any service or supply to eliminate or reduce dependency or an addiction to tobacco, including but not limited to; nicotine withdrawal programs, nicotine products such as transdermal patches and gums, hypnotism or goal oriented behavioral therapy
• any surgical removal of an organ or tissue unless medically necessary
• private duty nursing
• charges related to human organ or tissue transplants except as provided in the certificate of coverage
• personal convenience services or supplies
• non-prescription medication
• charges for voice training for a lisp.

Pre-certification Requirements

Pre-certification is a screening process that uses established medical criteria to determine whether the proposed length of a hospital stay, a proposed treatment plan, or proposed services and supplies are medically necessary and appropriate.
Pre-certification may also include proposing alternative treatment plans, concurrent length of stay reviews and discharge planning.

Your plan requires that the following services and supplies be pre-certified:

- all proposed inpatient hospital confinements
- all proposed stays in an extended care or skilled care nursing facility
- all proposed home health services
- all proposed hospice services
- complications of pregnancy (must be pre-certified within 7 days of diagnosis)
- prescription drug orders for growth hormones, immuno-suppressants, AZT or HIV antiretroviral medication, "off label" use, orphan drugs, investigative new drugs and Group C cancer drugs
- in addition, all outpatient tests and services should be precertified

In non-emergency situations you must contact the pre-certification service at least 7 days before incurring expenses on account of any of the above occurrences. Simply call the pre-certification service listed on your health plan identification card. They will contact your doctor for any necessary additional information.

In an emergency, you should go directly to the hospital to receive immediate care. If you are then admitted as an inpatient in the hospital, you must contact the pre-certification service within 48 hours of admission, or as soon as reasonably possible. Your doctor must verify that an emergency existed.

If you do not pre-certify an inpatient hospital stay as outlined above or complications of pregnancy, you will be responsible for an additional $500 deductible per occurrence. If you do not pre-certify any of the medications listed above, then NO benefits are payable toward their cost. If you follow pre-certification requirements, these additional deductible amounts will be waived.

Pre-certification is not a guarantee of payment. We will determine eligibility, covered expenses and benefits to be paid in accordance with the master policy.

CompleteCare Personal Health Insurance Plans

Fidelity Security Life Insurance Company, Kansas City, Missouri, is the insurer for medical benefits described in this overview. Fidelity Security Life Insurance Company has been rated A- (Excellent), based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry. While the A- (Excellent) rating reflects the company's outstanding financial performance and capitalization, it is not a warranty of the company's present or future financial position. A.M. Best reports that companies rated A- (Excellent) "have strong ability to meet their obligations to policyholders over a long period of time."

The National Consumers Awareness Association makes the CompleteCare Personal Health Insurance Plans available in the states of Arkansas, Indiana, Michigan and Missouri.

The National Consumers Awareness Association is a non-profit association that offers its members access to numerous health, purchasing/general consumer, travel and business-related benefits. All membership dues are used solely for the administration of member benefits. Administrative offices for the National Consumers Awareness Association are located in St. Louis, Missouri.

Insurers Administrative Corporation, (IAC), located in Phoenix, Arizona, is a licensed and bonded third-party administrator established in 1978.

IAC offers total services of underwriting, billing and claims administration for the CompleteCare Personal Health Plans. With more than 350 employees serving the insurance needs of individuals and employers in the areas of medical, dental, vision, life and AD&D, critical care coverage, self-funding, 401K and Section 125 plans, IAC is one of the nation's largest third-party administrators.

Important Information

The information included in this brochure is an outline of features, plan provisions, benefits and other information about the CompleteCare Personal Health Plans. Plans offered may be subject to change. It is not intended to serve as legal interpretation of the benefits, which are provided under the Master Policies issued to the Multiple Unit Security Trust II (M-5028) and to the National Consumers Awareness Association (M-5031). The exact provisions governing the insurance contract are contained in the Master Policy underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. Some provisions, benefits, exclusions or limitations may vary depending on your state of residence. Certain terms and conditions apply. Any provision of this Policy that is in conflict with any applicable federal or state law is hereby amended to meet the minimum requirements of such law. For complete details about the CompleteCare Personal Health Plans, please refer to the Certificate of Coverage (C-5028 or C-5031, C-9004). Vision benefits described herein are governed by policy form M-9004, and are underwritten by Fidelity Security Life Insurance Company. Services provided through MyHealthCompass, Optum® and MEDEX are not insurance benefits and are not underwritten by Fidelity Security Life Insurance Company.

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