# SIGNATURE HEALTH PLAN

## ELITE OPTION SCHEDULE OF BENEFITS

The benefits, coverage, and exclusions, listed herein are only a summary and are subject to the specific terms and conditions of the plan concerning eligible benefits, limitations, eligibility, and exclusions. Please refer to your Policy Wording for specific terms, conditions and other details concerning your benefits, limitations, eligibility, and exclusions.

### PRE-CERTIFICATION REQUIREMENTS

Penalties to the benefits payable under this policy may apply if the requirements are not met. Please refer to the section labeled Pre-Certification of Services for a more detailed description. You must contact the pre-certification provider number listed on your identification card. The following services must be pre-certified:

In-patient hospitalization | Home Health Care | Organ Transplant | Emergency Air Ambulance | Cardiac Care | Emergency Transportation of a Family Member | Repatriation of Mortal Remains | Evacuation | Oncology Treatment/ Radiation and Chemotherapy Inpatient and Outpatient |

Failure to perform the pre-certification requirements within a minimum of 72-hours in advance of a non-emergency service or within 48-hours of an emergency service will result in a penalty of 50% of the allowable charge for the entire episode of care. This out-of-pocket and co-insurance amount will not be applied towards your defined limit shown on your Certificate of Coverage.

| SERVICE | COVERAGE |
|---|---|
| **AREA OF COVERAGE** (Certificate of Coverage defines your selection) | Worldwide including U.S. Coverage |
| **POLICY LIFETIME MAXIMUM PER INSURED** | 5,000,000 USD |
| **POLICY YEAR DEDUCTIBLE OPTIONS** (Certificate of Coverage defines your selection)<br>• Individual<br>• Family | • 250 USD \| 500 USD \| 1,000 USD \| 2,500 USD \| 5,000 USD \|<br>• Two (2) times the chosen individual deductible |
| **POLICY YEAR OUT-OF-POCKET CO-INSURANCE LIMIT**<br>After the Deductible, all benefits under this policy outside of the United States are payable at 100% of UCC. Benefits within the United States within the network subject to twenty (20%) coinsurance for the first $5,000 of covered expenses, up to an out of pocket limit per covered person, per policy year. | 500 USD per individual |

***Usual Customary and Reasonable Charges = UCC. All amounts are in USD.**

| HOSPITAL CARE | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **ROOM AND BOARD**<br>Limited to Private accommodations. | 90% | 50% UCC | 100% UCC |
| **INTENSIVE CARE UNIT** | 90% | 50% UCC | 100% UCC |
| **INPATIENT PHYSICIAN VISITS**<br>Limited to one visit per day per specialty when considered medically necessary. | 90% | 50% UCC | 100% UCC |
| **OTHER HOSPITAL SERVICES**<br>Including but not limited to miscellaneous charges. | 90% | 50% UCC | 100% UCC |
| **INPATIENT SURGEON'S FEES** | 90% | 50% UCC | 100% UCC |
| **SECONDARY PROCEDURE**<br>When multiple procedures are performed during the same surgery, procedure or incision the secondary procedure if any will be paid at a maximum of fifty percent (50%) of the usual, customary and reasonable charges for such procedure(s). | 50% | 50% UCC | 50% UCC |
| **INPATIENT ASSISTANT SURGEON**<br>Limited in total to a maximum of twenty percent (20%) of the fees approved for the principal surgeon for the surgical procedure. | 20% | 20% UCC | 20% UCC |
| **INPATIENT ANESTHESIOLOGIST**<br>Limited in total to the lesser of usual, customary and reasonable charges or twenty percent (20%) of the fees approved for the primary surgeon's fees. | 20% | 20% UCC | 20% UCC |

| OUTPATIENT SERVICES | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL** | 90% | 50% UCC | 100% UCC |
| **EMERGENCY ROOM AND RELATED SERVICES:** Subject to a per visit co-payment of $250 USD. This co-payment does not count towards your Policy Year Deductible or Co-Insurance. | 90% | 50% UCC | 100% UCC |
| **ONCOLOGY** Chemotherapy and Radiation treatment. | 90% | 50% UCC | 100% UCC |
| **EXTENDED CARE OR INPATIENT REHABILITATION** Care must begin upon discharge from a hospital confinement of no less than 3 days. 30 days Max per Policy Year. | 90% | 50% UCC | 100% UCC |

| OUTPATIENT SURGERY | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **SURGEON'S FEES** | 90% | 50% UCC | 100% UCC |
| **SECONDARY PROCEDURE** When multiple procedures are performed during the same surgery, procedure or incision the secondary procedure if any will be paid at a maximum of fifty percent (50%) of the usual, customary and reasonable charges for such procedure(s). | 50% | 50% UCC | 50% UCC |
| **ASSISTANT SURGEON FEES** Limited in total to a maximum of twenty percent (20%) of the fees approved for the principal surgeon for the surgical procedure. | 20% | 20% UCC | 20% UCC |
| **ANESTHESIOLOGIST FEES** Limited in total to the lesser of usual, customary and reasonable charges or twenty percent (20%) of the fees approved for the primary surgeon's fees. | 20% | 20% UCC | 20% UCC |
| **SECOND SURGICAL OPINION** With the pre-approval of the Claims Administrator. | 90% | 50% UCC | 100% UCC |

| PHYSICIAN CARE | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **OFFICE VISITS** | 90% | 50% UCC | 100% UCC |
| **INPATIENT AND OUTPATIENT MENTAL NERVOUS** 12-month waiting period. | 90% Lifetime Maximum $50,000 | 50% UCC Lifetime Maximum $50,000 | 100% UCC Lifetime Maximum $50,000 |
| **CHIROPRACTIC CARE** Physicians Referral Required. | 90% | 50% UCC | 100% UCC |
| **THERAPEUTIC SERVICES: PHYSICAL, OCCUPATIONAL AND SPEECH** Limited to treatment resulting from surgery or illness. Treatment plan must be provided to include length of time and the number of treatments weekly. Speech therapy covered for restoration of lost function only. | 90% Maximum per visit $50 | 50% UCC Maximum per visit $50 | 100% UCC Maximum per visit $50 |
| **INFUSION THERAPY** Including but not limited to chemotherapy, antibiotic therapy, human growth hormone, pain management, aerosol therapies, transfusions, IV Gamma Globulin, Epogen and Neupogen, total parenteral nutrition, enteral nutrition. | 90% | 50% UCC | 100% UCC |

| ALTERNATIVE MEDICINE | COVERAGE |
|---|---|
| **ACUPUNCTURE** | 80% up to $150 per policy year maximum |
| **AROMA THERAPY** | 80% up to $50 per policy year maximum |
| **HERBAL THERAPY** | 80% up to $50 per policy year maximum |
| **MAGNETIC THERAPY** | 80% up to $75 per policy year maximum |
| **MASSAGE THERAPY** | 80% up to $150 per policy year maximum |
| **VITAMIN THERAPY** | 80% up to $100 per policy year maximum |

| HUMAN ORGAN TRANSPLANT BENEFIT (24-MONTH WAITING PERIOD) | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **HUMAN ORGAN TRANSPLANT** There is no coverage outside the Organ Transplant Network. Refer to policy wording for complete details. The covered Transplants are:<br>• Heart, Lung, Kidney, Pancreas, Liver, Cornea<br>• Bone Marrow, Transplants are covered only for approved diagnoses; Aplastic anemia, Severe immune deficiency, Hodgkins disease, acute and chronic Myelogeneous, Granulocytic Ileukenia, multiple Myeloma<br>** Benefit is subject to a 24 month waiting period.* | 90% Up to Lifetime Maximum $2,000,000 | Not Covered | 100% UCC Up to Lifetime Maximum $2,000,000 |

| DIAGNOSTIC SERVICES | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **DIAGNOSTIC TESTS**<br>Including but not limited to laboratory tests and X-rays, pathology, MRI, CT Scans, PET Scans. | 90% | 50% UCC | 100% UCC |

| HOME HEALTH CARE SERVICES | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| Care must be accompanied by attending physicians orders. | | | |
| **HOME CARE**<br>Charges are made by a home health agency and care must be provided at the person's home. | 90% | 50% UCC | 100% UCC |
| **HOSPICE CARE**<br>Benefit available for patients who are considered terminally ill whereby the physician has certified no more than 180 day life expectancy.<br>** Maximum Policy Allowance: 180-Days* | 90% | 50% UCC | 100% UCC |

| MATERNITY CARE | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| Refer to your Certificate of Coverage for option selected. Care is limited to the Insured and Dependent spouse only. Pregnancy and or any condition related to pregnancy that arises during the first twelve (12) months of coverage under this policy are excluded. Any fertility or infertility services, tests, treatments and or procedures of any kind, including but not limited to fertility or infertility drugs, artificial insemination, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to such treatments, complications of that pregnancy, delivery and postpartum care are also excluded. **Normal Delivery/ Medically Nec. C- Section, deductible waived with deductible options of: $250, $500, $1,000, $2,500.** | | | |
| **MATERNITY CARE / MEDICALLY NEC. C. SECTION / COMPLICATIONS OF PREGNACY**<br>All cost associated including but not limited to hospital fees for mother and newborn, obstetrician fees or midwife fees, child birth, prenatal and postnatal care. | 90% Lifetime Maximum $50,000 | 50% UCC Lifetime Maximum $50,000 | 100% UCC Lifetime Maximum $50,000 |
| **CONGENITAL BIRTH DEFECTS**<br>Premature newborns, congenital conditions and birth anomalies (from Covered Maternities) for newborns enrolled within 31-days from the date of birth. | 90% Lifetime Maximum $250,000 | 50% UCC Lifetime Maximum $250,000 | 100% UCC Lifetime Maximum $250,000 |

| ADDITIONAL BENEFIT | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **EMERGENCY GROUND AMBULANCE**<br>Limited to one trip to the nearest hospital. | 90% | 50% UCC | 100% UCC |
| **DURABLE MEDICAL EQUIPMENT**<br>Benefits must be accompanied by the attending physicians orders. | 90% | 50% UCC | 100% UCC |
| **PRESCRIPTION MEDICATION**<br>Drugs and medicines which by law need a physician's prescription and are not available over the counter. Coverage is limited to $20,000 USD Per policy year. | 90% | 50% UCC | 100% UCC |
| **OTHER MEDICAL EXPENSES AS OUTPATIENT**<br>Including but not limited to miscellaneous charges. | 90% | 50% UCC | 100% UCC |
| **EMERGENCY DENTAL TREATMENT**<br>Coverage is provided for treatment necessary to restore or replace sound natural teeth, damaged or lost as a consequence of a covered accident when treatment is received in a hospital emergency room or while confined in a hospital, provided that it takes place within the first 90 days. | 90% | 50% UCC | 100% UCC |

| WELLNESS BENEFIT (12-MONTH WAITING PERIOD) | COVERAGE |
|---|---|
| **ADULT MALES**<br>18 years of age and over. Benefits are provided for routine physical exams including office visit, routine blood, urinalysis, and PSA exams. | 100% Policy Year Maximum: $500<br>Deductible Waived |
| **ADULT FEMALES**<br>18 years of age and over. Benefits are provided for routine physical exams including office visit, routine blood, urinalysis, PAP test and routine mammogram. | 100% Policy Year Maximum: $500<br>Deductible Waived |
| **CHILDREN**<br>1 to 18 years of age. Benefits are provided for routine physical exams including office visit, routine blood, urinalysis and immunizations. | 100% Policy Year Maximum: $400<br>Deductible Waived |
| **NEWBORNS**<br>Born under this plan to 1 year of age. Benefits are provided for routine physical exams including office visit, routine blood, urinalysis and immunizations. | 100% Policy Year Maximum: $200<br>Deductible Waived |

| EMERGENCY ASSISTANCE | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| Pre-certification must be coordinated as defined in the policy. Failure to pre-certify and gain approval will result in no coverage. Transportation for the covered member will be provided to the nearest hospital or medical facility equipped to treat the injury, illness or medical emergency. | | | |
| **EMERGENCY MEDICAL EVACUATION**<br>To the nearest suitable medical facility. Condition for which treatment cannot be provided locally were by transportation by any other method would result in loss of life or limb. Please refer to complete policy wording for terms of coverage. Benet is conditional and must be pre-approved and coordinated by the Claims Administrator. | 90% Deductible Waived | 90% Deductible Waived | 100% UCC Deductible Waived |
| **EMERGENCY TRANSPORTATION OF 1 FAMILY MEMBER** | 100% Lifetime Maximum $10,000 Deductible Waived | 100% Lifetime Maximum $10,000 Deductible Waived | 100% UCC Lifetime Maximum $10,000 Deductible Waived |
| **REPATRIATION OF MORTAL REMAINS**<br>Lifetime Maximum: $50,000 USD. | 100% Deductible Waived | 100% Deductible Waived | 100% UCC Deductible Waived |

| ROUTINE DENTAL COVERAGE (6 MONTHS WAITING PERIOD) | COVERAGE |
|---|---|
| **POLICY YEAR MAXIMUM** | $700 |
| **POLICY YEAR DEDUCTIBLE** | $50 |
| **CLASS A**<br>Oral exams once every 6 months. This includes: prophylaxis and cleaning of teeth. Topical application of sodium or stannous fluoride for persons under 15 years of age. Emergency palliative treatment. First installation of a space maintainer for persons under 19 years of age to replace any baby tooth which is lost prematurely. X-rays for diagnosis. Also other X-rays not to exceed: one full mouth series in a 36 month period; and one set of bitewings in a 6 month period. | 90% No deductible applies |
| **CLASS B**<br>Non-surgical extractions. Fillings. Injection of antibiotic drugs. Repair of re-cementing of crowns, inlays, bridgework or dentures. General anesthetics given in connection with covered dental services. Non-surgical endodontic treatment. This includes root canal therapy. Relining or rebasing of dentures not to exceed one of these in any 36 consecutive month period. Neither of these is covered for the six months after the denture is first installed or replaced. | $50 Deductible then payable at 70% |
| **CLASS C**<br>Extra coronal and other splinting when a necessary part of complete periodontal treatment. Inlays, onlays, gold fillings or crowns. This includes precision attachments for dentures. First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered. This includes inlays and crowns as abutments. Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. But, the "Prosthesis Replacement Rule" below must be met. First installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6 month period following the date they were installed. Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture. But, the 'Prosthesis Replacement Rule' must be met. | $50 Deductible then payable at 50% |
| **ORTHODONTIA** | Not Covered |

| ROUTINE VISION (24 MONTH WAITING PERIOD APPLIES) | IN NETWORK U.S. | OUT OF NETWORK | OUTSIDE OF THE U.S. |
|---|---|---|---|
| **EXAMINATION:**<br>One routine eye examination allowed every two years. | 100% Up to $100 | 100% Up to $100 | 100% Up to $100 |
| **EYEGLASSES, CONTACTS**<br>Eyeglasses or contacts prescribed as the result of an eye examination to correct defective eyesight. Benefit available once every two years. | 100% Up to $150 | 100% Up to $150 | 100% Up to $150 |