

## Schedule of Benefits – Select Silver

The following benefits for Select Silver are subject to the Policyholder's Calendar Year Deductible and Coinsurance.

After satisfaction of the Calendar Year Deductible, carrier will pay the eligible benefits set forth in this Schedule at 80% of the Allowable Charge. Once the Calendar Year Coinsurance requirement has been met, eligible benefits are payable at 100% of the Allowable Charge for the remainder of the Calendar Year.

This Schedule of Benefits is a brief outline of the benefits payable under the Select Silver Contract. All Benefits described are subject to the definitions, exclusions, and provisions of this Contract. All figures in U.S. Dollars. Dependent children less than 19 years of age are covered under the 19-49 Schedule except as indicated.

Lifetime Maximum Benefit <sup>1</sup>	Select Silver
Per Covered Person	\$2,000,000

Calendar Year Maximum Benefit	Select Silver
Per Covered Person (Age 69 or less)	To Lifetime Maximum
Per Covered Person (Age 70 or more)	\$500,000

Calendar Year Deductible Choices
<b>Select Silver</b>
\$500, \$1,000, \$2,000, \$2,500, \$4,000, \$5,000, \$10,000, \$15,000, \$20,000, \$25,000
Individual Deductible – Per Covered Individual, Per Calendar Year (January 1 through December 31)

Calendar Year Family Deductible
<b>Select Silver</b>
No
* Family Deductible – Two Times the Individual Deductible Per Calendar Year (January 1 through December 31)

Fourth Quarter Carry Over (Applies to Select Silver)
Fourth quarter Deductible Carry Over - <b>The Insured may carry over into the new calendar year any Allowable Charges which were incurred and applied towards the Deductible in October, November and December for the preceding year.</b> The Deductible Carry Over will be permitted only for the period for which coverage is continuous. Charges applied to the Coinsurance expense are not carried over.

**SILVER PLAN ONLY COVERS EMERGENCY SERVICES IN THE US AND CANADA.  
THERE IS AN ADDITIONAL 20% COPAY FOR FAILURE TO USE THE US PPO NETWORK.**

<sup>1</sup> The **Maximum Benefit** amount for Major Medical Benefits includes any and all other Maximum Benefit amounts shown in the Schedule of Benefits or added by the Contract Endorsement or Amendment. Any unused portion of the Maximum Benefit is only payable for covered expenses incurred while a Covered Person is eligible for coverage while the Contract is in force. (GBG 12/07)

**SILVER PLAN NOT AVAILABLE TO RESIDENTS OF US, CANADA, SINGAPORE, HK, UK & SWITZERLAND.**

<b>Calendar Year Coinsurance (Out of Pocket Limit After Deductible)</b>
<b>Select Silver</b>
\$2,000

<b>Calendar Year Family Coinsurance</b>
<b>Select Silver</b>
No
* Family Coinsurance – Two Times the Individual Coinsurance Per Calendar Year (January 1 through December 31)

<b>Benefit Limitation First 120 Days of Coverage (except for emergency &amp; infectious diseases)</b>
<b>Select Silver</b>
\$1,000

<b>Pre-Certification Requirements (Applies to Select Silver)</b>
The following services require Pre-Certification regardless of the location. If the following services are received within the United States, use of the PPO Network is also required. Failure to Pre-Certify and/or use the appropriate Network as required will result in a penalty for the entire episode of care. For Select Silver the penalty is 75%. Please refer to the “Pre-Certification” section in this Contract for details. Refer to the “Human Organ Transplant” and “Air Ambulance” section of this Contract for details on those benefits.
<b>Hospitalization</b> – Pre-Certification is required for all locations. For Hospitalization occurring within the United States, Pre-Certification and use of PPO Network is required.
<b>Outpatient Surgery</b> - Pre-Certification is required for all locations. For Outpatient Surgery occurring within the United States, Pre-Certification and use of PPO Network is required. Outpatient Surgery is inclusive of all invasive procedures including colonoscopy and endoscopy procedures.
<b>Cancer and Heart Surgery</b> – Pre-Certification is required for all locations. For Cancer or Heart Surgery within the United States, Pre-Certification and use of PPO Network is required.
<b>Chemotherapy and Radiation Therapy</b> - Pre-Certification is required in all locations. For Chemotherapy or Radiation Therapy within the United States, Pre-Certification and use of the PPO Network is required.
<b>CAT Scan, PET Scan and MRI procedures</b> - Pre-Certification is required in all locations. For CAT Scans, PET Scans or MRI procedures within the United States, Pre-Certification and use of the PPO Network is required.
<b>Human Organ Transplants</b> - Pre-Certification and use of Organ Transplant Network is required for all locations.
<b>Air Ambulance</b> – Pre-Certification and Authorization is required for all locations.

<b>Hospitalization and Inpatient Benefits</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Semi-private room	100% No Daily Limit	\$850 per day Maximum 250 consecutive days
Intensive Care ( <i>medically necessary</i> )	100% No Daily Limit	\$2,600 per day Maximum 250 consecutive days
Medical treatment, medicines, laboratory and diagnostic tests	100%	100%
Inpatient Consultation by Physician or Specialist	100%	100%
Inpatient Surgery	100%	100%
Inpatient Surgeon	100%	100%
Assistant Surgeon	20% of allowable surgeon's fee	20% of allowable surgeon's fee
Anesthesiologist	30% of allowable surgeon's fee	30% of allowable surgeon's fee
Blood Transfusions, Plasma (per calendar year)	\$1,000	\$1,000

<b>Outpatient Benefits</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Emergency Room	100%	100%
Emergency Medical Services	100%	100%
Outpatient Physician Visit	100%	100%
Consultation by Specialist	100%	100%
Echocardiography, Ultrasound	100%	\$600 per exam
CAT Scan	100%	\$800 per exam
MRI or PET Scan	100%	\$850 per exam
Endoscopy (e.g., gastroscopy, colonoscopy, cystoscopy)	100%	\$750 per exam
X-Rays	100%	\$300 per exam
Laboratory	100%	\$250 per exam
Outpatient or Ambulatory Surgery	100%	100%
Outpatient Surgeon	100%	100%
Outpatient Assistant Surgeon	20% of allowable surgeon's fee	20% of allowable surgeon's fee
Outpatient Anesthesiologist	30% of allowable surgeon's fee	30% of allowable surgeon's fee

<b>Maternity Benefits</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
Benefits for Mother only, including prenatal care, postnatal care and complications of pregnancy. <b>Subject to 21 months of continuous enrollment (Waiting Period).</b> Maternity Benefits not covered for Dependent daughter or for Insureds age 50 or greater. Any fertility/infertility services, tests, treatments, drugs and/or procedures, including the resulting pregnancy, complications of that pregnancy, delivery and postpartum care are excluded from coverage. Midwife services are not covered under this Contract. Please refer to the "Maternity" section in this Contract for details.		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Normal Delivery or Elective C-Section (maximum per pregnancy)	\$5,000	Not Covered
Medically Necessary C-Section (maximum per pregnancy)	\$5,000	Not Covered
Premature birth, congenital conditions, birth anomalies (Lifetime maximum for newborns covered under the contract)	\$100,000	Not Covered

<b>Prescription Drugs (Per Calendar Year Maximum)</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
Mandatory use of U.S. Pharmacy Network is required for Prescription Drugs purchased in the United States. <b>Failure to follow requirements will result in a 50% penalty.</b> Please refer to the "U.S. Prescription Drug" section in this Contract.		
<b>Prescription Drugs</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Inpatient Prescription Drugs including Injectibles (per calendar year)	100%	100%
Outpatient Prescription Drugs including Injectibles (per calendar year)	100% up to \$1,000 maximum	100% up to \$1,000 maximum

<b>Diagnostic and Therapeutic Services (Outpatient)</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Physical Therapy	\$50 per visit 20 visit maximum	\$65 per visit 40 visit maximum
Occupational Therapy	Not Covered	Not Covered
Speech Therapy (video laryngoscopy procedure)	Not Covered	Not Covered

<b>Human Organ Transplant (one or more)</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Transplant Maximum <i>(subject to lifetime maximum)</i>	\$125,000	\$125,000
Lifetime Maximum	\$250,000	\$250,000
<b>Subject to 24 months of continuous enrollment (Waiting Period).</b> Expenses for Donor are not covered. Please refer to the "Human Organ Transplant" section in this Contract for details.		

<b>Extended Care / Inpatient Rehabilitation</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Extended Care Daily Benefit	\$500 per day	\$500 per day
Extended Care Calendar Year Maximum Benefit	\$15,000	\$15,000

<b>Hospice</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Hospice Lifetime Maximum	\$5,000	\$5,000

<b>Emergency Ambulance</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Ground Ambulance	100%	100%
Air Ambulance Per Occurrence	\$25,000	\$25,000
Air Ambulance Lifetime Maximum	\$100,000	\$100,000
Repatriation of Mortal Remains	Not Covered	Not Covered
<b>Pre-Certification for Air Ambulance required no matter the location.</b> Please refer to the "Air Ambulance Services" section in this Contract for details.		

<b>Durable Medical Equipment</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Rental Up to Purchase Price	100%	100%

<b>Visiting Nurse / Home Health Care</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Visiting Nurse Home Health Care	Not Covered	\$250 per day 4 hours per visit 40 visits per calendar year

<b>Private Duty Nursing (Inpatient Service Only)</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Private Duty Nursing (Inpatient Only)	Not Covered	Not Covered

<b>Mental Health Benefits (Inpatient and Outpatient)</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Mental Health Calendar Year Maximum	50% up to \$1,000 per calendar year	50% up to \$1,000 per calendar year
Mental Health Lifetime Maximum	\$10,000	\$10,000

<b>Wellness Diabetic Education</b> (Maximum of Allowable Charge after Deductible and Coinsurance)		
<b>Treatment or Service</b>	<b>Select Silver (Age 19-49)</b>	<b>Select Silver (Age 50+)</b>
Wellness Diabetic Education	\$100 calendar year maximum	\$100 calendar year maximum

Wellness and Preventative Benefits (Not Subject to Deductible and Coinsurance)		
Please refer to the "Wellness" section of this contract for details regarding wellness benefits.		
Treatment or Service	Select Silver (Age 19-49)	Select Silver (Age 50+)
One Vision Exam per 24 month period	Not Covered	Not Covered
Child Wellness (Up to Age 12 months)	N/A	N/A
Child Wellness (Up to 9 years of age)	\$50 Per visit Up to \$100 per calendar year	N/A
Child Wellness (13 months to 18 years)	N/A	N/A
Adult Female Wellness (required every 24 months for females age 50 or more)	Age 40 or more only \$100 per calendar year Routine PAP & Mammogram	\$250 per calendar year <b>Routine wellness exam including PAP &amp; Mammogram required every 24 months or all benefits reduced 50%</b>
<i>Adult female wellness benefits provided for routine physical examinations, including office visit, routine blood, urinalysis, Papanicolaou Screening (PAP) and routine mammogram. Please refer to the "Wellness" section of this Contract for details.</i>		
Adult Male Wellness (required every 24 months for males age 50 or more)	Age 40 or more only \$100 per calendar year Routine PSA Exam	\$250 per calendar year <b>Routine wellness exam including PSA Exam required every 24 months or all benefits reduced 50%</b>
<i>Adult male wellness benefits provided for routine physical examinations, including office visit, routine blood, urinalysis and PSA exam. Please refer to the "Wellness" section of this Contract for details.</i>		

Required Wellness Examinations – Adults 50 years or age or more
<i>Required Wellness Exams are covered as part of the Wellness and Preventative Benefits above. Exams must be conducted every 24 months. <b>Failure to have the required wellness exams every 24 months as required will result in a 50% penalty for all treatments and services cover by this Contract.</b></i>

### Optional Dental Insurance

Dental insurance benefits are only available to those Insureds who have added the optional dental insurance to their health insurance policy and paid the required additional premium.

The expenses described in the Dental Schedule are reimbursed at the indicated percentage subject to the Annual Dental Deductible and Annual Maximum Benefit. Class I Dental Services are not subject to the Dental Deductible. Class III Dental Services and Orthodontic Treatments are not covered during the first six (6) months of Dental Insurance Coverage. Orthodontic Treatments are subject to the Orthodontic Lifetime Maximum.

<b>Dental Schedule of Benefits (optional coverage, additional premium required)</b>	
Maximum Annual Benefit (Class I, Class II and Class III Services)	\$ 1,500
Annual Deductible (Class II and Class III Services)	\$ 50
Orthodontic Treatments <i>50% up to a Lifetime Orthodontic Maximum</i>	\$1,500
<i>The insurance pays 50% of the Allowable Charge for Orthodontic treatment with no Deductible subject to the Lifetime Maximum. Once the Lifetime Orthodontic Maximum is reached the Insured has no right to any further Orthodontic treatment benefit. Orthodontic treatment is not covered during the first six (6) months of insurance coverage.</i>	

<b>Class I Dental Services (not subject to Deductible)</b>	<b>100%</b>
<i>The insurance pays 100% of the Allowable Charge with no Deductible for necessary diagnostic examinations and preventative treatment subject to the Annual Dental Maximum.</i>	
Oral exams, but not more than twice in a calendar year	
X-Rays <ul style="list-style-type: none"> <li>• Full mouth x-rays, but not more than once every five (5) years</li> <li>• Bitewing x-rays, but not more than once in a calendar year</li> </ul>	
Preventative Treatment <ul style="list-style-type: none"> <li>• Cleaning and scaling of teeth (oral prophylaxis), but not more than twice a calendar year</li> <li>• Topical fluoride treatment for a covered child under 19 years of age, but not more than once in a calendar year</li> </ul>	
Space maintainers for a covered child under 19 years of age	

<b>Class II Dental Services</b>	<b>80%</b>
<i>The insurance pays 80% of the Allowable Charge after Deductible for basic restoration, endodontic, periodontal treatments and oral surgery subject to the Annual Dental Maximum.</i>	
Fillings – amalgam, silicate, acrylic, synthetic porcelain or composite fillings	
Extractions	
Root Canal Treatments	
Treatment of periodontal disease and other diseases of the gums and tissues of the mouth	
Oral Surgery except procedures covered under any medical plan	
Administration of general anesthesia, when medically necessary in connection with oral surgery	
Emergency palliative treatment	
Injections of antibiotic drugs	

<b>Class III Dental Services</b>	<b>50%</b>
<p><i>The insurance pays 50% of Allowable Charge after the Deductible for necessary crowns, bridges and dentures subject to the Annual Dental Maximum. Covered expenses include the necessary supplies and services of a physician for installation or replacement.</i></p>	
<p>Those services needed to replace one or more natural teeth that are lost while dental expense benefits for the covered person are in effect for:</p> <ul style="list-style-type: none"> <li>• Installation of fixed bridgework done for the first time;</li> <li>• Installation for the first time of a partial or full removable denture;</li> <li>• Replacing an existing removable denture or fixed bridgework if it is needed because of loss of one or more natural teeth after the existing denture or bridge work was installed or because the existing denture or bridgework can no longer be used and was installed at least 5 years prior to its replacement;</li> <li>• Replacing an existing immediate temporary full denture by a new permanent full denture when the existing denture can not be made permanent and the denture is installed within 12 months after the existing denture was installed;</li> <li>• Adding of teeth to an existing partial removable denture or to bridgework when needed to replace on or more natural teeth removed after the existing denture or bridgework was installed.</li> </ul>	
Inlays and Onlays	
Crowns and their replacements, but not more than one replacement per crown every five years	
Repair or re-cementing of Crowns, Inlays, Onlays, Dentures and Bridgework	