SIGNATURE HEALTH PLAN

SELECT 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	3,000,000 USD
POLICY YEAR DEDUCTIBLE OPTIONS (Certificate of Coverage defines your selection) • Individual • Family	• 250 USD | 500 USD | 1,000 USD | 2,500 USD | 5,000 USD | • Three (3) times the chosen individual deductible
POLICY YEAR OUT-OF-POCKET CO-INSURANCE LIMIT 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.	1,000 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 Limited to semi-private accommodations.	80%	50% UCC	100% UCC
INTENSIVE CARE UNIT	80%	50% UCC	100% UCC
INPATIENT PHYSICIAN VISITS Limited to one visit per day per specialty when considered medically necessary.	80%	50% UCC	100% UCC
OTHER HOSPITAL SERVICES Including but not limited to miscellaneous charges.	80%	50% UCC	100% UCC
INPATIENT SURGEON'S FEES	80%	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
INPATIENT ASSISTANT SURGEON 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 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

OUTPATIENT SERVICES	IN NETWORK U.S.	OUT OF NETWORK	OUTSIDE OF THE U.S.
OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL	80%	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.	80%	50% UCC	100% UCC
ONCOLOGY Chemotherapy and Radiation treatment.	80%	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.	80%	50% UCC	100% UCC

OUTPATIENT SURGERY	IN NETWORK U.S.	OUT OF NETWORK	OUTSIDE OF THE U.S.
SURGEON'S FEES	80%	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 a maximum of twenty percent (20%) of the fees approved for the principal surgeon for the surgical procedure.	20%	20% UCC	20% UCC
SECOND SURGICAL OPINION With the pre-approval of the Claims Administrator.	80%	50% UCC	100% UCC

PHYSICIAN CARE	IN NETWORK U.S.	OUT OF NETWORK	OUTSIDE OF THE U.S.
OFFICE VISITS	80%	50% UCC	100% UCC
INPATIENT AND OUTPATIENT MENTAL NERVOUS 12-month waiting period. Policy Year Maximum: $10,000 USD and Lifetime Maximum: $50,000 USD.	80%	50% UCC	100% UCC
CHIROPRACTIC CARE Physicians Referral Required.	80%	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.	80% 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.	80%	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: • Heart, Lung, Kidney, Pancreas, Liver, Cornea • Bone Marrow, Transplants are covered only for approved diagnoses; Aplastic anemia, Severe immune deficiency, Hodgkins disease, acute and chronic Myelogeneous, Granulocytic Ileukenia, multiple Myeloma ** Benefit is subject to a 24 month waiting period.*	80% Up to Lifetime Maximum $1,000,000	Not Covered	100% UCC Up to Lifetime Maximum $1,000,000

DIAGNOSTIC SERVICES	IN NETWORK U.S.	OUT OF NETWORK	OUTSIDE OF THE U.S.
DIAGNOSTIC TESTS Including but not limited to laboratory tests and X-rays, pathology, MRI, CT Scans, PET Scans.	80%	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 Charges are made by a home health agency and care must be provided at the person's home.	80%	50% UCC	100% UCC
HOSPICE CARE Benefit available for patients who are considered terminally ill whereby the physician has certified no more than 180 day life expectancy. ** Maximum Policy Allowance: 180-Days*	80%	50% UCC	100% UCC

OPTIONAL MATERNITY CARE WITH PURCHASE OF RIDER	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. **Deductible waived with deductible options of: $250, $500, $1,000, $2,500.**			
MATERNITY CARE For Normal Delivery / Elective C-Section, all cost associated including but not limited to hospital fees for mother, newborn, obstetrician fees or midwife, childbirth, prenatal and postnatal care.	80% up to $5,000	50% UCC up to $5,000	100% UCC up to $5,000
C-SECTION DELIVERY ON MEDICAL GROUNDS AND COMPLICATIONS OF PREGNANCY Medical necessary cesarean, all cost associated including hospital fees for mother and newborn, obstetrician fees,prenatal and postnatal care: physician must submit complete medical records for review of Medical Necessity. Lifetime Maximum: $50,000 USD.	80% up to $7,500	50% UCC up to $7,500	100% UCC up to $7,500
CONGENITAL BIRTH DEFECTS Premature newborns, congenital conditions and birth anomalies (from Covered Maternities) for newborns enrolled within 31-days from the date of birth.	80% 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 Limited to one trip to the nearest hospital.	80%	50% UCC	100% UCC
DURABLE MEDICAL EQUIPMENT Benefits must be accompanied by the attending physicians orders.	80%	50% UCC	100% UCC
PRESCRIPTION MEDICATION 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.	80%	50% UCC	100% UCC
OTHER MEDICAL EXPENSES AS OUTPATIENT Including but not limited to miscellaneous charges.	80%	50% UCC	100% UCC
EMERGENCY DENTAL TREATMENT 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.	80%	50% UCC	100% UCC

WELLNESS BENEFIT (12-MONTH WAITING PERIOD)	COVERAGE
ADULT MALES Benefits are provided for routine physical exams including office visit, routine blood, urinalysis, and PSA exams.	100% Policy Year Maximum: $250 Deductible Waived
ADULT FEMALES Benefits are provided for routine physical exams including office visit, routine blood, urinalysis, PAP test and routine mammogram.	100% Policy Year Maximum: $250 Deductible Waived
CHILDREN 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: $200 Deductible Waived
NEWBORNS 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 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 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.	80% Deductible Waived	80% Deductible Waived	100% UCC Deductible Waived
EMERGENCY TRANSPORTATION OF 1 FAMILY MEMBER	80% Lifetime Maximum $10,000 Deductible Waived	80% Lifetime Maximum $10,000 Deductible Waived	100% UCC Lifetime Maximum $10,000 Deductible Waived
REPATRIATION OF MORTAL REMAINS Lifetime Maximum: $25,000 USD.	100% Deductible Waived	100% Deductible Waived	100% UCC Deductible Waived

ROUTINE DENTAL COVERAGE	IN NETWORK U.S.	OUT OF NETWORK	OUTSIDE OF THE U.S.
EMERGENCY DENTAL DUE TO SUDDEN UNEXPECTED PAIN	80% up to $100	80% up to $100	100% up to $100

ROUTINE VISION (24 MONTH WAITING PERIOD APPLIES)	IN NETWORK U.S.	OUT OF NETWORK	OUTSIDE OF THE U.S.
EXAMINATION One routine eye examination allowed every two years.	Not Covered	Not Covered	Not Covered
EYEGLASSES, CONTACTS Eyeglasses or contacts prescribed as the result of an eye examination to correct defective eyesight. Benefit available once every two years.	Not Covered	Not Covered	Not Covered