

# SONNY A. HENNING INSURANCE

9671 CASTLE WOODS COVE, INDIANAPOLIS, IN 46280 FAX 888-766-8288  
TOLL FREE 1-888-SONNY-32 (888-766-6932)

Thank you for your interest in our Health Plans. I have attached a more detailed description for the quoted program.

Please print the attached file and complete all application forms per the instructions. Paperwork and checks must be returned to:

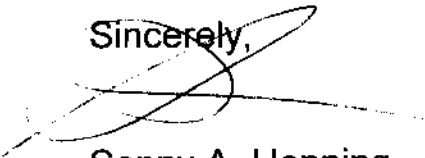
**SONNY A. HENNING  
SONNY HENNING INSURANCE  
9671 CASTLE WOODS COVE  
INDIANAPOLIS, IN 46280**

Please include a check, payable to the name instructed on the attached and be sure to include any requested tax documentation. **In addition, please include a check, payable to Sonny Henning Insurance in the amount of \$50.00 as a one time processing and handling fee.**

All forms must be received by the 15<sup>th</sup> of the month for a 1st of the month effective date.

If you have any questions, please feel free to call, toll free, at your convenience **1-888-SONNY-32 (1-888-766-6932)**.

Sincerely,



Sonny A. Henning  
SAH:ms  
Attachments

**BE SURE TO REMEMBER US FOR ALL YOUR LIFE AND  
HEALTH INSURANCE NEEDS, INCLUDING LIFE, HEALTH,  
DISABILITY, LONG TERM CARE AND OTHER SENIOR  
PRODUCTS.**

## **HOW TO GET STARTED?**

JUST FOLLOW THE SIMPLE INSTRUCTION BELOW AND MAIL  
ALL PAPERWORK AND CHECKS TO :

SONNY HENNING INSURANCE  
9671 CASTLE WOODS COVE  
INDIANAPOLIS, IN 46280

### **HORIZON HEALTH PLAN - EPO** **NO GATEKEEPER** **NY&NJ**

**WWW.HORIZONHEALTHCARE.COM**  
**STANDARD HETWORK**

- COMPLETE PARTICIPATION STATEMENT
- COMPLETE UNITED HEALTH & WELFARE BENEFITS PLAN FORM
- COMPLETE MEMBERSHIP DEDUCTION FORM
- MSE AFFILIATION AGREEMENT FORM
- COMPLETE HORIZON HEALTH PLAN ENROLLMENT FORM
- TAX DOCUMENTATOIN

**INLCUDE ONE CHECK FOR THE FIRST MONTH'S PREMIUM  
PLUS THE ANNUAL ADMINISTRATION FEE OF \$40,  
PAYABLE TO "MSE" (MHL SERVICE EMPLOYEES)**

**PLUS**

**A ONE TIME PROCESSING FEE OF \$50.00, PYABALE TO  
SONNY HENNING INSURANCE.**

# **HORIZON HEALTH PLAN – EPO NO GATEKEEPER**

**THROUGH UNITED HEALTH & WELFARE FUND**

**Rates effective 11/1/03 through 10/31/04**

**SINGLE:     \$ 392.00  
FAMILY:    \$ 1,011.00**

**Plus \$40 Annual Administration Fee**

**TAKE A LOOK AT THESE BENEFITS:**

**IN NETWORK ONLY**

**PCP/SPECIALIST - \$30 COPAY  
\$50 – E.R. COPAY  
\$500 HOSPITAL COPAY  
RX - \$10/\$25/\$50 COPAY  
\$100 RX DEDUCTIBLE PER PERSON**

**WWW.HORIZONHEALTHCARE.COM  
STANDARD NETWORK – NY/NJ**

# PARTICIPATION STATEMENT

COMPANY NAME \_\_\_\_\_

I CONFIRM THAT THE ABOVE NAMED COMPANY IS COMPLYING WITH DIVERSIFIED EMPLOYEES' UNION, LOCAL 4 REQUIREMENTS PURSUANT TO ERISA. THE FOLLOWING EMPLOYEES COVERED BY THE COLLECTIVE BARGAINING AGREEMENT WITH LOCAL 4, ARE EMPLOYED AS A FULL-TIME BASIS WORKING AT LEAST (30) HOURS PER WEEK.

EMPLOYEE NAME

EMPLOYEE NAME

- |           |           |
|-----------|-----------|
| 1) _____  | 13) _____ |
| 2) _____  | 14) _____ |
| 3) _____  | 15) _____ |
| 4) _____  | 16) _____ |
| 5) _____  | 17) _____ |
| 6) _____  | 18) _____ |
| 7) _____  | 19) _____ |
| 8) _____  | 20) _____ |
| 9) _____  | 21) _____ |
| 10) _____ | 22) _____ |
| 11) _____ | 23) _____ |
| 12) _____ | 24) _____ |

I HEREBY REPRESENT AND AGREE THAT ALL ANSWERS AND STATEMENTS IN THIS STATEMENT ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE SAID ANSWERS AND STATEMENTS FROM THE BASIS UPON WHICH PARTICIPATION WILL BE MADE EFFECTIVE AND OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS ABOUT EMPLOYMENT HISTORY COULD RESULT IN DENIAL OF PARTICIPATION IN THE DIVERSIFIED EMPLOYEE'S UNION, LOCAL 4. I AFFIRM THAT THE FOREGOING STATEMENTS ARE TRUE UNDER THE PENALTIES OF PERJURY.

SIGNATURE OF OWNER

PRINT NAME

TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_

(631) 499-0008

**UNITED HEALTH AND WELFARE BENEFITS PLAN**

PLEASE PRINT

NAME (PRINT) \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_  
(LAST) (FIRST)

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

( ) MARRIED ( ) SINGLE NO. OF DEPENDENTS UNDER AGE 18 \_\_\_\_ ( ) INDIVIDUAL ( ) FAMILY

EMPLOYED BY: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

PRIOR CARRIER: \_\_\_\_\_ FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**DEPENDENTS**

**FIRST NAME      DATE OF BIRTH      RELATIONSHIP      SOCIAL SECURITY #**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGN HERE: \_\_\_\_\_ DATE: \_\_\_\_\_

# MEMBERSHIP FEE DEDUCTION AUTHORIZATION

I HEREBY AUTHORIZE AND DIRECT MY EMPLOYER TO DEDUCT FROM MY WAGES AND PAY OVER TO DIVERSIFIED EMPLOYEE'S UNION, LOCAL 4, THE AMOUNT OF (\$12.00) PER MONTH AS AND FOR MEMBERSHIP FEES IN CONNECTION WITH THE UNION'S REPRESENTATION OF MY INTERESTS. I FURTHER AUTHORIZE LOCAL 4, TO REPRESENT ME WITH MY EMPLOYER.

THIS AUTHORIZATION SHALL NOT BE REVOCABLE FOR A PERIOD OF ONE YEAR FROM THE DATE HEREOF. IT SHALL THEREAFTER CONTINUE IN FULL FORCE AND EFFECT FOR SIMILAR PERIODS UNLESS REVOKED BY ME BY NOTICE IN WRITING TO THE UNION AND TO THE EMPLOYER.

PARTICIPATING EMPLOYEE \_\_\_\_\_ PARTICIPATING EMPLOYEE'S SIGNATURE \_\_\_\_\_  
(PRINT NAME)

SOCIAL SECURITY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_ EMPLOYER'S TELEPHONE#: \_\_\_\_\_

# **MSE, LTD. AFFILIATION AGREEMENT**

**MHL SERVICE EMPLOYEES LIMITED HAS ENTERED INTO A COLLECTIVE BARGAINING AGREEMENT ON MARCH 1, 2001 WITH DIVERSIFIED EMPLOYEE'S UNION, LOCAL 4 AFFILIATED WITH U.C.T.I.E.**

**AS A MEMBER OF MSE, LTD. THE COMPANY UNDERSTANDS THAT IT IS BOUND TO THE COLLECTIVE BARGAINING AGREEMENT IN EFFECT BETWEEN THE MSE AND THE UNION. THE TOTAL REMITTANCES MADE BY THE COMPANY TO MSE, LTD. ARE AS FOLLOW: CHECKED OFF UNION DUES, BENEFIT PLAN CONTRIBUTIONS, AND AMINISTRATIVE AND BILLING FEES.**

**THE COMPANY UNDERTAKES TO INDEMNIFY MSE, LTD. FROM ANY AND ALL LIABILITY THAT MIGHT RESULT FROM THE ABOVE SAID COLLECTIVE BARGAINING AGREEMENT.**

**MSE, LTD. / UNION AGREEMENT IS ON FILE AT THE OFFICE OF MSE, LTD. LOCATED AT:**

**154 COMMACK ROAD  
COMMACK, NEW YORK, 11725**

**BY: \_\_\_\_\_**

**COMPANY**

**BY: \_\_\_\_\_**

**GROUP COVERAGE  
EMPLOYEE  
ENROLLMENT APPLICATION**

For Products:  
HORIZON EPO  
HORIZON PPO  
VISTA  
VISTA PLUS

PLEASE PRINT CLEARLY, COMPLETE ALL PERTINENT SECTIONS TO AVOID PROCESSING DELAYS.

| SUBSCRIBER INFORMATION   |  |       |             |                          |   |   |   |
|--|--|-------|-------------|--------------------------|---|---|---|
| 1. EMPLOYEE'S LAST NAME  |  | FIRST | MI          | 2. PHONE-WORK<br>( ) ( ) |   | 3. HOME<br>( ) ( )  |   |
| 4. EMPLOYEE NUMBER   |  |       |             | 5. CONTRACT TYPE HEALTH  |   | <input type="checkbox"/> Single <input type="checkbox"/> Family<br><input type="checkbox"/> Husband/Wife<br><input type="checkbox"/> Parent/Child |   |
| 6. ADDRESS-STREET  |  |       | CITY, STATE |                          | ZIP   |   | COUNTY  |
| 7. EMPLOYER NAME AND LOCATION (CITY AND STATE)   |  |       |             |                          | 8. DATE OF HIRE   |   | 9. WORKING STATUS<br><input type="checkbox"/> Active <input type="checkbox"/> Retired |
| 10. MARITAL STATUS<br><input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated   |  |       |             |                          | 11. PRODUCT<br><input type="checkbox"/> HORIZON EPO <input type="checkbox"/> HORIZON PPO <input type="checkbox"/> VISTA <input type="checkbox"/> VISTA PLUS |   |   |
| PRESCRIPTION<br><input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> HW <input type="checkbox"/> PC<br>DENTAL, IF OFFERED<br><input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> HW <input type="checkbox"/> PC |  |       |             |                          |   |   |   |

| ELIGIBLE PERSONS TO BE ENROLLED   |  |                   |    |   |  |  |  |
|---|--|-------------------|----|---|--|--|--|
| 12. SELF - LAST NAME  |  | FIRST             | MI | 13. RELATION<br>Self  |  | 14. SEX<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  |
| 15. BIRTHDATE   |  | 16. SOC. SEC. NO. |    |   |  |  |  |
| DEPENDENT #1 - LAST NAME  |  | FIRST             | MI | 13. RELATION<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |  | 14. SEX<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  |
| 15. BIRTHDATE   |  | 16. SOC. SEC. NO. |    |   |  |  |  |
| DEPENDENT #2 - LAST NAME  |  | FIRST             | MI | 13. RELATION<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |  | 14. SEX<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  |
| 15. BIRTHDATE   |  | 16. SOC. SEC. NO. |    |   |  |  |  |
| DEPENDENT #3 - LAST NAME  |  | FIRST             | MI | 13. RELATION<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |  | 14. SEX<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  |
| 15. BIRTHDATE   |  | 16. SOC. SEC. NO. |    |   |  |  |  |
| DEPENDENT #4 - LAST NAME  |  | FIRST             | MI | 13. RELATION<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |  | 14. SEX<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  |
| 15. BIRTHDATE   |  | 16. SOC. SEC. NO. |    |   |  |  |  |
| 17. DO YOU HAVE A DISABLED CHILD DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF DEPENDENT IS DISABLED, PLEASE ATTACH MEDICAL DOCUMENTATION (FROM EMPLOYER) TO DETERMINE COVERAGE BEYOND YOUR EMPLOYER'S MAXIMUM DEPENDENT AGE. |  |                   |    |   |  |  |  |

**COORDINATION OF BENEFITS**

YOUR HORIZON HEALTHCARE CONTRACT CONTAINS A COORDINATION OF BENEFITS (C.O.B.) PROVISION. COORDINATION OF BENEFITS IS IN EFFECT WHEN MORE THAN ONE GROUP HEALTHCARE PLAN OR PROGRAM COVERS A PERSON. IF YOU OR ANY FAMILY MEMBER ARE COVERED BY ANOTHER GROUP HEALTHCARE PLAN PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM WHERE APPLICABLE.

**SIGNATURE**

18. PLEASE READ THE FOLLOWING AND SIGN IN THE SPACE PROVIDED.  
I HEREBY APPLY FOR HORIZON HEALTHCARE COVERAGE FOR ME AND MY ELIGIBLE DEPENDENTS WHO ARE LISTED ON THIS APPLICATION. I UNDERSTAND AND AGREE THAT OUR COVERAGE WILL BE CONTROLLED BY THE WRITTEN AGREEMENT BETWEEN HORIZON HEALTHCARE OF NEW YORK AND MY EMPLOYER. I AUTHORIZE MY EMPLOYER TO MAKE DEDUCTIONS FROM MY EARNINGS, IF REQUIRED, FOR MY HORIZON HEALTHCARE COVERAGE. THE UNDERSIGNED HEREBY AUTHORIZE ANY HEALTH CARE FACILITY OR PROVIDER TO RELEASE TO HORIZON HEALTHCARE ALL INFORMATION RELATING TO PAST, PRESENT, AND FUTURE HEALTH CARE EXAMINATIONS OR TREATMENTS RECEIVED BY EACH PERSON COVERED BY THIS APPLICATION. I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS COMPLETE AND ACCURATE AND THAT EACH PERSON COVERED BY THIS APPLICATION RESIDES WITHIN A HORIZON HEALTHCARE SERVICE AREA. I UNDERSTAND THAT ANY CLAIM BY ME OR ONE OF MY ELIGIBLE DEPENDENTS MAY BE DENIED AND OUR COVERAGE CANCELLED WITHOUT WRITTEN NOTICE IF I HAVE USED MATERIALLY FALSE INFORMATION IN THIS APPLICATION. I ALSO UNDERSTAND THAT SUCH A TERMINATION WILL BE RETROACTIVE TO THE EFFECTIVE DATE OF OUR COVERAGE. IF HORIZON HEALTHCARE ADVANCES PAYMENT TO ANY PROVIDER FOR COVERED SERVICES, I THE UNDERSIGNED WILL RETURN ANY REIMBURSEMENT RECEIVED FOR THESE PREPAID SERVICES TO HORIZON HEALTHCARE.  
\*ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY, HEALTH MAINTENANCE ORGANIZATION OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.\*

|   |      |   |      |
|---|------|---|------|
| SIGNATURE OF APPLICANT                                | DATE | SIGNATURE OF SPOUSE (NOT MANDATORY)                   | DATE |
| SIGNATURE OF DEPENDENT AGE 18 OR OVER (NOT MANDATORY) | DATE | SIGNATURE OF DEPENDENT AGE 18 OR OVER (NOT MANDATORY) | DATE |

| EMPLOYER USE ONLY  |                     |                   | HORIZON HEALTHCARE USE |
|--|---------------------|-------------------|------------------------|
| REASON FOR APPLICATION<br><input type="checkbox"/> NEW HIRE<br><input type="checkbox"/> OPEN ENROLLMENT<br><input type="checkbox"/> REHIRE<br><input type="checkbox"/> COBRA<br><input type="checkbox"/> OTHER | GROUP NUMBER:       | EFFECTIVE DATE:   | SALES REP:             |
|  | EMPLOYER NAME:      | EMPLOYER PHONE #: | PROCESSED BY:          |
|  | EMPLOYER ADDRESS:   |                   | DATE:                  |
|  | EMPLOYER SIGNATURE: | DATE:             | HMU:                   |

**HORIZON HEALTHCARE OF NEW YORK**  
**HORIZON STANDARD BENEFITS**  
 United Health & Welfare Local 143 Fund

**In-Network** - The payment for eligible expenses when services are provided by a Horizon Hospital or a Traditional Network Physician. Horizon STANDARD provides benefits for in-network care only. Members do not have to file claims. Horizon STANDARD reimburses at the applicable allowance after any deductible, coinsurance, or copay. Network providers accept this allowance as payment in full.

**Out-of-Network** - No payment is made for out of network services, except for emergency situations.

| In-Network  |   |
|---|---|
| ALL SERVICES  |   |
| Benefit Period  | Calendar Year   |
| Deductible (Total combined per year)  |   |
| Hospital/Facility   | \$500 Per Admission   |
| Professional  | \$500 Per Admission   |
| Supplemental  | \$500 Per Admission   |
| Family Limit Factor   |   |
| Coinsurance   |   |
| Hospital/Facility   | 100%  |
| Professional  | 100%  |
| Supplemental  | 100%  |
| Out of Pocket Maximum (Services are reimbursed at 100% after OOP max is reached)  |   |
| Hospital/Facility   | None  |
| Professional  | None  |
| Supplemental  | None  |
| Family Limit Factor   |   |
| Maximums  |   |
| Benefit Period  | Unlimited   |
| Lifetime  | Unlimited   |
| HOSPITAL/FACILITY SERVICES  |   |
| <b>Inpatient Services</b>   |   |
| Room & Board (semi-private room)  | 100% after \$500 Per Admission Charge   |
| Intensive Care & Other Hospital Services (therapy/diagnostic services, blood administration, general nursing, operating room, etc.) | 100% after \$500 Per Admission Charge   |
| Maternity Benefits  | 100% after \$500 Per Admission Charge   |
| Child Dependent Maternity   | 100% after \$500 Per Admission Charge   |
| Organ Transplants   | 100% after \$500 Per Admission Charge   |
| <b>Outpatient Services</b>  |   |
| Routine Medical Care (other than in the ER)   | 100%  |
| Hospital Services (operating room, blood administration, general nursing, therapy/diagnostic services, etc.)                        | 100%  |
| Pre-Admission Testing   | 100%  |
| Medical Emergency/Accidental Injury In the Emergency Room   | 100% after \$50 copay<br>\$50 copay applies to facility charges                   |
| Surgical Center   | 100%  |
| Skilled Nursing Facility  | 100%  |
| Home Health Care  | 60 days per benefit period following a 3 or more day prior hospital stay.<br>100% |
| Birthing Center   | 40 visits per benefit period<br>100%  |

10/1/2002

| <b>PHYSICIAN SERVICES</b>   |   |
|---|---|
| <b>Inpatient Services</b>   |   |
| Medical Care (including consultations)  | 100%  |
| Surgical Services (including assistant surgeon and anesthesia)  | 100%  |
| Obstetrical Services (i.e., normal delivery, cesarean section, abortion)  | 100%<br>Subject to annual and lifetime maximums   |
| Diagnostic/Therapy Services   | 100%  |
| <b>Outpatient/Out-of-Hospital Services</b>  |   |
| Office Visits (including allergy testing, related diagnostic/therapy services) when medically necessary                   | 100% after \$30 copay   |
| Medical and Surgical Care (including related diagnostic/therapy services)   | 100%  |
| Diagnostic X-ray and Lab  | 100% after \$30 copay   |
| OB/Gyn Exam for medically necessary services  | 100% after \$30 copay   |
| Routine Annual Pap Smears, Mammography Screening, and Prostate Screening  | 100%<br>1 Annual Pap Smear over age 18<br>1 Baseline Mammography between 35-40<br>Annual Mammography over age 40<br>Prostate screening - 1 per year over age 50 |
| Routine Annual OB/GYN Exam  | 100%  |
| Maternity Care  | 100% after \$30 copay<br>Copay applies to initial visit only  |
| Infertility Services  | 100% after \$30 copay<br>\$10,000 lifetime combined maximum for employee and spouse   |
| Medical Emergency/Accidental Injury   | 100% after \$30 copay   |
| Child Immunizations/Lead Testing  | 100%  |
| Well Child Care (through child dependent limiting age)  | 100%  |
| Routine Annual Adult Physicals  | 100%  |
| Short Term Therapies: Physical, Speech Occupational, Cognitive Rehabilitation   | 100% after \$30 copay<br>30 visits for each therapy per benefit period.   |
| Chiropractic Care   | 100% after \$30 copay<br>Maximum of 3 visits per benefit period   |
| Nutritional Counseling  |   |
| <b>SUPPLEMENTAL SERVICES</b>  |   |
| Ambulance (Ground and Air Transport)  | 100% if deemed medically necessary, 0% if not.  |
| Vision Care   | 100% after \$30 copay<br>One eye exam per year. Hardware limited to \$50 in a 2 calendar yr. period.  |
| Private Duty Nursing  | 100%<br>240 hrs per yr., subject to medical necessity   |
| Durable Medical Equipment   | 100% with \$50,000 Lifetime Max   |
| Diabetic Education  | 100% after \$30 copay   |
| Diabetic Supplies   | 100% with \$50,000 Lifetime Max   |
| Blood Charges   | 100%<br>In-Network  |
| <b>MENTAL HEALTH*</b>   |   |
| Inpatient Services  | 100%<br>30 days maximum per benefit period  |
| Outpatient Services   | 100% after \$50 copay<br>30 visit maximum per benefit period  |
| <b>ALCOHOL/SUBSTANCE ABUSE*</b>   |   |
| Inpatient Services  | 100%<br>30 days inpatient rehab/ 7 days detox per yr  |
| Outpatient Services   | 100% after \$50 copay<br>60 visits (includes 20 family visits) per yr.  |
| <i>*All Inpatient Mental Health/Substance Abuse Care services must be coordinated through Magellan Behavioral Health.</i> |   |

| <b>PRESCRIPTION DRUG</b>  |   |
|---|---|
|   | Retail: \$10/25/50; Mail Order: \$20/50/100                     |
| Copayments  | 100   |
| Deductible  | No  |
| Mandatory Generic   | Included  |
| Contraceptives  | Retail: 30 days; Mail Order: 90 days                            |
| Days Supply   | Covered at highest copay with \$2,500 maximum per calendar year |
| Enteral Formulas  | Covered at highest copay with \$2,500 maximum per calendar year |
| <b>COST MANAGEMENT</b>  |   |
| Catastrophic Case Management  | Included  |
| Pre-Admission Review  | 50% benefit reduction for noncompliance                         |
| <b>ELIGIBILITY</b>  |   |
| Children are covered to the end of the calendar year in which they turn age 19. Full-time students are covered until the end of the month they turn 23 or until the end of the month during which their full-time student status ends. Handicapped dependents are covered beyond the child removal age, if the handicap occurred prior to age 19. |   |

**Pre-Existing Condition Exclusion**

For the first six months after an eligible person's enrollment under the contract, no benefits will be provided for services incident to, resulting from, or relating to any disease, injury, or condition which was treated or diagnosed by a health care professional within the six month period prior to enrollment for that eligible person. Note: This does not apply to children who enroll within 30 days of birth or adoption. Employees and dependents will receive credit for the time they were covered under a previous contract if the coverage was continuous to a date not more than 63 days prior to the enrollment date of this coverage.

Pre-existing condition exclusion will apply to any new hires after the initial group effective date and late entrants (those not enrolling within 31 days of eligibility).

This summary highlights the major features of your health benefit program. It is not a contract and some limitations and exclusions may apply. Payment of benefits is subject solely to the terms of the contract. Please refer to your booklet for more information.