Sky 100

6006 North Mesa Street - Suite 108
El Paso, Texas 79912

THIS POLICY CONTAINS COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY THE TEXAS INSURANCE CODE. FOR A FURTHER DESCRIPTION OF THESE BENEFITS, PLEASE REFER TO SECTION VIII OF THE POLICY

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TEXAS LIFE AND HEALTH INSURANCE ASSOCIATION ACT

Residents of TEXAS who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the TEXAS Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The TEXAS Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in TEXAS. You should not rely on coverage by the TEXAS Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association for the purpose of sales or to induce you to purchase any kind of insurance policy*.

The TEXAS Life and Health Insurance Guaranty Association

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Austin, TX 78701
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Fax: 512-472-1470
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The state law that provides for this safety-net coverage is called the TEXAS Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage's, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the TEXAS Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are *not* protected by this Association if:

• they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

• the insurer was not authorized to do business in this state;

• their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

• any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

• any policy of reinsurance (unless an assumption certificate was issued);

• interest rate yields that exceed an average rate;

• dividends;

• credits given in connection with the administration of a policy by a group contract holder;

• annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;

• unallocated annuity contracts (which give rights to group contract holders, not individuals).

• any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

LIMITS ON AMOUNT OF COVERAGE – EFFECTIVE 07/01/2012

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $250,000 in cash surrender values for life insurance policies , $500,000 for basic hospital, medical and surgical insurance or major medical insurance, $300,000 for disability insurance, disability income insurance and long-term care insurance, $200,000 for coverages not defined as disability insurance or disability income insurance or basic hospital medical and surgical insurance or major medical insurance or long term care insurance, including any net cash surrender and net cash withdrawal values, $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values, or $300,000 in life insurance death benefits -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

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SECTION III. DEFINITIONS

This section defines many of the terms and words that are found later in this Agreement. The terms and words defined here are capitalized wherever they are used elsewhere in the Agreement. NOTE: Not every service and supply discussed in the DEFINITIONS section is a covered benefit of this Agreement.

A. *ADULT AND DEPENDENT MEMBERSHIP*
A membership that covers the Subscriber and one or more eligible dependent children.

B. *AGGREGATE DEDUCTIBLE*
A specified amount of Allowable Charges for Covered Services that Participants under Family, Adult and Dependent, and Two Adult memberships are responsible for within a specified period of time before all the Participants under that coverage are considered to have met their Deductibles.

C. *AGREEMENT*
This Agreement as limited and extended in its effect by the application and by any rider, endorsement and fee schedule, now or hereafter in effect.

D. *ALLOWABLE CHARGES*
The maximum amount allowed for Covered Services under this Agreement. Allowable Charges are determined by the First Health Network payment system in effect at the time the services are provided.

E. *ANNIVERSARY DATE*
The date each year on which the Group may renew its SKY 100 coverage for the next twelve (12) months.

F. *APPLICANT*
The person who applies for coverage.

G. *BILLING SERVICE DATE*
The date used by SKY 100 in assigning effective dates
and issuing billings. This date will always be the 1st of the month.

H. *First Health Network*
A nationwide program coordinated by the First Health Network and FIVE POINTS STUDENT HEALTH PLAN that enables Participants to reduce claims filing paperwork and to take advantage of available local provider networks, medical discounts, and cost saving measures when they receive care in states other than Texas.

I. *COINSURANCE*
An agreement in which a Participant pays a certain part of the cost of his or her care after the Deductible has been met. In the case of services obtained out of Sky 100's service area, a local SKY 100 (Host Plan)

provider contract may require a Coinsurance calculation that is not based on the discounted price the provider has agreed to accept from the Host Plan, but is, instead, based on the provider's full billed charges. This may result in a higher or, in some cases, lower Coinsurance payment for certain claims incurred when outside of Sky 100's service area. Because of the many different arrangements between the host Plans and their providers, it is not possible to give specific information for each out-of-area provider. (NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.)

J. COINSURANCE MAXIMUM

A specified dollar amount of Coinsurance paid by the Participant for covered services received in a calendar year. The Coinsurance Maximum does not include the Deductible amount, Copayments, non-covered amounts, or charges in excess of Sky 100's Allowable Charges. When the Coinsurance Maximum is reached, the level of benefits is increased as specified in the Schedule of Benefits. (NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.)

K. COPAYMENT

A specified amount of Allowable Charges for Covered Services that the Participant must pay each time a specific occurrence takes place. (NOTE: Pharmacy expenses are subject to separate Copayment and Coinsurance requirements.)

L. COVERED SERVICE

A service or supply specified in this Agreement for which benefits will be provided when rendered by a provider.

M. CREDITABLE COVERAGE

Creditable Coverage as defined in the Health Insurance Portability and Accountability Act of 1996 as amended, 42 U.S.C. Section 300 gg et seq.

N. DEDUCTIBLE

A specified amount of expense for Covered Services that the Participant must pay within a calendar year before benefits are provided.

O. DEPENDENT

A Subscriber's Dependents are the following:

1. Legal spouse who is currently a permanent resident in the home of the Subscriber.
2. The children, including newborn children, step children, adopted children, Dependents which the court has decreed support to the Subscriber and Legal wards of the Subscriber or the Subscriber's spouse. The limiting age for covered children is the end of the month in which age 26 is attained.

   Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the

Subscriber for their support and maintenance by reason of mental retardation or physical handicap. Continuous coverage will be established at the same level of benefits. Dues may be adjusted accordingly. Proof of incapacity and dependency must be furnished to SKY 100 within thirty-one
(31) days of the end of the month in which the limiting age is attained. Incapacity and dependency upon the Subscriber must both continue in order for the coverage to continue and SKY 100 may, from time to time, require continued proof of such incapacity and dependency. If the conditions of BOTH incapacity and dependency by reason of mental retardation or physical handicap are not continuously met, coverage will continue as required by Federal or State law as applicable.

P. DIAGNOSTIC SERVICE

A test or procedure rendered because of specific symptoms and which is directed toward the determination of a definite condition or disease. A Diagnostic Service must be ordered by a Physician or Professional Other Provider.

Q. ENROLLMENT DATE

The Enrollment Date for timely entrants means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The Enrollment Date for late entrants will be the effective date of coverage.

R. EXPERIMENTAL/INVESTIGATIONAL

A drug, device, or medical treatment or procedure is experimental or investigational:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. If reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

NOTE: Services related to cancer clinical trials will be covered in accordance with state law. Coverage shall be provided for individuals enrolled in a cancer clinical trial as follows:

1. Coverage will be provided for Phase I, II, III and IV cancer clinical trial;
2. The cancer clinical trial must be approved by one or more of the following agencies of the National Institutes of Health or, the United States Food and Drug Administration or, the Department of Veterans Affairs, or the Department of Defense;
3. The National Institutes of Health, The Centers for Disease Control and Prevention, The Agency for Health Care Research and Quality, and The Centers for Medicare & Medicaid Services are required under 42 U.S.C. 300gg-8 (d)(1)(A)(i-iv);
4. A cooperative group or center of the National Institutes of Health, The Centers for Disease Control and Prevention, The Agency for Health Care Research and Quality, The Centers for Medicare & Medicaid Services, The Department of Defense or The Department of Veterans Affairs as required under 42 U.S.C. 300gg-8(d)(A)(v);
5. A qualified "non-governmental" research entity identified in the guidelines issued by the National Institutes of Health for center support grants as required under 42 U.S.C. 300gg-8(d)(A)(v);
6. The Department of Veterans Affairs, The Department of Defense, The Department of Energy if for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines (A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review as required under 42 U.S.C. 300gg-8(d)(1)(A)(vii);
7. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration under 42 U.S.C. 300gg-8(d)(1)(C).
8. The study or investigation is a drug trial that is exempt from having such an investigational new drug application under 42 U.S.C. 300GG-8(d)(1)(C).
9. Coverage is only available if medical care is rendered by a licensed health care provider operating within the scope of the provider's license;
10. Coverage for medical treatment shall be limited to routine patient care costs as follows:
    a. A medical service or treatment that is a benefit under the Agreement that would be covered if the patient were receiving standard cancer treatment;
    b. A drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal Food and Drug Administration for use in treating the patient's particular condition.
11. Coverage shall be available for:
    a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
    b. Any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;
    c. Health care services customarily paid by the sponsor of the clinical trial or study.
    d. Extraneous expenses related to the clinical trial or study including but not limited to travel, housing or other such expenses for the Participant or the Participant's family or companions;

e. Any item or service solely provided to satisfy a need for data collection or analysis or related to the clinical management of the patient;
f. Any costs for management of research relating to the trial or study.

Note: For a complete description of coverage and limitations for cancer clinical trials, please refer to Texas State Statutes, Texas Insurance code chapter 463.

S. FACILITY OTHER PROVIDER

A medical facility other than a hospital which is licensed, where required, to render Covered Services. Facility Other Providers include, but are not limited to:

1. Substance Use Disorder Treatment Center or Facility is a detoxification and/or rehabilitation facility licensed by Texas or another state to treat alcoholism, or a Facility Other Provider which is primarily engaged in providing detoxification and rehabilitation treatment for drug abuse.
2. Ambulatory Surgical Facility is a Facility Other Provider, with an organized staff of Physicians, which:
   a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis,
   b. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility,
   c. does not provide inpatient accommodations, and
   d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician, or Professional Other Provider.
3. Freestanding Dialysis Facility is a Facility Other Provider other than a Hospital which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an outpatient or home care basis.
4. Outpatient Psychiatric Facility is a Facility Other Provider which for compensation from its patients is primarily engaged in providing diagnostic and therapeutic services for the treatment of Mental Illness on an outpatient basis.
5. Psychiatric Hospital is a Facility Other Provider which for compensation from its patients, is primarily engaged in providing rehabilitation care services on an inpatient basis. Psychiatric rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.
6. Skilled Nursing Facility is a Facility Other Provider which is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:
   a. minimal care, custodial care, ambulatory care, or part-time care services, or
   b. care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.
7. Hospice is a Facility Other Provider that offers a coordinated program of home care for a terminally ill patient and the patient's family.

8. Other medical facilities not specifically listed above.

T. FAMILY MEMBERSHIP

A membership that covers the Subscriber, the Subscriber's eligible spouse, and one or more eligible dependent children.

U. FIDUCIARY

Sky 100, as claims administrator, has the right to determine Participant eligibility for benefits, and to process and determine claims payment or denials and to otherwise administer and interpret this Agreement.

V. FORMULARY

A continually updated list of medications and related information, representing the clinical judgment of Physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health, as determined by Sky 100.

W. GROUP

The plan sponsor who has signed an agreement with SKY 100
PLAN to provide health care benefits to its eligible employees and Dependents.

X. GROUP CONVERSION

A program designed for the Participant who is no longer a covered member of a group health plan.

Y. HOME HEALTH AGENCY

A private or public organization certified by the U.S. Department of Health and Human Services. It provides skilled nursing services and other therapeutic services to patients in their homes.

Z. HOSPITAL

A provider that is a short-term, acute, general Hospital which:

1. Is a duly licensed institution.
2. For compensation from its patients, is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians.
3. Has organized departments of medicine and Surgery.
4. Provides 24-hour nursing services by or under the supervision of registered graduate nurses, which are both physically present and on duty.
5. Is not other than incidentally a:
    a. skilled nursing facility,
    b. nursing home,
    c. custodial care home,
    d. health resort,
    e. spa or sanitarium,
    f. place for rest,
    g. place for the aged,
    h. place for the treatment of Mental Illness,
    i. place for the treatment of alcoholism or drug abuse,
    j. place for the provision of hospice care,
    k. place for the provision or rehabilitative care,
    l. place for the treatment of pulmonary tuberculosis.

AA. INPATIENT

A Participant who is treated as a registered bed patient in a Hospital or Facility Other Provider and for whom a room and board charge is made. In computing days, a stay up to and including midnight of the date of admission shall be considered one day, and an additional day will be counted at each midnight census after the first day that the Participant is still a patient.

BB. LATE ENROLLEE

An eligible employee or Dependent who requests coverage more than thirty (30) days after his initial date of eligibility. An eligible employee or Dependent will NOT be considered a Late Enrollee if:

1. The individual applied during one of the special enrollment periods described in the section on HOW TO ADD, CHANGE, OR END MEMBERSHIP, or
2. The individual is employed by a group which offers multiple health benefit plans and the individual elects a different plan during an Open Enrollment Period, or
3. A court has ordered coverage be provided for a spouse or minor child under a covered Subscriber's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

CC. MEDICAL CARE

Professional services rendered by a Physician or a Professional Other Provider for the treatment of an illness or injury.

DD. MEDICAL EMERGENCY

A Medical Emergency condition is:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
    b. Serious impairment to bodily functions, or
    c. Serious dysfunction of any bodily organ or part, or
2. With respect to a pregnant woman who is having contractions:
    a. If there is inadequate time to effect a safe transfer to another Hospital before delivery, or
    b. If transfer may pose a threat to the health or safety of the woman or the unborn child.

EE. MEDICAL NECESSITY

1. A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
    a. Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
    b. Provides for the diagnosis, direct care and treatment of the Participant’s condition, illness, disease or injury;
    c. Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care;
    d. Is not primarily for the convenience of the Participant, Physician or other health care provider; and

2. A medical service, procedure or supply shall not be excluded from being a Medical Necessity solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:
   a. Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or
   b. Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t) (2) of the federal Social Security Act.

FF. MENTAL ILLNESS

Those conditions listed in the International Classification of Diseases as psychoses, neuroses, personality disorders and other non-psychotic mental disorders.

GG. OPEN ENROLLMENT PERIOD

The period of time as set forth in the Group Master Schedule of Benefits
SKY 100 has open enrollment 365 days a year.

HH. OUTPATIENT

A Participant who receives services or supplies while not an Inpatient.

II. PARTICIPANTS

The Subscriber and the Subscriber's covered Dependents.

JJ. PARTICIPATING

1. Participating Hospitals and Facility Other Providers have entered into an agreement with SKY 100 or another Sky 100 to accept the Allowable Charge as the full allowance for Covered Services. Payment for services provided by Participating Hospitals and Facility Other Providers will be made directly to them. Participants are not responsible for amounts charged for Covered Services that are over the Allowable Charge.
2. Participating Physicians and Professional Other Providers have entered into an agreement with SKY 100 or another SKY 100 to accept the Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Participating Physicians and Professional Other Providers will be made directly to them. Participants are not responsible for amounts charged for Covered Services that are over the Allowable Charge.

NOTE: A Hospital, Facility Other Provider, Physician, or Professional Other Provider who has not entered into an agreement with SKY 100 or another SKY 100 is called "Non- participating." When Covered Services are provided outside of Sky 100's service area by such Non-participating Providers, the amount(s) a Participant pays for Covered Services

will generally be based on either the Sky 100's Non-participating Provider local payment or the pricing arrangements required by applicable state law. In some instances, a Non-participating Physician or Professional Other Provider may bill Participants directly and payments will be made directly to the Participant. Similarly, if Participants choose a Non-participating Hospital or Facility Other Provider, they may be billed directly and payments may be made directly to the Participant. Participants will be responsible to Non-participating Providers of services for all charges, regardless of the Allowable Charges or the amount of payment made under this Agreement.

KK. PARTICIPATING PHARMACY

A pharmacy which has entered into an agreement with Sky 100 or its prescription drug card administrator to bill SKY 100 directly for covered services. Sky 100's payment will be made directly to the participating pharmacy.

NOTE: A pharmacy which has not entered into an agreement with SKY 100 is called non-participating. A non-participating pharmacy will bill Participants directly and the Participants will be responsible for all charges.

LL. PHARMACY

Pharmacy means any licensed establishment where prescription legend drugs are dispensed by a licensed pharmacist.

MM. PHARMACY OUT-OF-POCKET MAXIMUM

A specified dollar amount of expense incurred by a participant under Optum Rx for Covered Services in a calendar year that exceeds benefits provided under this Agreement. When the out-of-pocket maximum has been reached, the Participant is no longer responsible for Prescription Drug Copayments and Coinsurance, but must still pay the difference in cost between a brand name drug and the generic equivalent, if a generic is available.

NN. PHYSICIAN

A licensed doctor of medicine or osteopathy licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

OO. PLAN ADMINISTRATOR

The administrator of the plan as defined by Section 3(16) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

PP. PLAN YEAR

For the purposes of this Agreement, the twelve (12) months following the group's Anniversary Date, unless otherwise defined by the employer under ERISA.

QQ. PRE-EXISTING CONDITIONS

A condition, (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within

the six (6) month period immediately preceding the Enrollment Date. Pregnancy shall not be treated as a Pre-existing Condition and genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of a condition related to such information.

RR. PRESCRIPTION DRUGS

Medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber.

SS. PROBATIONARY/WAITING PERIOD

A length of time (e.g., 30, 60, 90 days) established by the Group which the Applicant must fulfill before the Applicant is eligible for coverage. Waiting Periods will not be considered in determining if a significant break in coverage has occurred.

TT. PROFESSIONAL OTHER PROVIDER

A person or practitioner who is licensed, where required, to render Covered Services. Professional Other Providers include, but are not limited to:

1. Chiropractor is a Board Qualified and licensed Doctor of Chiropractic who treats disease by manipulation of the joints of the body.
2. Clinical Psychologist is a licensed clinical psychologist. When there is no licensure law, the psychologist must be certified by the appropriate professional body.
3. Dentist includes, and only includes, a dentist duly licensed to practice by the state in which the services shall have been provided.
4. Optometrist is a person (O.D.) who measures the eye's refractive powers, performs medical eye examinations and fits glasses to correct ocular defects.
5. Physical Therapist is a licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.
6. Physician Assistant is an individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a licensed Texas Physician and must be certified by the state to practice.
7. A Nurse Practitioner is a registered nurse who performs primary care patient services such as acts of medical diagnosis or prescription of medical therapeutic or corrective measures and is licensed and certified by the state.

UU. PROTECTED HEALTH INFORMATION (PHI)

Information, including summary and statistical information, collected from or on behalf of a Participant that:

1. Is created by or received from a health care provider, health care employer, or health care clearinghouse.
2. Relates to a Participant’s past, present or future physical or mental health or condition.
3. Relates to the provision of health care to a Participant Relates to the past, present, or future payment for health care to or on behalf of a Participant; or
4. Identifies a Participant or could reasonably be used to identify a Participant.
5. Educational records and employment records are not considered PHI under federal law.

VV. SINGLE MEMBERSHIP

A membership which covers one person (the Subscriber).

WW. SUBSCRIBER

The Participant whose name appears on the identification card.

XX. SURGERY

1. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examination and other invasive procedures,
2. The correction of fractures and dislocations,
3. Usual and related pre-operative and post-operative care,

YY. THERAPY SERVICE

Services or supplies used for the treatment of an illness or injury to promote the recovery of the Participant.

1. Radiation Therapy is the treatment for malignant diseases and other medical conditions by means of X-ray, radon, cobalt, betatron, telecobalt, and telecesium, as well as radioactive isotopes.
2. Chemotherapy is drug therapy administered as treatment for conditions of certain body systems.
3. Dialysis Treatments are the treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
4. Physical therapy involves the use of physical agents for the treatment of disability resulting from disease or injury. Physical therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries.
5. Respiratory Therapy is the treatment of respiratory illness and/or disease by the use of inhaled oxygen and/or medication.
6. Occupational Therapy is the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
7. Speech Therapy includes those services used for diagnosis and treatment of speech and language disorders which result in difficulty in communication.

ZZ. REHABILITATIVE/HABILITATIVE/HABILITATIVE SERVICES AND ADMISSIONS

Admissions primarily for the purpose of receiving therapeutic or rehabilitative treatment (such as physical, occupational or oxygen therapy, etc.).

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (§ 1302(b)(1))

AAA. TWO ADULT MEMBERSHIP

A membership that covers the Subscriber and the Subscriber's eligible spouse.

SECTION IV. MEMBERSHIP DUES

A. HOW DUES ARE ESTABLISHED AND CHANGED

The required membership dues are determined and established by Sky 100 which may change membership dues according to any of the following:

1. Subject to Federal and State law.
2. By creating different membership classifications (i.e., single to two adults, family to adult with Dependents, etc.) or when a Subscriber's age changes making them eligible for the next age bracket as listed:
   a. 0 - 29
   b. 30 - 39
   c. 40 - 44
   d. 45 - 49
   e. 50 - 54
   f. 55 - 59
   g. 60 - 64
   h. 65 and older.
3. After giving the Group decision maker fifteen (15) days' written notice.
4. Payment of dues will be conclusive proof of agreement to any change.
5. Dues under this Agreement will be as specified on the Group billing statement.

B. HOW AND WHEN TO PAY DUES

1. Dues should be paid on or before the effective date of coverage under this Agreement. Group members will not be covered until SKY 100 receives the first payment.
2. After the first payment, dues will be payable on the same date in each billing period. Payment of dues can be made monthly or quarterly - whichever billing period is agreed upon.

C. WHAT HAPPENS WHEN DUES ARE NOT PAID ON TIME

If Group dues are not paid after the thirty-one (31) day grace period as provided in this section, SKY 100 reserves the right to cancel the coverage under this Agreement. Such a cancellation will occur at the end of the last billing period for which dues were paid.

D. DUES PAYMENT GRACE PERIOD

The Group is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, and during the grace period this Agreement shall continue in force unless the Group gave SKY 100 written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of this Agreement. The Group is liable to SKY 100 for the payment of a pro rata premium for the time this Agreement was in force during the grace period provided by this paragraph.

E. *DUES ADJUSTMENTS FOR AGE*

In the event the dues or benefits under terms and conditions of this Agreement vary by age, an equitable adjustment of those dues, or benefits, or both will be made by SKY 100 if it determines, any time after the effective date of coverage, that the age of a Subscriber, or their Dependent, has been misstated.

F. *OTHER PROVISIONS*

The Group is not the agent, employee, or other representative of Sky 100.

SECTION V. ELIGIBILITY REGULATIONS

Employees, Dependents, directors, partners, and owners will be eligible for coverage under this Agreement according to the following paragraphs and in accordance with this Agreement and applicable state and federal law, based on information received from the Group or otherwise obtained.

A. ELIGIBILITY

1. Unless otherwise specified, all regular (non-seasonal, non-temporary) full-time employees who are employed thirty (30) or more hours a week by the firm that is making application for benefit coverage (or any affiliated companies as determined by Sky 100) are eligible.
2. Employees must have deductions made for Federal Income Taxes and Social Security by the Group.
3. Directors are eligible only if they are also employed thirty (30) or more hours per week by the firm that is making application for benefit coverage (or any affiliated companies as determined by Sky 100).
4. Partners and owners are eligible only if they are employed thirty (30) or more hours per week by the firm that is making application for benefit coverage (or any affiliated companies as determined by Sky 100).
5. The employer must, upon request, provide documentation satisfactory to SKY 100 supporting the eligibility of all employees, directors, partners, and owners.

   NOTE: Any eligible employee who enters the armed forces on full-time duty may elect continuation of coverage, *provided that* membership dues continue to be paid timely and in full. See CONTINUATION OF GROUP COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP under the section on HOW TO ADD, CHANGE, OR END MEMBERSHIP.

   NOTE: The following are not eligible for coverage:

   a. Retired employees
   b. Directors, partners, owners who do not work 30 hours or more per week
   c. Independent contractors
   d. Volunteers or non-compensated employees

B. DEPENDENT ELIGIBILITY

1. All Dependents of the eligible individuals as defined in SECTION III., DEFINITIONS are eligible.
2. Dependents of an eligible individual who enters the armed forces on full-time duty are eligible for continuation of coverage under this Agreement, regardless of whether the eligible employee elects to retain coverage for him/herself. See CONTINUATION OF GROUP COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP under the section on HOW TO ADD, CHANGE, OR END MEMBERSHIP.

3. The employer must, upon request, provide documentation satisfactory to SKY 100 supporting the eligibility of all Dependents.

C. GROUP ELIGIBILITY

1. The employer must be actively engaged in business and provide, upon request, evidence to this effect satisfactory to Sky 100.
2. The employer or Group must maintain a minimum enrollment of the following numbers and percentages of the total potential enrollees as determined by SKY 100 to continue group coverage under this Agreement. The number of potential enrollees will include employees of all affiliated companies as determined by Sky 100.

If the number of potential enrollees is:	Percentage of enrollment must be:
2-4	100%
5-9	100% less one potential enrollee
10 and over	8 potential enrollees or 75%, whichever is greater

3. The employer is required to comply with the minimum contribution requirements as established by Sky 100. NOTE: This requirement does not apply to an employee who enters the armed forces on full-time duty, but elects to maintain coverage under this Agreement. In such an event, while the employer *may* continue to pay for part or the entire employee's membership dues, it is the employee's obligation to pay such amount timely to maintain coverage under this Agreement.
4. If the Group reduces to fewer than two (2) eligible persons or fails to meet the percentage and/or contribution requirements, the group coverage will be cancelled subject to applicable State and/or Federal requirements. If the Group has not sponsored another carrier, then Participants under age 65 shall be offered the right to convert to the Group Conversion Program. Participants age 65 or over will be offered a Senior Health Care Program.

SECTION VI. HOW TO ADD, CHANGE, OR END MEMBERSHIP

There are a number of ways that Participants may want to add, change, or end membership. This section explains how changes may be made.

A. HOW TO ADD SUBSCRIBERS

1. The employee should complete an application which must be received by Sky 100 within thirty (30) days of the end of any applicable Probationary Period. If there is no Probationary Period, the application must be received within thirty (30) days of the date of hire.
2. Based on the completeness and acceptability of the application, the effective date will be the first of the month following receipt of the completed application.
3. If an application is not submitted as described above, the employee will be considered a Late Enrollee. Late Enrollees are eligible to apply for coverage during the Group's annual Open Enrollment Period as set forth in the Schedule of Benefits. Provided the application is received by SKY 100 during the Open Enrollment Period, a Late Enrollee:
    a. Will have coverage effective under this Agreement on the first day of the first calendar month immediately following the Group's Open Enrollment Period, and
    b. Will have coverage for any Pre-existing Conditions following the effective date of coverage.
4. In addition to the methods of application described above, an employee may also be eligible to apply for coverage during a special enrollment period. (See ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS below.)

B. HOW TO ADD DEPENDENTS

1. Eligible Dependents can be added at the time the employee applies for coverage by including their names, dates of birth, and medical information on the application and checking the appropriate box. Based upon the acceptability of the application, the effective date of coverage will be the same as that of the employee.
2. To add eligible Dependents who were not included on the original application, a new application is required. Eligible Dependents who are considered to be Late Enrollees because their application was not received by SKY 100 within thirty (30) days of their initial date of eligibility are eligible to apply for coverage during the Group's annual Open Enrollment Period as set forth in the Schedule of Benefits. Provided the application is received by SKY 100 during the Open Enrollment Period, a Late Enrollee:
    a. Will have coverage effective under this Agreement on the first day of the first calendar month immediately following the Group's Open Enrollment Period, and

b. Will have coverage for any Pre-existing Conditions following the effective date of coverage.

3. To add newly acquired eligible Dependents, the Subscriber should complete an application and forward it to SKY 100 immediately. The application must be received by SKY 100 within the prescribed period following the acquisition of the new Dependent as described below.
4. The effective date of coverage for newly acquired Dependents will be as follows:
   a. The new spouse will be effective on the date of marriage providing an application for coverage is received prior to the date of marriage. When the application is received within thirty (30) days after the date of marriage, coverage will be effective on the day following receipt by Sky 100.
   b. Coverage for a newborn child will be automatic beginning on the date of birth and extending for a period of thirty-one (31) days. A completed application for coverage of the child will be required before claims will be processed. The Subscriber may continue coverage for the newborn child beyond the 31-day automatic coverage provided that the completed application for coverage of the newborn child is received by SKY 100 within sixty- one (61) days of the child's date of birth. If such application is received and accepted by Sky 100, dues will be adjusted and payable to account for the newborn's coverage after the automatic 31-day coverage period.
   c. Coverage for an adopted child or legal ward will be automatic beginning on the earlier of the date the petition for adoption is filed or the child's date of entry into the adoptive home (unless the child is in the custody of the State, in which case the coverage will be automatic beginning on the date of entry of a final adoption decree by the court), and extending for a period of thirty-one (31) days. A completed application for coverage of the child will be required before claims will be processed. The Subscriber may continue the coverage for the adopted child or legal ward beyond the 31-day automatic coverage provided that the completed application for coverage of the adopted child or legal ward is received by SKY 100 within sixty-one (61) days of the earlier of the date of filing of the petition for adoption, or date the child enters the adoptive home (unless the child is in the custody of the State, in which case the application must be received by SKY 100 within sixty-one (61) days of the date of entry of a final adoption decree by the court). If such application is received and accepted by Sky 100, dues will be adjusted and payable to account for the adopted child's or legal ward's coverage after the automatic 31-day coverage period. NOTE: (1) The adoption or legal guardianship papers must accompany the application for

coverage; (2) If coverage is made effective upon the filing of a petition for adoption, coverage will continue unless the petition is denied.

NOTE: If a new application is not received by SKY 100 within the prescribed periods as described above or during a special enrollment period, the Dependent will be considered a Late Enrollee. Late Enrollees are eligible to apply for coverage during the Group's annual Open Enrollment Period as set forth in the Schedule of Benefits. Provided the application is received by SKY 100 during the Open Enrollment Period, a Late Enrollee:

a. Will have coverage effective under this Agreement on the first day of the first calendar month immediately following the Group's Open Enrollment Period, and
b. Will have coverage for any Pre-existing Conditions following the effective date of coverage.

C. CHANGES

1. The Subscriber or the Group shall notify SKY 100 within thirty (30) days of all changes in the Subscriber's status, such as those resulting from marriage, divorce, birth, adoption, or change of residence and within ninety (90) days of death or entrance into, or return from, the armed services. These changes will be made only upon approval by Sky 100. All changes must be in accordance with Section V of this Agreement and receipt by SKY 100 of any dues required.
2. The Group shall notify SKY 100 of any changes in Subscriber eligibility status within ten (10) days of the date of change.

D. WHEN COVERAGE UNDER THIS AGREEMENT ENDS

1. When the Subscriber leaves employment or otherwise becomes ineligible, membership will terminate the first of the month following the last day of eligibility. The Subscriber has thirty-one (31) days from the last day of coverage to apply to SKY 100 for continuation of group coverage (See CONTINUATION OF GROUP COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP below.)

   NOTE: Accrued vacation time and sick leave will not extend coverage beyond the first Billing Service Date following the last day of employment.
2. When SKY 100 is notified within thirty (30) days of a leave of absence for a Group Subscriber, the Subscriber may remain on the group coverage for ninety (90) days, providing the Group continues to contribute the same portion of the premium and remittance of dues is received from the Group. If, after the initial leave of absence, the Subscriber will not be returning to work or is not maintained on the payroll, he or she must be removed from the Group on the first

Billing Service Date following the 90-day leave of absence. The Subscriber then has thirty-one (31) days from the last day of coverage to apply to SKY 100 for continuation of group coverage as described below under CONTINUATION OF GROUP COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP.

NOTE: If the employer does not contribute the same amount toward the premium as for other employees, SKY 100 will consider that the Subscriber has left employment and coverage will no longer be available through the Group. Continuous coverage may be available as described under CONTINUATION OF G R O U P COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP below.

3. Upon the death of the Subscriber.
4. When the Group Master Agreement is terminated. No Group Conversion coverage will be offered if the Group adopts another insurance carrier or other group insurance arrangements.
5. By the Subscriber's request. Coverage ends on the next Billing Service Date following receipt of the written request.
6. When there is improper use of this Agreement or the identification card, or when there is fraud or material misrepresentation **must also be intentional in order for coverage to be rescinded** associated with the application for coverage, or with the filing of a claim by the Participant. The Subscriber is liable for any benefits payments made through such improper actions.
7. When a Subscriber is age 65 or over and leaves employment, coverage will terminate. However, if the Subscriber applies for continuous coverage, he or she will be transferred to a Senior Health Care Program with billings sent directly to him or her.

E. WHEN COVERAGE FOR DEPENDENTS ENDS

Coverage for a Dependent ends on the earliest of the following dates:

1. When the Subscriber's coverage ends. However, the eligible Dependent may apply for a continuation of coverage as described below in CONTINUATION OF GROUP COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP.

   NOTE: Upon death of the Subscriber, surviving eligible Dependents remain covered up to the next Billing Service Date. Also, any surviving Dependent has the right to continue membership for himself or herself as described under CONTINUATION OF GROUP COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP. A written application for such continuation must be received by SKY 100 within thirty-one (31) days after the death of the Subscriber.
2. The end of the month in which a dependent child attains age 26.

   Eligibility will be continued past the limiting age for unmarried children who are BOTH incapable of self-sustaining employment and chiefly dependent upon the Subscriber for their support and maintenance by reason of mental retardation or physical handicap. Continuous coverage will be established at the same level of benefits. Dues may be adjusted accordingly. Proof of incapacity and dependency must be furnished to SKY 100 within thirty-one (31) days of the end of the month in which the limiting age is attained. Incapacity

and dependency upon the Subscriber must both continue in order for the coverage to continue and SKY 100 may, from time to time, require continued proof of such incapacity and dependency. If the conditions of BOTH incapacity and dependency by reason of mental retardation or physical handicap are not continuously met, coverage will continue as required by Federal or State law as applicable.

3. When no longer qualifying as a Dependent as defined in this Agreement.
4. The next Billing Service Date following a final divorce decree or separation for a dependent spouse.
5. When the Subscriber notifies SKY 100 in writing to end coverage for a Dependent. Coverage ends on the next Billing Service Date following receipt of the written request.
6. For newborn and adopted children, at the end of the 31-day automatic coverage period, unless a completed application for coverage of the child is received by SKY 100 no later than thirty (30) days after the end of that automatic coverage period.

F. CONTINUATION OF GROUP COVERAGE AFTER TERMINATION OF EMPLOYMENT OR MEMBERSHIP

When the Participant's group coverage is terminated due to loss of employment or loss of eligibility, the Participant is eligible for continuation of coverage under the group health plan.

Continuation is only available to a Participant who has been continuously insured under the group policy and for similar benefits under any group policy which it replaced, during the entire three (3) month period ending with the termination of eligibility. Continuation is not available for any person who is:

1. Covered by Medicare (excluding the spouse or dependent children who shall be entitled to continuation), or
2. Covered by any other insured or uninsured arrangement which provides Hospital, surgical, or medical coverage for individuals in a group.

A Participant who wishes continuation of coverage must request the continuation in writing within the thirty-one (31) day period following the date of termination of coverage. The written request, together with the premium, must be sent to SKY 100 and be post-marked no later than the 31st day following the date of the termination of coverage.

The Participant electing continuation of coverage is responsible for payment of the premium, in advance, on a monthly basis.

Continuation of coverage will be for twelve (12) months (24 months if the Participant left employment and entered the Armed Forces on a full time basis) after the date the Participant's insurance under the policy would otherwise have terminated due to termination of employment or eligibility. Continuation of coverage ends when:

1. The Participant fails to pay the monthly premium in advance,

2. The Participant is covered by Medicare,
3. The Participant is covered under any other insured or uninsured arrangement which provides Hospital, surgical, or medical coverage for individuals in a group,
4. The date on which the group policy is terminated.
5. There is improper use of this Agreement or the identification card, or when there is fraud or material misrepresentation associated with the application for coverage, or with the filing of a claim by the Participant.

Upon termination of the continuation period, the Participant may apply for the Group Conversion Program. Notification must be sent to SKY 100 and the required premium must be paid within thirty-one (31) days of the termination of the continued coverage under the Group Agreement.

G. ADDING PARTICIPANTS DURING SPECIAL ENROLLMENT PERIODS

Employees and Dependents can be added for coverage under this Agreement during special enrollment periods as described in applicable federal and state law. Employees and Dependents eligible for special enrollment will not be considered Late Enrollees.

1. If at the time of initial eligibility, employees or Dependents decline coverage under this Agreement because of other group health insurance coverage, they may be eligible for a special enrollment, provided they request enrollment within 30 days after the other health insurance coverage ends. To qualify for this special enrollment, the employees or Dependents must have lost their other coverage due to either:

    a. The termination of employer contributions,
    b. The employee's or Dependent's loss of eligibility due to divorce, death, legal separation, termination of employment, or reduction in work hours, or
    c. The exhaustion of group continuation coverage if the employee or Dependent had been on group continuation coverage at the time of initial eligibility.

    The employee must complete an application which must be received by SKY 100 within 30 days after the employee's or Dependent's other coverage ends. The effective date of coverage under this Agreement will be the 1st of the month following receipt by SKY 100 of a substantially complete application.
2. If employees gain a new Dependent as a result of marriage, birth, adoption, or placement for adoption, they may be eligible for a special enrollment for themselves and their Dependents, provided they complete an application which is received by SKY 100 within 30 days after the marriage, birth, adoption, or placement for adoption. The effective date of coverage will be:

    a. In the case of marriage, the day following receipt by SKY 100 of a substantially complete application,
    b. In the case of a Dependent's birth, the date of birth, and
    c. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

3. If the employee or any Dependents dropped coverage under this Agreement due to the employee's entrance into the armed forces on full-time duty. The employee and any Dependents being added to the coverage must complete an application which must be received by SKY 100 within thirty (30) days after the date of termination of the employee's full-time duty status. The effective date of coverage under this Agreement for all such Applicants will be the date of application, assuming receipt by SKY 100 of a substantially complete application. Such coverage shall be without any exclusion of Pre-existing Conditions, except as otherwise set forth in this Agreement, including the remainder of any waiting period that was unfulfilled at the time of the employee's termination of coverage.
4. If the employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, they may be eligible for coverage if the employee completes an application which is received by SKY 100 within sixty (60) days after the termination. The effective date of coverage will be the first of the month following receipt of the application.
5. If the employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or the Children's Health Insurance Program (CHIP), they may be eligible for coverage if the employee requests coverage within sixty (60) days after eligibility is determined. The effective date of coverage will be the first of the month following receipt of the application.

H. CERTIFICATE OF CREDITABLE COVERAGE

When coverage under this Agreement is terminated, SKY 100
PLAN will, within a reasonable period of time, issue a Certificate of Creditable Coverage to the affected Subscriber and/or Dependents. Upon notification by the Subscriber of the ineligibility of a Dependent, a Certificate of Creditable Coverage will be issued in a timely fashion thereafter. Certificates of Creditable Coverage may also be obtained from SKY 100 upon request within 24 months after coverage is terminated. Certificates of Creditable Coverage will only reflect continuous coverage provided through Sky 100.

SECTION VII. HOW BENEFITS WILL BE PAID

SKY 100 will process claims in accordance with this Agreement.

All Covered Services for which a benefit has been provided or incurred under any section of this Agreement during the calendar year shall be included.

A. HOSPITALS AND FACILITY OTHER PROVIDERS

Payment by SKY 100 for inpatient services will be based on the Allowable Charges. If Participants have a private room in a Hospital, covered charges under their Agreement will be limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

1. Participating Hospitals and Facility Other Providers have entered into an agreement with SKY 100 or another SKY 100 plan to accept the Allowable Charge as the full allowance for Covered Services. Payment for services provided by Participating Hospitals and Facility Other Providers will be made directly to them. Subscribers are not responsible for amounts charged for Covered Services that are over the Allowable Charge.

2. Payment for Covered Services provided to Participants by non-participating Hospitals or Facility Other Providers may be made to the Subscriber. Subscribers are responsible to non-participating providers of services for all charges, regardless of the Allowable Charge or the amount of payment made under this Agreement.

   If Participants choose a Hospital or Facility Other Provider which is non-participating, The visit is not covered and the participant will be responsible for 100% of the total charges.

PRE-ADMISSION REVIEW

If a Physician recommends that a Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Sky 100's pre-admission review program.

SKY 100 will reduce benefits by $ 200.00 if pre- admission review is not obtained from SKY 100 and a Participant is hospitalized as an Inpatient. (The additional $ 200.00 a Participant must pay CANNOT be applied toward satisfaction of the Deductible or Coinsurance Maximum.)

NOTE: Benefits will also be reduced by $ 200.00 if SKY 100 determines that services can be performed on an outpatient basis, but the Participant elects to be hospitalized as an Inpatient.

PRE-CERTIFICATION

SKY 100 may require pre-certification of certain Covered Services as a requirement for payment. Pre-certification may include the required use of designated providers who have demonstrated high quality, cost efficient care. Services that require pre-certification are either identified through the pre-admission review process described above, or are listed under PRE-CERTIFICATION in the section on GENERAL LIMITATIONS AND EXCLUSIONS.

B. PHYSICIANS AND PROFESSIONAL OTHER PROVIDERS

Payment by SKY 100 for Covered Services will be based on the Allowable Charges.

1. Participating Physicians and Professional Other Providers have entered into an agreement with SKY 100 or another SKY 100 to accept the Allowable Charge as the full allowance for Covered Services. Payment for Covered Services provided by Participating Physicians and Professional Other Providers will be made directly to them. Subscribers are not responsible for amounts charged for Covered Services that are over the Allowable Charge.

2. Payment for Covered Services provided to Participants by non-participating Physicians or Professional Other Providers will be made to the Subscriber and Subscribers are responsible for all charges, regardless of the Allowable Charges or the amount of payment made under this Agreement.

If a Physician recommends that a Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Sky 100. See PRE-ADMISSION REVIEW under HOSPITAL AND FACILITY OTHER PROVIDERS above.

C. DEDUCTIBLE REQUIREMENTS

Under a Single Membership, there is no Deductible amount to be met for each calendar year is shown on the Schedule of Benefits. (The Deductible does not apply to PREVENTIVE CARE.)

Under a Two Adult, Adult and Dependent, or Family Membership, there is no Deductible amount to be met for each calendar year is shown on the Schedule of Benefits page.

D. PAYMENT ALLOWANCES UNDER THIS COVERAGE

Benefits will be provided for Covered Services as shown below unless otherwise specified:

1. 60% of the Allowable Charges shown on the Schedule of Benefits page is met, unless otherwise specified within this Agreement.
2. One hundred percent (100%) of the Allowable Charges **applied to the out-of-pocket maximum**.
3. The total amount payable for covered medical expenses incurred by each Participant during a calendar year, will not exceed the maximum amount shown on the Schedule of Benefits page.

NOTE: Participant's Coinsurance liability does not apply to PREVENTIVE CARE.

E. NON-PARTICIPATING PROVIDERS OUTSIDE SKY 100'S SERVICE AREA

a. Participant's Liability Calculation

When Covered Services are provided outside of Sky 100's service area by Non-participating Providers, the amount the Participant pays for such services will generally be based on either the Sky 100's Non- participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Participant may be liable for the difference between the amount that the Non-participating Provider bills and the payment SKY 100 will make for the Covered Services as set forth in this paragraph.

b. Exceptions

In certain situations, SKY 100 may use other payment bases, such as billed charges, the payment SKY 100 would make if the Covered Services had been obtained within its service area, or a special negotiated payment, as permitted under Inter-Plan Programs' policies, to determine the amount SKY 100 will pay for Covered Services rendered by Non-participating Providers. In these situations, the Participant may be liable for the difference between the amount that the Non- participating Provider bills and the payment SKY 100 will make for the Covered Services as set forth in this paragraph.

SECTION VIII. BENEFITS

The following pages describe the various services and supplies that SKY 100 covers and to what extent these items are covered on an inpatient or outpatient basis by different types of providers.

Benefits are only provided for services and supplies related to and required for the treatment of a specific illness or injury. All benefits are subject to SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS, in this Agreement, and SECTION VII. HOW BENEFITS WILL BE PAID.

If a claim is submitted for a service not listed on the following pages as a benefit, SKY 100 will deny that claim as not a benefit of this Agreement. Before doing so, SKY 100 will review the claim to determine whether the service or supply qualifies to be paid in whole, or in part, as a benefit, or is an exclusion. In making this decision, it may request the advice of medical or other professionals.

Any decision rendered by SKY 100 is subject to the right of appeal in accordance with the appeal procedures found in this Agreement.

A. ACCIDENTS

DEFINITION - An "accident" is an unexpected traumatic incident which is identified by time and place of occurrence, identifiable by body member or part of the body affected, and caused by a specific event on a single day. Examples include a blow or fall, animal bites, allergic reactions to insect bites or medication, or poisoning. Accidents are *not* the result of either services received (e.g., a massage), physical training (e.g. a strain from an exercise routine), an activity of daily living not resulting from a blow or fall, or an intentionally self-inflicted injury (unless the injury is the result of a medical condition [either physical or mental] or domestic violence).

BENEFITS -

Inpatient: See ROOM EXPENSES AND ANCILLARY SERVICES.

Outpatient: Covered when services are provided by a Physician, Professional Other Provider, Hospital, or Facility Other Provider.

See SUPPLEMENTAL ACCIDENT BENEFIT for additional information relating to accidents.

LIMITATIONS AND EXCLUSIONS -

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

SUPPLEMENTAL ACCIDENT BENEFIT

Benefits are provided when a Participant incurs accidental bodily injury (as defined under ACCIDENTS), The following benefits are provided to the maximum shown on the Schedule of Benefits, but not exceeding the Allowable Charges for such care:

1. Medical or surgical treatment by a Physician; or by a doctor of dental Surgery in connection with treatment for injury to sound, natural teeth;
2. Confinement and covered care in a licensed general Hospital;
3. Services of a registered nurse (R.N.) not related to nor a resident in the home of the patient;
4. Laboratory and X-ray examinations;
5. Ambulance service;
6. Any necessary supply or service.

LIMITATIONS AND EXCLUSIONS -

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

B. AMBULANCE SERVICES

DEFINITION - An "ambulance" is a specially designed or equipped vehicle which is licensed for transferring the sick or injured. It must have customary patient care, safety, and life-saving equipment, and must employ trained personnel.

BENEFITS - The following professional ambulance services are covered when the Participant cannot be safely transported by any other means. Benefits will be determined based on the final diagnosis:

1. For inpatient care to the nearest Hospital with appropriate facilities or, under similar restrictions, from one Hospital to another.
2. For outpatient care to the nearest Hospital with appropriate facilities when such care is related to a Medical Emergency or an accident.
3. From the nearest Hospital to the Participant's home, nursing home, or skilled nursing facility in the same locale.

LIMITATIONS AND EXCLUSIONS -

1. Air Ambulance: In most cases, ground ambulance is the normally approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Participant's condition warrants air ambulance services.

2. Other Transportation Services: SKY 100 will not pay for other transportation services (such as private automobile or wheelchair ambulance charges) not specifically covered.

3. Patient Safety Requirement: If Participants could have been transported by automobile or public transportation without danger to their health or safety, an ambulance trip will not be covered. No benefits will be provided for such ambulance services even if other means of transportation were not available.

NOTE: No benefits will be provided for ambulance charges for the convenience of the family or Participant. (Example: Transportation of an infant to be closer to the family's home.)

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

C. ANESTHESIA SERVICES

DEFINITION - "Anesthesia" services are performed by a Physician or Certified Registered Nurse Anesthetist (C.R.N.A.) trained in this specialty. General anesthesia produces unconsciousness in varying degrees with muscular relaxation and reduced or absent pain sensation. Regional or local anesthesia produces similar muscular and pain effects in a limited area with no loss of consciousness.

BENEFITS -

Inpatient: Anesthesia services provided by a Physician or C.R.N.A. are covered when necessary for covered Surgery. Allowances are determined by the type of Surgery and the amount of time necessary for anesthesia services.

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, SKY 100 will provide benefits according to where services are rendered as follows:

1. Services performed in the Physician's office or at an Ambulatory Surgical Facility will be payable **at 60%** of the Allowable Charges.
2. Services performed in the outpatient department of a Hospital will be payable at **60%** of the Allowable Charges.

Allowances will be based on the type of Surgery and the amount of time necessary for anesthesia services.

LIMITATIONS AND EXCLUSIONS -

1. Hypnosis: Not covered for anesthesia purposes.

2. Other: The "limitations and exclusions" that apply to SURGERY benefits also apply to anesthesia service.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

D. BLOOD EXPENSES

DEFINITION - "Blood" expenses include the following:

1. Charges for processing, transportation, handling, and administration.
2. Cost of blood, blood plasma, and blood derivatives.

BENEFITS - Blood transfusions, including the cost of blood, blood products and blood processing except when donated or replaced.

LIMITATIONS AND EXCLUSIONS -

1. General: The "limitations and exclusions" that apply to SURGERY benefits also apply to blood expense.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

E. CONSULTATIONS

DEFINITION - When requested by the Physician in charge, a "consultation" is the service of another Physician to provide advice in the diagnosis or treatment of a condition which requires the consultant's special skill or knowledge.

BENEFITS -

Inpatient and Outpatient: Benefits will be provided for Physician consultations.

Second Surgical Opinion: Benefits will be provided for the Physician's services, as well as for any charges for tests necessary to receive a second surgical opinion before undergoing any Surgery. If possible, Participants should provide any test results provided by their Physician when they obtain the second surgical opinion.

If the first and second opinions differ, benefits will also be provided for covered expenses incurred for a third opinion.

LIMITATIONS AND EXCLUSIONS -

1. Staff Consultations: Consultations that are required by rules and regulations of a Hospital or other facility are not covered.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

F. DENTAL, ORAL AND VISION SERVICES

DEFINITION - "Dental**, Oral and Vision** services" are those which are performed for treatment of conditions related to the teeth or structures supporting the teeth and **mouth, vision services are those related to the treatment of the eyes.**

BENEFITS- Are provided when a Participant incurs accidental bodily injury (as defined under ACCIDENTS), providing such care is related to and received**.** The following benefits are provided to the maximum shown on the Schedule of Benefits, but not exceeding the Allowable Charges for such care:

Hospital:

Inpatient: If a Participant is hospitalized for one of the following reasons, benefits will be provided as shown under ROOM EXPENSES AND ANCILLARY SERVICES, provided by a Hospital:

1. Excision of exostoses of the jaw, hard palate, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation for a prosthesis).
2. Surgical correction of accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth (provided the procedure is not done in preparation for a prosthesis).
3. Treatment of fractures of facial bones.
4. Incision and drainage of cellulitis not originating in the teeth or gums.
5. Incision of accessory sinuses, salivary glands or ducts.
6. Reduction of dislocations of the temporomandibular joints.
7. Accidental injury (see limitation #1).

Benefits will also be provided for the room allowance and ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICE) in a Hospital if a Participant has a hazardous medical condition (such as heart condition) which makes it necessary for him or her to have an otherwise non-covered dental procedure performed in the Hospital. (See "limitations".)

Outpatient: Benefits will be provided for initial services provided by a Hospital or other facility for any one of the seven procedures listed above under "INPATIENT" benefits.

Physician:

Inpatient and Outpatient: Benefits will be provided for the seven procedures listed above under "INPATIENT" benefits when provided by a Physician, dentist, or oral surgeon. The benefit allowance for Surgery includes payment for pre-operative visits, local infiltration of anesthesia, and follow-up care.

1. PREVENTIVE CARE: **Pediatric dental services two Prophylaxis, wing bite x-rays no more than two sets per year, emergency palliative treatment, fluoride treatments, space maintainers, sealant one per un-restored permanent molar every 36 months subject to cost sharing amounts, full month x-rays but not more than one (1) set in**

thirty-six (36) consecutive months, x-rays required in connection with diagnosis of a specific condition requiring treatment, except x-rays provided in connection with orthodontic procedures and treatment, extractions except extractions for orthodontic; oral surgery excluding procedures covered under the Dental Services portion of this Benefit Document; Fillings including silver amalgam, silicate, acrylic, plastic, composite except gold; General anesthetics; Periodontal treatment, diseases of gums; Endodontic treatment (Pulp infection and root canal therapy); Injection of antibiotic drugs; Prosthodontic Treatment; Initial installation of fixed bridgework; Initial installation of partial or full removable dentures; Inlays, onlays, crowns, Gold fillings; Repair or replacement or addition to bridgework; dentures, crowns, inlays including re-cementing where necessary because of (a.) one (1) or more teeth extracted after existing denture or bridgework was installed; (b) Existing denture or bridgework was installed five (5) years prior to its replacement and cannot be made serviceable; and Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth) when determined to be dental necessity and Pre-certification is obtained.

LIMITATIONS AND EXCLUSIONS -

1. Accidental Injury Benefit: Benefits will not be provided for restoring the mouth, tooth, or jaw because of injuries from biting or chewing. Benefits will be provided for accident-related dental expenses only under the following conditions:
   a. Services, supplies, and appliances must be required due to an accidental injury. Treatment must be for injuries to sound natural teeth.
   b. Services must be necessary for restoring the teeth to the condition they were in immediately before the accident.
   c. All services must be performed while the Participant's coverage is still in effect.

2. Hazardous Medical Conditions: If, due to a hazardous medical condition (e.g., a heart condition), a Participant must be hospitalized for a non-covered dental procedure; he or she may receive benefits for inpatient Hospital charges. However, benefits for the services provided by the dentist or oral surgeon will still be limited to those described under the Dental Expense Rider.

3. Pre-certification: Before benefits will be allowed for hazardous medical conditions, SKY 100 must give written authorization of such benefits in advance of the date the Participant is hospitalized. A Physician other than a dentist or oral surgeon must certify that hospitalization is necessary to safeguard the life or health of the patient. Psychiatric reasons for admissions will be considered hazardous medical conditions. If a Physician, dentist, or oral surgeon needs to perform a dental procedure for non-dental reasons, benefits will be allowed only if written authorization is given by SKY 100 in advance of the date services are performed.

4. Restorative Services: Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement of serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.

5. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.

6. No Physician services are provided for dentistry or services related to dental care. Benefits will be provided for general anesthesia if the hospitalization is covered.

7. Benefits will not be provided for any Dental Services not specifically detailed above except as provided under the Dental Expense Rider, if applicable.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

G. DIABETES & INHERITED ENZYMATIC DISORDER SERVICES

DEFINITION - The term "diabetes services" applies to self-management training, education, and equipment and supplies for the management of diabetes.

DEFINITION - The term "inherited enzymatic disorders" applies to self-management training, education, and equipment and supplies for the management of inherited enzymatic disorders but not limited to, phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperysinemia, glutaric acidemias, methylmalonic academia and propionic academia.

BENEFITS -

Inpatient: Not covered under DIABETES & **INHERITED ENZYMATIC DISORDERS SERVICES**. (See ROOM EXPENSES AND ANCILLARY SERVICES).

Outpatient Diabetic Services: Benefits will be provided for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin using diabetes, if prescribed by a health care professional legally authorized to prescribe such items under law.

Covered diabetes outpatient self-management training and education shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes. Required covered outpatient self-management training and education shall be limited to:

Outpatient Inherited Enzymatic Disorders Services: Benefits will be provided for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of Inherited Enzymatic Disorders caused by single gene defects involved in the metabolism of amino, organic and fatty acids, as prescribed by a health care professional.

Covered Inherited Enzymatic Disorders outpatient self-management training and education shall be provided by a certified, registered, or licensed health care professional with expertise in Inherited Enzymatic Disorders. Required covered outpatient self-management training and education shall be limited to:

1. A one-time evaluation and training program when medically necessary,

2. Additional medically necessary self-management training shall be provided upon a significant change in symptoms, condition, or treatment. This additional training shall be limited to three (3) hours per year.

LIMITATIONS AND EXCLUSIONS -

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

H. HEMODIALYSIS AND PERITONEAL DIALYSIS

DEFINITION - "Hemodialysis" is the treatment of a kidney disorder by removal of blood impurities with dialysis equipment.

"Peritoneal dialysis" is a treatment where blood impurities are removed by using the lining of the peritoneal cavity as the filter.

BENEFITS - Hemodialysis and peritoneal dialysis are covered when a Physician treats a Participant as an Inpatient, in the outpatient department of a Hospital or Facility Other Provider, or in the Participant's home. SKY 100 will also pay for rental (but not to exceed the total cost of purchase) or, at its option, the purchase of equipment when prescribed by a Physician and required for therapeutic use.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

I. HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY WITH BONE MARROW TRANSPLANT AND/OR PERIPHERAL STEM CELL SUPPORT

THIS SECTION IS APPLICABLE ONLY TO BENEFITS FOR HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY WITH ALLOGENEIC OR AUTOLOGOUS BONE MARROW TRANSPLANT AND/OR PERIPHERAL STEM CELL TRANSPLANT ("HDC/ABMT"), AND ONLY TO THOSE DIAGNOSES FOR WHICH HDC/ABMT IS NOT EXCLUDED FROM COVERAGE ENTIRELY UNDER THE GENERAL LIMITATIONS AND EXCLUSIONS SECTION OF THIS AGREEMENT, INCLUDING WITHOUT LIMITATION THE EXCLUSION AT SECTION IX INVOLVING EXPERIMENTAL AND INVESTIGATIVE PROCEDURES, AND THE EXCLUSION AT SECTION IX FOR STUDIES. ONLY HDC/ABMT IN THOSE CIRCUMSTANCES NOT OTHERWISE EXCLUDED BY THIS AGREEMENT IS ELIGIBLE FOR COVERAGE, AND THEN ONLY IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF THIS SECTION.

DEFINITIONS - "High Dose Chemotherapy or Radiation Therapy" is the administration of chemotherapeutic drugs and/or radiation therapy when the dose or manner of administration is expected to result in damage to or suppression of the bone marrow, the blood or blood forming systems, warranting or requiring receipt by the patient of autologous or allogeneic stem cells, whether derived from the bone marrow or the peripheral blood.

"Donor" is, in the case of an allogeneic transplant, the individual supplying the bone marrow and/or stem cells.

"Recipient" is the individual receiving the bone marrow and/or stem cells.

BENEFITS -

Pre-certification by SKY 100 is required before benefits are payable.

Benefits are provided for high dose chemotherapy and/or radiation therapy with allogeneic or autologous bone marrow transplant or peripheral stem cell support in those circumstances not otherwise excluded from coverage under other provisions of this Agreement. Covered Services include:

1. A clinical evaluation at the transplant facility.
2. Room expenses and ancillary services. See ROOM EXPENSES AND ANCILLARY SERVICES.
3. Administration of high dose chemotherapy and or radiation therapy.
4. Laboratory, pathology and X-ray services. See LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES.
5. Physician services, including those related to the procurement of bone marrow and/or stem cells.
6. Donor expenses in the case of allogeneic transplant.
7. Prescription medications, including immunosuppressive drugs.

LIMITATIONS AND EXCLUSIONS -

1. Coverage of this benefit is subject to all SKY 100 pre- admission review and pre-certification requirements, including the use of designated facility providers.

2. Donor expenses are not covered if the donor is a Participant but the recipient is not.

3. Donor expenses for which benefits are available from another source are not covered.

4. Services and supplies for which government funding of any kind is available are not covered.

5. Transportation, meals, lodging: The cost of transportation, meals, and lodging related to a human organ transplant are not covered.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS.

J. HOME HEALTH CARE

DEFINITION - "Home health care" is Medical Care provided in the patient's home in lieu of inpatient hospitalization.

To obtain benefits, the Participant must meet all of the following conditions:

1. The Participant would have to be admitted to a Hospital or skilled nursing facility if he or she did not receive home health care.
2. The Participant's home health care must be ordered by a Physician.
3. Care must be provided by a licensed home health care agency.
4. The home health care program must be directly related to the condition for which hospitalization was required.

BENEFITS -

Pre-certification by SKY 100 is required before benefits are payable. Inpatient: Not covered.

Outpatient: Benefits will be provided only for the following services:

1. Nursing Care: Part-time or periodic home nursing care. A registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed public nurse, or a licensed vocational nurse under the supervision of a registered nurse may provide the service.

2. Home Health Aide Care: Part-time or periodic care by home health aides.

3. Rehabilitative Care: Physical, occupational, or speech therapy, if provided by the home health care agency.

4. Medical Supplies: Medicines and medical supplies ordered by a Physician and provided by the home health care agency.

Benefits will be provided at 100% of the Allowable Charges Benefits will NOT be payable for custodial care such as the provision of meals, housekeeping or other non-medical assistance or for services provided by a member of the patient's immediate family or a person ordinarily residing in the patient's home.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

K. HOSPICE BENEFITS

DEFINITION - A "hospice" offers a coordinated program of home care for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social, and economic stresses which are often experienced during the final stages of terminal illness and during dying and bereavement.

To obtain benefits, the Participant must meet all of the following conditions:

1. The Participant must experience an illness for which the attending Physician's prognosis for life expectancy is estimated to be six months or less.
2. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.
3. The attending Physician must refer the Participant to the program and must be in agreement with the plan for treatment of the Participant’s condition.

BENEFITS -

Pre-certification by SKY 100 is required before benefits are payable. Benefits are provided for the

following:

1. Periodic nursing care by registered or practical nurses.
2. Home health aides.
3. Homemaker services.
4. Physical, occupational and respiratory therapy.
5. Medical social workers.
6. Bereavement counseling sessions for covered family members during the twelve (12) months following the death of the terminally ill patient. SKY 100 will provide benefits up to $25.00 for each bereavement counseling session for covered family members up to a limit of twelve (12) sessions.

Benefits will be provided at 100% of the Allowable Charges. These hospice benefits are in place of all other benefits provided under any other part of the Agreement for the same services.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

L. HUMAN ORGAN TRANSPLANTS

DEFINITION - "Human Organ Transplant" services are those required in connection with the replacement of a diseased human organ by transplantation of a healthy human organ from a donor. Those transplants covered under this benefit include, but are not limited to, the following:

1. Heart Transplants
2. Liver Transplants
3. Heart-Lung Transplants
4. Pancreas Transplants
5. Kidney Transplants
6. Corneal Transplants

BENEFITS -

Pre-certification by SKY 100 is required before benefits are payable. Hospital:

Inpatient and Outpatient: Benefits will be provided for recipient expenses directly related to the transplant procedure, including pre-operative and post-operative care.

Physician:

Inpatient and Outpatient: Benefits will be provided for recipient expenses directly related to the transplant procedure including pre-operative and post-operative care. Benefits will also be provided for surgical costs directly related to the donation of the organ used in a covered organ transplant procedure.

LIMITATIONS AND EXCLUSIONS –

1. Transportation, meals, lodging: The cost of transportation, meals, and lodging related to a human organ transplant are not covered.

2. Coverage of these services is subject to all SKY 100 pre- admission review and pre-certification requirements, including the use of designated facility providers.

3. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

M. LABORATORY, PATHOLOGY, X-RAY, RADIOLOGY, & MRI SERVICES

DEFINITIONS - "Laboratory" and "pathology" services are testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures which require the use of technical equipment for evaluation of body systems are also allowed as laboratory services. (Examples: electrocardiograms and electroencephalograms).

"X-ray", "radiology", and "MRI" services involve the use of radiology, nuclear medicine, and ultrasound equipment for the purpose of obtaining a visual image of internal body organs or structures, and the interpretation of these images.

BENEFITS – Benefits will be provided at 60% of the Allowable Charges after the Deductible for services provided by a Hospital or Facility Other Provider, or by a Physician, independent pathology laboratory, or independent radiology laboratory. Routine pap smears will be paid as indicated under PREVENTIVE CARE.

Pre-Admission Testing: Benefits will be provided for pre-admission testing ordered by the Participant's surgeon leading up to Surgery, if:

1. Proper diagnosis and treatment require the tests;
2. An operating room has been reserved before the tests are given; and
3. The Surgery actually takes place within seven (7) days after the tests are given.
4. Fertility Treatment and Testing

Benefits for pre-admission testing will be provided at 60% of Allowable Charges has been satisfied. If a Participant receives these tests while hospitalized, benefits will only be provided at 60% of Allowable Charges after the Deductible. Pre-admission testing that is repeated in the Hospital will *not* be paid unless medically necessary.

LIMITATIONS AND EXCLUSIONS -

1. Unrelated services: Services which are not related to a specific illness or injury are not covered.

2. Routine Examinations: Services related to routine examinations (such as yearly physicals or screening examinations for school, camp, or other activities) are not covered except as described under PREVENTIVE CARE.

3. Weight Loss Programs: SKY 100 will not pay for laboratory or X- ray services related to weight loss programs.

4. When more than one MRI is performed on the same day, benefits for the technical component will be limited to 50% of the Allowable Charge for each MRI after the first.

5. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

6. Venipuncture/Handling Fee: Charges for venipuncture, including any handling fee, will be covered only when the blood specimen is sent out to an independent laboratory.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

N. MATERNITY, COMPLICATIONS OF PREGNANCY, AND NEWBORN CARE

DEFINITIONS - "Maternity" services are those required by either female Subscribers or spouses of male Subscribers or dependent children for the diagnosis and care of a pregnancy and for delivery services.

Delivery services include the following:

1. Normal delivery.
2. Caesarean section.
3. Spontaneous termination of pregnancy prior to full term.
4. Therapeutic or elective termination of pregnancy prior to full term.
5. Ectopic pregnancies.

"Newborn" services include the following:

1. Routine nursery charges for a newborn well baby billed by a Hospital.
2. Routine care of a newborn well baby billed by a Physician.

NOTE: Under provisions of federal law, group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods.

BENEFITS -

DEDUCTIBLE: A $5,000.00 individual per year out of pocket Deductible (to be applied to out of pocket max. $7,350) will be applied to all services related to maternity care, delivery, and newborn services covered under plan. Once this Deductible has been met, Covered Services will be paid at 100% of the Allowable Charges. A $5,000.00 FAMILY, per member of family, per year out of pocket Deductible (to be applied to out of pocket max. $14,700) will be applied to all services related to maternity care, delivery, and newborn services covered under plan. Once this Deductible has been met, Covered Services will be paid at 100% of the Allowable Charges, the out of pocket does not include plan premiums, out of network provider balance billing, out of network cost-sharing, or spending for non-EHBs.

Hospital:

Inpatient: Benefits include charges for services for room expenses and ancillary services for the eligible female Participant. See ROOM EXPENSES AND ANCILLARY SERVICES.

Outpatient: The following charges are covered for the eligible female Participant:

1. Delivery in the outpatient department of a Hospital or other facility.
2. Pathology and X-ray services (see LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

Physician: The following services are covered when obtained by an eligible female Participant and billed by a Physician:

1. Delivery services (pre- and post-natal Medical Care is included in the allowance for delivery services).
2. Laboratory and X-ray services (see LABORATORY, PATHOLOGY, X-RAY AND RADIOLOGY SERVICES).

Complications of Pregnancy - Benefits for complications of pregnancy will be paid as any other illness, subject to the standard Deductible and Coinsurance requirements. Complications of pregnancy are defined as:

1. Interruption of pregnancy (i.e., missed, spontaneous, therapeutic, or elective abortions), and/or
2. Ectopic pregnancy, and/or
3. Placenta previa, and/or
4. Abruptio placenta, and/or
5. Eclampsia and toxemia, and/or
6. Hyperemesis gravidarum, and/or
7. Gestational diabetes, and/or
8. Cephalo-pelvic disproportion, and/or
9. Hydatiform mole.

Complications of Pregnancy do NOT include:
1. Fetal distress.
2. Previous Caesarian section.
3. Pre-term labor.
4. Fetal position.
5. Conditions associated with the management of a difficult or high risk pregnancy.
6. Prolonged or difficult labor.
7. All other conditions not specifically set forth as "Complications of Pregnancy".

Newborn Care - Newborn care includes the following:

1. Routine nursery charges billed by a Hospital.

2. Routine inpatient care of the newborn child and standby care of a pediatrician at a caesarean section.

LIMITATIONS AND EXCLUSIONS -
1. Artificial conception: Benefits will not be provided for artificial insemination, in vitro ("test tube") fertilization, or other artificial methods of conception.

2. Genetic and chromosomal testing or counseling: Genetic molecular testing is not covered except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

   As used herein, “genetic molecular testing” means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.

3. Dependent children are not eligible for maternity-related benefits.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

O. MEDICAL CARE FOR GENERAL CONDITIONS

DEFINITIONS - "Inpatient Medical Care" expenses are those billed by a Physician for services provided while a Participant is confined as an Inpatient in a Hospital for a condition which does not require Surgery. For services provided by a Hospital, inpatient Medical Care includes both medical and surgical services.

"Outpatient Medical Care" expenses are those billed by a Physician, Other Professional Provider, Hospital, or Other Facility Provider for services rendered in the provider's office, the outpatient department of a Hospital or Other Facility Provider, or in the Participant's home, for a condition which does not require Surgery.

BENEFITS -

Hospital:

Inpatient: Benefits include charges for the room allowance and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

If a Physician recommends that a Participant be hospitalized (for a non-maternity or non- emergency condition), services MUST be submitted in advance to Sky 100's pre-admission review program. See PRE-ADMISSION REVIEW under SECTION
VII. HOW BENEFITS WILL BE PAID.

Outpatient: Benefits will be provided for Medical Care rendered at a Hospital or Other Facility Provider when medically necessary.

Physician:

Inpatient: Benefits will be provided for care by a Physician in a Hospital for:

1. A condition requiring only Medical Care, or
2. A condition that, during an admission for Surgery, requires Medical Care not normally related to surgical care. This is only payable after approval by Sky 100's Medical Review Department.
3. Only one medical visit per day when charged by the same Physician will be covered.

Inpatient Medical Care benefits will be payable for one Physician per covered hospitalization. (See CONSULTATIONS if more than one Physician is involved.)

NOTE: If a Physician recommends that a Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Sky 100's pre- admission review program. See PRE-ADMISSION REVIEW under SECTION
VII. HOW BENEFITS WILL BE PAID.

Outpatient: Benefits will be provided for Medical Care by a Physician when required for the treatment of a specific illness or injury.

Covered Services for spinal manipulations are limited to fifteen (15) visits per Participant per calendar year.

LIMITATIONS AND EXCLUSIONS -

1. Private Room Expenses: If a Participant has a private room in a Hospital, covered charges under this Agreement are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

2. Routine Examinations: Services related to routine examinations and immunizations (such as yearly physicals or screening examinations for school, camp or other activities) are not covered except as described under PREVENTIVE CARE.

3. Eye Care: Pediatric eye care (two vision exam, one frame, one pair of lenses, or contact lenses (as needed) per calendar year), services will be covered for the condition of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia**.**

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

P. MENTAL / AUTISM HEALTH OR SUBSTANCE USE DISORDER CARE

DEFINITIONS – "Mental (to include autism) health or substance use disorder" is a condition requiring specific treatment primarily because the Participant requires psychotherapeutic treatment, rehabilitation from a substance use disorder or both.

"Mental health benefits" means benefits with respect to services for mental health conditions as defined under the terms of this Agreement and in accordance with any applicable Federal and State Law.

"Substance use disorder benefits" means benefits with respect to services for substance use disorders as defined under the terms of this Agreement and in accordance with any applicable Federal and State Law.

"Inpatient care" expenses are those billed by a Physician, Professional Other Provider, Hospital, or Facility Other Provider while the Participant is confined as an Inpatient.

"Outpatient care" expenses are those services billed by a Physician, Professional Other Provider, Hospital, or Facility Other Provider, for services provided in either the Physician's or Professional Other Provider's office, the outpatient department of a Hospital, or Facility Other Provider, or the Participant's home.

BENEFITS -

Inpatient:

Hospital: Benefits will be provided based on the Allowable Charge per calendar year.

Physician or Professional Other Provider: Benefits will be provided based on the Allowable Charge per Participant per calendar year.

Shock therapy will be considered as one (1) inpatient day when provided by a Physician or Professional Other Provider.

Intensive Outpatient: Benefits will be provided based on the Allowable Charge for intensive outpatient services provided by a Hospital or Facility Other Provider.

Other Outpatient or Office: Benefits will be provided at **60**% of the Allowable Charge

100% of the Allowable Charge will be applied toward your out-of-pocket.

LIMITATIONS AND EXCLUSIONS -

1. Diagnosis: Services must be for the diagnosis and/or treatment of manifest mental disorders. These disorders are described in two publications:

    a. The most current edition of the International Classification of Diseases Adapted (Public Health Service Publication No. 1693).

    b. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

2. Educational Credits: Benefits will not be paid for psychoanalysis or medical psychotherapy that can be used as credit towards earning a degree or furthering a Participant's education or training. (It makes no difference what the diagnosis is or what symptoms may be present.)

3. Marital Counseling: Benefits will not be paid for marital counseling or related services.

4. Professional Services: Professional services must be performed by a Physician or Professional Other Provider who is properly licensed or certified. A Professional Other Provider must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All providers, whether performing services or supervising the services of others, must be acting within the scope of their license.

5. Tobacco Dependency: Benefits will not be paid for services, supplies, or drugs related to tobacco dependency except as described under PREVENTIVE CARE.

6. The calendar year maximums cited for inpatient, intensive outpatient, and other outpatient and office services include all services provided for both mental health and substance use disorder care.

7. Co-dependency Treatment: Services related to the treatment of the family of a person receiving treatment for nicotine, chemical, or alcohol dependence are not covered.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

Q. PRESCRIPTION DRUGS AND MEDICINES

"Prescription Drugs and medicines" are medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber. All drugs and medicines must be approved by the Food and Drug Administration for the condition for which they are prescribed and not be identified as "investigational" or "experimental".

SKY 100 may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain covered Prescription Drugs. Such discounts are the sole property of SKY 100 and will not be considered in calculating any Participant's Coinsurance, Copayment, or benefit maximums. Any funds generated through pharmaceutical manufacturer discounts will be credited to the pharmaceutical drug claims experience of the Group plan.

A. BENEFITS AVAILABLE THROUGH THE Optum Rx RETAIL PHARMACY PROGRAM

Prescription Drugs and medicines are covered by Optum Rx when purchased from a Participating Pharmacy. When a Participant needs a prescription filled, the Participant should go to a Participating Pharmacy and present his or her membership card with the Optum Rx logo. The Participating Pharmacy will only charge for the Copayment and Coinsurance as shown below. The Pharmacy will be reimbursed for the remaining balance. When Prescription Drugs and medicines are covered through Optum Rx, the Pre- existing Conditions clause as defined in this Agreement will be waived for such Prescription Drugs and medicines.

Benefits for Prescription Drugs and medicines purchased through a Participating Pharmacy are based on Allowable Charges and payable as follows:

1. Tier 1 Drugs: Covered generic drugs require a $ 7.00 Copayment and 40% of Allowable Charges as Coinsurance.
   Tier 2 Drugs: Covered Formulary brand drugs require a $20.00 Copayment and 40% of Allowable Charges as Coinsurance.
   Tier 3 Drugs: Covered non-Formulary brand drugs require a $45.00 Copayment and 40% of Allowable Charges as Coinsurance.

   Insulin and diabetic supplies are considered to be covered under Optum Rx benefits. Prescription birth control products that are self-administered and do not require the services of a Physician beyond the writing of the prescription (for example: oral medication, patches, and the Nuvaring), are also covered. Tier 1 and Tier 2 prescription birth control products prescribed for the purpose of contraception will be covered as indicated under PREVENTIVE CARE.

   Formulary drugs are determined by Sky 100. Copayments and Coinsurance for covered Prescription Drugs and medicines under this benefit cannot be

applied toward the Deductible or Coinsurance Maximum requirements of any other benefit of this Agreement.

2. If the Participant chooses a brand drug (whether Tier 2 or Tier 3) when a generic drug is available and authorized by the Physician, the Participant must pay the appropriate Copayment and Coinsurance for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug. When the out-of-pocket maximum has been reached, the Participant still pays the difference in cost between the brand name and the generic drug, even though the Participant is no longer responsible for Prescription Drug Copayments and Coinsurance.
3. The Maximum amount or quantity of Prescription Drugs that will be considered as eligible charges may not exceed a ninety (90) day supply when taken in accordance with the direction of the prescriber. A Copayment will be collected for each thirty (30) day supply.
4. The total Copayment and Participant's Coinsurance expenses for Optum Rx and the Mail Service Prescription Drug Program for which Participants are responsible are limited to an out-of-pocket maximum of $2,500.00 per covered Participant per calendar year.

If a Participant must purchase drugs from a non-participating Pharmacy, SKY 100 can provide the Participant with special claim forms to obtain benefits under this section of the Agreement. The claim forms must be sent to the address indicated on the form. When using a non-participating Pharmacy, the Participant will be responsible for the difference between Optum Rx Allowable Charge and the actual charge made by the Pharmacy. When the out-of-pocket maximum has been reached, the Participant still pays the difference between Optum Rx Allowable Charge and the actual charge made by the Pharmacy, even though the Participant is no longer responsible for Prescription Drug Copayments and Coinsurance.

B. BENEFITS AVAILABLE THROUGH THE OPTUM RX MAIL SERVICE PHARMACY PROGRAM:

Prescription Drugs and medicines taken on a long term basis ("maintenance drugs") may be purchased through the Mail Service Prescription Drug Program. The Pre-existing Condition clause as defined in this Agreement will be waived for those drugs purchased through the Mail Service Prescription Drug Program.

Insulin and diabetic supplies are considered to be covered under Optum Rx benefits. Prescription birth control products that are self-administered and do not require the services of a Physician beyond the writing of the prescription (for example: oral medication, patches, and the Nuvaring), are also covered. Tier 1 and Tier 2 prescription birth control products prescribed for the purpose of contraception will be covered as indicated under PREVENTIVE CARE.

Benefits for Prescription Drugs and medicines purchased through the Mail Service Prescription Drug Program are based on Allowable Charges and payable as follows:

1. Tier 1 Drugs: Covered generic drugs require a $ 7.00 Copayment and 40% of Allowable Charges as Coinsurance.

Tier 2 Drugs: Covered Formulary brand drugs require a $20.00 Copayment and 40% of Allowable Charges as Coinsurance.

Tier 3 Drugs: Covered non-Formulary brand drugs require a $45.00 Copayment and 40% of Allowable Charges as Coinsurance.

Formulary drugs are determined by Sky 100. Copayments and Coinsurance for covered Prescription Drugs and medicines under this benefit cannot be applied toward the Deductible or Coinsurance Maximum requirements of any other benefit of this Agreement.

2. If the Participant chooses a brand drug (whether Tier 2 or Tier 3) when a generic drug is available and authorized by the Physician, the Participant must pay the appropriate Copayment and Coinsurance for the brand drug selected, as well as the difference in cost between the brand drug and the generic drug. When the out-of-pocket maximum has been reached, the Participant still pays the difference in cost between the brand name and the generic drug, even though the Participant is no longer responsible for Prescription Drug Copayments and Coinsurance.
3. The maximum amount or quantity of Prescription Drugs that will be considered as eligible charges may not exceed a 90 day supply when taken in accordance with the directions of the prescriber.
4. The total Copayment and Participant's Coinsurance expenses for Optum Rx and the Mail Service Prescription Drug Program for which covered employees and Dependents are responsible are limited to a maximum of $2,500.00 per covered Participant per calendar year.

LIMITATIONS AND EXCLUSIONS -

1. Non-Prescription Items: SKY 100 will not cover drugs and medicines that can be purchased without a written prescription, even if the Physician has prescribed such "over-the-counter" medications, except as described under PREVENTIVE CARE.

2. Take-Home Drugs: Drugs and medicines which are provided as "take-home supply" by the Hospital are not covered under Optum Rx.

3. Weight loss: Prescription Drugs and medicines related to weight loss programs are not covered.

4. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

5. Hair Loss: Prescription Drugs and medications related to hair loss are not covered.

6. Tobacco Dependency: Prescription Drugs and medications related to tobacco dependency are not covered except as described under PREVENTIVE CARE.

7. Cosmetic Drugs: Prescription Drugs and medicines used for cosmetic purposes are not covered.

8. Orthomolecular Therapy: Orthomolecular therapy, including nutritional supplements, vitamins and food supplements, is not covered.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

R. PREVENTIVE HEALTH SERVICES

DEFINITION - "Preventive Health Services" includes the preventive health services recommended by:

1. (a) United States Preventive Services Task Force (USPSTF) recommendations Grade A and B only;

   (b) Center for Disease Control and Prevention's (CDC) and Prevention's Advisory Committee on Immunization Practices' (ACIP) recommendations for immunizations;

   (c) Heath Resources and Services Administrations' (HRSA) recommendations for children and women preventive care and screenings;

2. (a) Testing procedures and examinations for cervical cancer and diabetes;

   (b) Testing procedures and examinations for Subscribers and covered spouses for breast cancer and prostate cancer.

BENEFITS – When PREVENTIVE CARE is provided by Participating providers or by a health fair including, but not limited to, the Texas Health Fair, benefits will be provided at 100% of the Allowable Charges for Covered Services without regard to any Deductible, Copayment or Coinsurance that might otherwise apply.

LIMITATIONS AND EXCLUSIONS

2. PREVENTIVE CARE provided by participating & non-participating providers: Benefits will be covered at 100%. .

3. Except for childhood screenings required due to recommendations by the HRSA, benefits are provided under PREVENTIVE CARE for either eye care (two vision exam, one frame, one pair of lenses, per calendar year) or dental services (two oral examination per calendar year, two Prophylaxis, wing bite x-rays no more than two sets per year, emergency palliative treatment, fluoride treatments, space maintainers, sealant one per un-restored permanent molar every 36 months subject to cost sharing amounts, full month x-rays but not more than one (1)set in thirty-six (36) consecutive months, x-rays required in connection with diagnosis of a specific condition requiring treatment, except x-rays provided in connection with orthodontic procedures and treatment, extractions except extractions for orthodontic; oral surgery excluding procedures covered under the Dental Services portion of this Benefit Document; Fillings including silver amalgam, silicate, acrylic, plastic, composite except gold; General anesthetics; Periodontal treatment, diseases of gums; Endodontic treatment (Pulp infection and root canal therapy); Injection of antibiotic drugs; Prosthodontic Treatment; Initial installation of fixed bridgework; Initial installation of partial or full removable dentures; Inlays, onlays, crowns, Gold fillings; Repair or replacement or addition to bridgework; dentures, crowns, inlays including re-cementing where necessary because of (a.) one (1) or more teeth extracted after existing denture or bridgework was installed; (b) Existing denture or bridgework was installed five

(5) years prior to its replacement and cannot be made serviceable; and Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth) when determined to be dental necessity and Pre-certification is obtained.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

S. PRIVATE DUTY NURSING SERVICES

DEFINITION - "Private duty nursing services" are those which require the training, judgment and technical skills of an actively practicing Registered Nurse (R.N.). They must be prescribed by the attending Physician for the continuous treatment of a condition.

BENEFITS -

Inpatient: Benefits will be provided for private duty nursing services only when:

1. The Participant's condition would ordinarily require that the Participant be placed in an intensive or coronary care unit, but the Hospital does not have such facilities, or
2. The Hospital's intensive or coronary care unit cannot provide the level of care necessary for the Participant's condition.
3. The private duty nurse is not employed by the Hospital or Physician and is not a resident of the household or a relative of the Participant.

Outpatient: Not covered.

LIMITATIONS AND EXCLUSIONS -

1. Alternative Care: Benefits will not be provided for nursing services which ordinarily would be provided by Hospital staff or its intensive care or coronary care units.

2. Claims Review: SKY 100 will review all claims for appropriateness and Medical Necessity.

3. Non-Covered Services: Benefits will not be provided for services which are requested by or for the convenience of the Participant or the Participant's family. (Examples: bathing, feeding, exercising, homemaking, moving the Participant, giving medication, or acting as a companion or sitter.) In other words, services which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not covered.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

T. REHABILITATION / HABILITATION

DEFINITION - Services primarily for the purpose of receiving therapeutic or rehabilitative treatment (such as physical, occupational, speech, or oxygen therapy, etc.).

BENEFITS -

Inpatient: Benefits will be provided to a maximum of forty-five (45) days per calendar year per Participant.

Outpatient: Benefits will be provided to a maximum of twenty (20) visits per calendar year per Participant.

LIMITATIONS AND EXCLUSIONS -

Benefits are only provided for CVA (Cerebral Vascular Accidents), head injury, spinal cord injury or as required as a result of post-operative brain Surgery.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

U. ROOM EXPENSES AND ANCILLARY SERVICES

DEFINITION - "Room expenses" include such items as the cost of a room, general nursing services, meal services for the Participant, and routine laundry service.

"Ancillary services" are those services and supplies (in addition to room services) that Hospitals and Other Facility Providers bill for and regularly make available to Participants when such services are provided for the treatment of the condition for which the Participant requires care. Such services include, but are not limited to:

1. Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
2. Drugs and medicines, biologicals, and pharmaceuticals.
3. Dressings and supplies, sterile trays, casts, and splints.
4. Diagnostic and therapeutic services.
5. Blood administration.
6. Intensive and coronary care units.

BENEFITS -

Inpatient:

Pre-Admission Review: If a Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-accidental condition), services MUST be submitted in advance to Sky 100's pre-admission review program. See PRE- ADMISSION REVIEW under SECTION VII. HOW BENEFITS WILL BE PAID.

Outpatient: Ancillary services billed by a Hospital or Facility Other Provider are covered. For additional outpatient benefits, see the following sections:

1. Laboratory, pathology, X-ray, and radiology services.
2. Therapies.

LIMITATIONS AND EXCLUSIONS -

1. Medical Care for General Conditions: All benefits for room expenses and ancillary services related to general conditions are paid according to MEDICAL CARE FOR GENERAL CONDITIONS.

2. Mental Health or Substance Use Disorders: All benefits for room expenses and ancillary services related to these conditions are paid according to the section of this Agreement titled MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE.

3. Personal or Convenience Items: Benefits will not be provided for services and supplies provided for personal convenience which are not related to the treatment of the Participant's

condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, and televisions.)

4. Private Room Expenses: If the Participant has a private room in a Hospital, Allowable Charges under the Agreement are limited to the Hospital's average semi-private room rate, whether or not a semi-private room is available.

5 Skilled Nursing Facilities: Services or supplies provided by skilled nursing facilities, extended care facilities, or similar institutions are not covered except as described under PRUDENT MEDICAL CARE in the GENERAL PROVISIONS section of this Agreement.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

V. SUPPLIES, EQUIPMENT AND APPLIANCES

DEFINITION - "Medical supplies" are expendable items (except Prescription Drugs) which are required for the treatment of an illness or injury.

"Durable medical equipment" is any equipment that can withstand repeated use, is made to serve a medical purpose, and is useless to a person who is not ill or injured, and is appropriate for use in the home.

"Prosthesis" is any device that replaces all or part of a missing body organ or body member.

"Orthopedic appliance" is a rigid or semi-rigid support. It is used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

BENEFITS -

1. Durable medical equipment – Benefits will be provided for either the rental or the purchase of durable medical equipment, whichever is less expensive. When a purchase is authorized, benefits will also be provided for repair, maintenance, replacement, and adjustment of the equipment.
2. Medical supplies, including but not limited to:

    a. Colostomy bags and other supplies for their use.
    b. Catheters.
    c. Dressings for cancer, diabetic and decubitus ulcers and burns.
    d. Syringes and needles for administering covered drugs, medicines, or insulin.

3. The following prosthesis and orthopedic appliances are covered, as well as fitting, adjusting, repairing, and replacement due to wear, or a change in the Participant's condition which makes a new appliance necessary.

    a. Artificial arms or legs.
    b. Leg braces, including attached shoes.
    c. Arm and back braces.
    d. Cervical collars.
    e. Surgical implants.
    f. Artificial eyes.
    g. Pacemakers
    h. Breast prosthesis and special bras.

4. One set of prescription glasses, intraocular lenses or contact lenses is covered when necessary to replace the human lens lost through intraocular Surgery or ocular injury. Replacement is covered if the Participant's Physician recommends a change in prescription.

5. Oxygen - SKY 100 will pay for oxygen and the equipment needed to administer it.

6. Breast pumps as indicated under PREVENTIVE CARE.

LIMITATIONS AND EXCLUSIONS -

1. Deluxe or Luxury Items: If the supply, equipment, or appliance which the Participant orders includes more features than are warranted for the Participant's condition, SKY 100 will allow only up to Allowable Charges for the item that would have met the Participant's medical needs. (Examples of deluxe or luxury items: Motorized equipment when manually operated equipment can be used, and wheelchair "sidecars.")

   Deluxe equipment is covered only when additional features are required for effective medical treatment, or to allow the Participant to operate the equipment without assistance.

2. Durable Medical Equipment: Items such as air conditioners, purifiers, humidifiers, dehumidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices which are not medical in nature are not covered, regardless of the relief they may provide for a medical condition.

3. Hearing Aids: Prescriptions for hearing aids and related services and supplies are not covered.

4. Hospital Beds: Benefits will not be provided for Hospital beds (including waterbeds or other floatation mattresses).

5. Medical Supplies: Items that would not serve a useful medical purpose, or which are used for comfort, convenience, personal hygiene, or first aid are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, antiseptics.)

6. Special Braces: Benefits will not be provided for special braces or special equipment.

See SECTION IX. WHAT SKY 100 WILL NOT PAY FOR - GENERAL LIMITATIONS AND EXCLUSIONS

W. SURGERY and Cleft lip/Cleft Palate

DEFINITION - "Surgery" is an operating (cutting) procedure for treatment of diseases or injuries, including specialized instrumentations, endoscopic examinations and other invasive procedures, the correction of fractures and dislocations, usual and related pre-operative and post-operative care.

BENEFITS

Hospital:

Inpatient: Benefits include charges for the room allowance and covered ancillary services (see ROOM EXPENSES AND ANCILLARY SERVICES).

If a Participant's Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition), services MUST be submitted in advance to Sky 100's pre-admission review program. See PRE-ADMISSION REVIEW under SECTION VII. HOW BENEFITS WILL BE PAID.

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, benefits will be provided according to where services are rendered as follows:

1. Services performed in the Physician's office or at an Ambulatory Surgical Facility will be payable at 60% of the Allowable Charges with zero Deductible.
2. Services performed in the outpatient department of a Hospital will be payable at 60% of the Allowable Charges with zero Deductible.

Physician:

Inpatient: The Allowable Charge for Surgery performed by a Physician includes payment for pre-operative visits, local administration of anesthesia, follow-up care and recasting.

If a Participant's Physician recommends that the Participant be hospitalized (for any non- maternity or non-emergency condition), services MUST be submitted in advance to Sky 100's pre-admission review program. See PRE-ADMISSION REVIEW under SECTION VII. HOW BENEFITS WILL BE PAID.

More than one Surgery performed by the same Physician during the course of only one operative period is called a "multiple surgery." Since allowances for Surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced as pre- and post-surgery allowances do not duplicate those of the primary Surgery. The reduced benefit varies, depending upon the circumstances of the multiple surgeries.

Outpatient: If a Participant undergoes a surgical procedure as an Outpatient, benefits will be provided according to where services are rendered as follows:

1. Services performed in the Physician's office or at an Ambulatory Surgical Facility will be payable at 60% of the Allowable Charges with zero Deductible.
2. Services performed in the outpatient department of a Hospital will be payable at 60% of the Allowable Charges after the Deductible.

LIMITATIONS AND EXCLUSIONS -

1. Cosmetic Surgery: "Cosmetic surgery" is beautification or aesthetic Surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery does not become reconstructive surgery because of psychiatric or psychological reasons.

   Coverage of cosmetic surgery is subject to all SKY 100 pre-admission review and pre-certification requirements, including the use of designated facility providers.

   Benefits for an approved cosmetic surgery procedure and related expenses are allowed only when reconstructive surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Reconstructive surgery will only be provided for the diseased body part except as noted below.

   NOTE: Subject to pre-certification by Sky 100, any Participant who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with federal law:

   a. Reconstruction of the breast on which the mastectomy has been performed,
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
   c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

2. Dental Surgery: For a complete description of benefits allowed for dental services, see DENTAL SERVICES.

3. Incidental Procedures: Incidental procedures are those that are routinely performed during the course of the primary Surgery. Additional benefits are not allowed for these procedures.

4. Obesity and Weight Loss: Benefits will be provided for Surgery required as the result of obesity only as specified in SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS.

5. Organ Transplants: See section on HUMAN ORGAN TRANSPLANTS.

6. Private Room Expenses: If the Participant has a private room in a Hospital, Allowable Charges are limited to the semi-private room allowance, whether or not a semi-private room is available.

7. Sex-Change Operations: Benefits will not be provided for sex change operations, or related expenses.

8. Sterilization Procedures: Sterilization procedures and related expenses will be covered. See PREVENTIVE CARE for certain Sterilization Procedures covered at 100% of the Allowable Charges for Covered Services without regard to Deductible, Copayment or Coinsurance that might otherwise apply. Reversals of sterilization procedures are not covered.

9. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

X. SURGICAL ASSISTANTS

DEFINITION - A "surgical assistant" is either a licensed Physician who actively assists the operating surgeon in the performance of a covered surgical procedure or a specially trained individual (physician's assistant or registered nurse) who has met the necessary certification or licensure qualifications in the state where the services are being performed.

BENEFITS -

Inpatient and Outpatient: Covered when services are provided by a Physician, physician's assistant, or registered nurse according to where services are rendered as follows:

1. Services performed in the Physician's office or at an Ambulatory Surgical Facility will be payable at 60% of the Allowable Charges.
2. Services performed in the outpatient department of a Hospital will be payable at 60% of the Allowable Charges.

NOTE: Benefits for surgical assistant services performed by another Physician will be based on 20% of the surgery allowance. Benefits for services performed by a Professional Other Provider will be based on 10% of the surgery allowance.

LIMITATIONS AND EXCLUSIONS -

1. Eligible Procedures: Surgical assistant benefits are available only for surgical procedures which are of such complexity that they require a surgical assistant as specified in the Medicare Correct Coding Initiative.

2. Other: The "limitations and exclusions" that apply to SURGERY benefits also apply to surgical assistant services.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

Y. THERAPIES
(CHEMOTHERAPY, RADIATION, OCCUPATIONAL, PHYSICAL, SPEECH)

DEFINITIONS - "Chemotherapy" is drug therapy administered as treatment for conditions of certain body systems.

"Radiation therapy" is the treatment for malignant diseases and other medical conditions by means of X-ray, radon, cobalt, betatron, telecobalt, and telecesium, as well as radioactive isotopes.

"Respiratory therapy" is the treatment of respiratory illness and/or disease by the use of inhaled oxygen and/or medication. The equipment used is necessary to allow adequate oxygen to be delivered to the lungs in an effort to appropriately oxygenate the blood.

"Occupational therapy" uses educational, vocational, and rehabilitative techniques in order to improve a patient's functional ability to achieve independence in daily living.

“Physical therapy” involves the use of physical agents for the treatment of disability resulting from disease or injury. Physical therapy also includes services provided by occupational therapists when performed to alleviate suffering from muscle, nerve, joint and bone diseases and from injuries. Some examples of physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet, radiation, massage, and therapeutic exercise.

"Speech therapy" (also called speech pathology) includes those services used for diagnosis and treatment of speech and language disorders which result in difficulty in communication.

BENEFITS -

Hospital:

Inpatient: When provided by a Hospital and related to improvement of the condition for which the Participant is admitted, the following types of therapy are covered:

1. Chemotherapy.
2. Radiation therapy.
3. Physical therapy.
4. Respiratory therapy.

Outpatient: When provided by a Hospital or other facility, the following types of therapy are covered:

1. Chemotherapy (drug and administration charges).
2. Radiation therapy.
3. Physical therapy provided by a registered physical therapist or Physician.
4. Respiratory therapy.

Physician:

Inpatient: When provided by a Physician, the following types of therapy are covered:

1. Chemotherapy.

2. Radiation therapy.

3. Respiratory therapy.

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

1. Chemotherapy (drug and administration charges).

2. Radiation therapy.

3. Physical therapy provided by a Physician or by a registered physical therapist

4. Respiratory therapy.

NOTE: Outpatient physical therapy (physiotherapy) is limited to forty (40) treatments per calendar year.

LIMITATIONS AND EXCLUSIONS -

1. Occupational and Speech Therapy: Benefits will not be provided for occupational or speech therapy services (except as described under REHABILITATION).

2. For high dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support, please see HIGH DOSE CHEMOTHERAPY AND/OR RADIATION THERAPY.

See SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

SECTION IX. GENERAL LIMITATIONS AND EXCLUSIONS

The general limitations and exclusions listed in this section apply to all benefits described in this Agreement. In accordance with the provisions of this Agreement, therefore, benefits will not be provided for any of the following services, supplies, situations, hospitalizations or related expenses:

A. *ACUPUNCTURE*
Services related to acupuncture, whether for medical or anesthesia purposes are not covered.

B. *ALTERNATIVE MEDICINE*
Treatments and services for alternative medicine are not covered benefits under this Agreement. Alternative medical therapies include, but are not limited to: interventions, services or procedures not commonly accepted as part of allopathic or osteopathic curriculums and practices, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies, massage therapy, and aromatherapy.

C. *ARTIFICIAL CONCEPTION*
Artificial insemination, "test tube" fertilization or other artificial methods of conception are not covered.

D. *AUTOPSIES*
Services related to autopsies are not covered.

E. *BIOFEEDBACK*
Services related to biofeedback are not covered.

F. *CARDIAC REHABILITATION*
Services designed to assist Participants recovering from recent heart problems are not covered.

G. *COMPLICATIONS OF NON-BENEFIT SERVICES*
Services or supplies that a Participant receives for complications resulting from services that are not allowed (such as non-covered cosmetic surgery and experimental procedures) are not covered.

H. *CONVALESCENT CARE*
Convalescent care is that care provided during the period of recovery from illness or the effects of injury and Surgery. Benefits for convalescent care are limited to those normally received for a specific condition, as determined by Sky 100's medical consultants.

I. *COSMETIC SURGERY*
Cosmetic Surgery: "Cosmetic surgery" is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic

surgery does not become reconstructive surgery because of psychiatric or psychological reasons.

Benefits for a cosmetic surgery procedure and related expenses are allowed only when reconstructive surgery is required as the result of a birth defect, accidental injury, or a malignant disease process or its treatment. Reconstructive surgery will only be provided for the diseased body part except as noted below. Pre-certification by SKY 100 is required before benefits are payable.

NOTE: Any Participant who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with the covered mastectomy shall also be covered for the following in accordance with federal law:

a. Reconstruction of the breast on which the mastectomy has been performed,
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

J. CUSTODIAL CARE

Services furnished to help a Participant in the activities of daily living which do not require the continuing attention of skilled medical or paramedical personnel are not covered regardless of where they are furnished.

K. DIAGNOSTIC ADMISSIONS

If a Participant is admitted as an Inpatient to a Hospital for diagnostic procedures, and could have received these services as an Outpatient without danger to his or her health, benefits will not be provided for Hospital room charges or other charges that would not be paid if the Participant had received Diagnostic Services as an Outpatient.

L. DOMICILIARY CARE

This type of care is provided in a residential institution, treatment center, or school because a Participant's own home arrangement is not appropriate. Such care consists chiefly of room and board and is not covered, even if therapy is included.

M. EDUCATIONAL PROGRAMS

Educational, vocational, or training services and supplies are not covered except as explicitly described in the Agreement.

N. ENVIRONMENTAL MEDICINE

Treatment and services for environmental medicine and clinical ecology are not covered benefits under this Agreement. Environmental medicine and clinical ecology encompass the diagnosis or treatment of environmental illness, including, but not limited to: chemical sensitivity or toxicity from past or continued exposure to atmospheric contaminants, pesticides, herbicides, fungi, molds, or foods exposed to atmospheric or environmental contaminants.

O. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Procedures which are experimental or investigational in nature as defined in SECTION III. are not covered.

P. EYE CARE

Except as described under PREVENTIVE CARE, services will not be covered for the conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia and presbyopia. Benefits will not be provided for refractions, eye glasses, contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, orthoptic training, servicing of visual corrective devices or consultations related to such services.

Q. FOOT CARE SERVICES

Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot (orthotics), the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered.

R. GENETIC AND CHROMOSOMAL TESTING/COUNSELING

Genetic molecular testing is not covered except when there are signs and/or symptoms of an inherited disease in the affected individual, when there has been a physical examination, pre-test counseling, and other diagnostic studies, and when the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

As used herein, "genetic molecular testing" means the analysis of nucleic acids to diagnose a genetic disease, including, but not limited to, sequencing, methylation studies, and linkage analysis.

S. GOVERNMENT INSTITUTIONS AND FACILITIES

Services and supplies furnished by a facility operated by, for, or at the expense of a federal, state, or local government or their agencies are not covered except as required by the federal, state, or local government. Benefits shall not be excluded when provided by, and when charges are made for such services by, a Texas tax-supported institution, providing the institution establishes and actively utilizes appropriate professional standard review organizations according to Section 35-17-101, Texas Statutes, 1977, as amended, or comparable peer review programs, and the operation of the institution is subject to review according to Federal and State laws.

T. HAIR LOSS

Wigs or artificial hairpieces, or hair transplants or implants, regardless of whether there is a medical reason for hair loss, are not covered.

U. HOSPITALIZATIONS

Hospitalizations, or portions thereof, which do not require 24-hour continuous bedside nursing care, or hospitalizations for services which could be safely provided on an outpatient basis, are not covered.

V. HYPNOSIS

Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

W. LEARNING DISABILITIES

Treatment for the reduction or elimination of learning disabilities is not covered.

X. LEGAL PAYMENT OBLIGATIONS

Services for which legally a Participant does not have to pay, or charges that are made only because benefits are available under this Agreement are not covered except as required by the federal, state, or local government. This includes services provided by any person related to the Participant or residing in the Participant's household.

Y. MEDICAL SERVICES RECEIVED AS A RESULT OF CONTRACTUAL OBLIGATIONS OR A THIRD PARTY'S GUARANTEE TO PAY

Benefits will not be paid for any claims related to medical services or supplies that a Participant receives in relation to a third party's offer of any form of compensation or promise to pay any part or all of the costs of the medical services or supplies, as an inducement for the Participant to seek, request, undergo or otherwise receive those medical services or supplies. This exclusion includes, but is not limited to, surrogate parenting, donation of body parts or organs, testing of medical procedures or supplies, gestational carrier services, pharmaceutical product testing and trials, and similar arrangements and agreements wherein the Participant receives compensation, directly or indirectly, in cash or any other form of consideration (including a promise to pay any part or all of the costs of such medical services or supplies), in exchange for the Participant's agreement to seek or receive such medical services or supplies.

Z. MEDICALLY NECESSARY SERVICES OR SUPPLIES

No benefits will be provided for services or supplies that are not medically necessary. (See SECTION III., DEFINITIONS.)

AA. OBESITY AND WEIGHT LOSS

Obesity in itself is not considered an illness or disease, and benefits are not allowed for the evaluation and treatment of obesity alone. The only situation under which benefits will be allowed for obesity is when a surgical procedure is required due to morbid obesity. Benefits will only be paid when:

1. The plan will provide surgery for obesity will be a covered service when required due to morbid obesity and benefits will be paid when the participant meets the current NIH (National Institutes of Health) surgical criteria:

   Bariatric Surgery may be an option for adults who have a body mass

index (BMI) of 40 or more; or a BMI of 35 or more with the serious health problem linked to obesity, such as type 2 diabetes, heart disease or sleep apnea; or a BMI of 30 or more with a serious health problem linked to obesity, for the gastric band only.

Surgery may be an option for teens who have gone through puberty and reached their adult height, and have a BMI of 35 or more with serious obesity related health problems, such as type 2 diabetes or severe sleep apnea; or a BMI of 40 or more with less sever health problems, such as high blood pressure or high cholesterol.

2. The condition of morbid obesity must be of at least five years duration.
3. Non-surgical methods of weight reduction must have been unsuccessfully attempted for at least five years under a Physician's supervision.
4. Pre-certified by Sky 100.

NOTE: The number of gastric bypass procedures covered under this Agreement is limited to a lifetime maximum of one (1) per Participant.

BB. ORTHOGNATHIC SURGERY

The following types of procedures are not covered except in the case of a congenital defect or restoration due to accidental injury:

1. Upper or lower jaw augmentation or reduction procedures, or
2. Reconstructive procedures which correct deformities of the jaw, or
3. Procedures related to facial skeleton and associated soft tissues (surgical procedures may include, but not be limited to, procedures involving repositioning and recontouring of the facial bones)

Pre-certification by Sky 100 is required before benefits are payable.

CC. PERSONAL COMFORT OR CONVENIENCE

Services and supplies that are primarily for the Participant’s personal comfort or convenience are not covered.

DD. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Services rendered by a physician assistant or nurse practitioner when the sponsoring Physician sees the patient or becomes directly involved in the medical service being provided are not covered. (A sponsoring Physician is a licensed Physician approved to sponsor a physician assistant by the State Board of Medical Examiners.)

EE. PRE-ADMISSION REVIEW

If the Participant’s Physician recommends that the Participant be hospitalized (for any non-maternity or non-emergency condition) services MUST be submitted in advance to Sky 100's pre-admission review program.

SKY 100 will *reduce benefits by $ 200.00* if the

Participant does NOT obtain pre-admission review from SKY 100 and is hospitalized as an Inpatient.

FF. PRE-CERTIFICATION

The following services MUST be authorized in advance as described in the BENEFITS section before benefits will be paid:

1. Breast reconstruction surgery
2. Cosmetic surgery
3. Dental-related services
4. High cost prescription drugs and medicines
5. High dose chemotherapy and/or radiation therapy with bone marrow transplant and/or peripheral stem cell support
6. Home Health Care
7. Hospice Care
8. Human organ transplants
9. Obesity and weight loss services
10. Orthognathic surgery

GG. PRE-EXISTING CONDITIONS

We do not impose any preexisting condition exclusion.

HH. PROCEDURES RELATED TO STUDIES

Procedures related to clinic trials are covered for routine patient care cost for approved clinic and all routine patient care costs associated with phase I trials or trails conducted in relation to the prevention, detection, or treatment of other life-threatening diseases or conditions in accordance with the Federal Statue. This includes any drugs and medicines, technologies, treatments, procedures, or services provided as a part of, or related to, any program, protocol, project, trial, or study in which the patient consent and/or protocol states that the program, protocol, project, trial, or study:

1. Is a "Phase I", "Phase II", or "Phase III" program, protocol, project, trial, or study, or
2. Is arranged so that the Participants selected to take part are randomized, with some Participants receiving the prescribed drugs, treatment, technologies, services, or procedures, and other Participants receiving a different drug, treatment, technology, service, or procedure, or

3. Is a "research" program, protocol, project, trial, or study, or
4. Is an "investigational" program, protocol, project, trial, or study, or
5. Is utilizing investigational or experimental drugs and medicines, technologies, treatments, or procedures, or
6. Has individuals administering the program, protocol, project, trial, or study who are identified as "investigators", or
7. Is a "controlled" program, protocol, project, trial, or study.

II. PROPHYLAXIS/PROPHYLACTIC MEDICINE

Except as explicitly described elsewhere in this Agreement, medical benefits and treatment that are of a preventive or prophylactic nature are not Covered Services under this Agreement. Preventive or prophylactic treatments and services are those which are rendered to a person for purposes other than treating a present and existing medical condition in that person including, but not limited to, immunizations or Surgery on otherwise healthy body organs and/or parts.

JJ. REPORT PREPARATION

Charges for preparing medical reports or itemized bills or claim forms are not covered.

KK. ROUTINE HEARING EXAMINATIONS

Except as indicated under PREVENTIVE CARE, services will not be covered for the testing of hearing acuity. Services will not be covered for the prescription or fitting of a hearing aid or for the services related to the prescription or fitting.

LL. ROUTINE PHYSICALS

Services connected with routine physical or screening exams and immunizations are not covered except as described in PREVENTIVE CARE. (Examples of services not covered: yearly physicals, screening examinations for school, camp or other activities.)

MM. SERVICES AFTER COVERAGE ENDS

No benefits are provided after the coverage is cancelled. (EXAMPLE: If the Participant is hospitalized on July 30th and the Group cancelled their group coverage effective August 1st, no benefits are provided for any services received on or after August 1st.)

NN. SERVICES NOT IDENTIFIED

Any service or supply not specifically identified as a benefit in this Agreement is not covered.

OO. SERVICES PRIOR TO THE EFFECTIVE DATE

Charges incurred for supplies and services received prior to the effective date of coverage are not covered.

PP. SEX CHANGE OPERATIONS

Services related to sex change operations and reversals of such procedures are not covered.

QQ. SUBLUXATION

For the detection and correction by manual or mechanical means (including incidental X-rays) of structural imbalance or subluxation for the purpose of removing nerve

interference resulting from or related to distortion, misalignment or subluxation of or in the vertebral column, unless requiring Surgery, is not covered.

RR. *TAXES*

Sales, service, mailing charges or other taxes imposed by law that apply to benefits covered under this Agreement are not covered.

SS. *TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)*

Benefits are not provided for the treatment of temporomandibular joint disorders and myofascial pain-dysfunction syndrome.

TT. *THERAPIES*

Special therapies not specifically covered in this Agreement. Such non-Covered Services include (but are not limited to): recreational and sex therapies, Z therapy, self-help programs, transactional analysis, sensitivity training, assertiveness training, encounter groups, transcendental meditation (TM), religious counseling, rolfing, primal scream therapy, and stress management programs.

UU. *TOBACCO DEPENDENCY*

Benefits will not be provided for services, supplies or drugs related to tobacco dependency except as described under PREVENTIVE CARE.

VV. *TRAVEL EXPENSES*

Travel expenses are not covered.

WW. *UNRELATED SERVICES*

Services which are not related to a specific illness or injury are not covered.

XX. *WAR*

Services or supplies required as the result of disease or injuries due to war, civil war, insurrection, rebellion, or revolution are not covered.

YY. *WEIGHT LOSS PROGRAMS*

Services and supplies related to weight loss programs are not covered.

ZZ. *WORKERS' COMPENSATION*

Services or supplies resulting from a work-related illness or injury, compensation for which is available, in whole or in part, under the provisions of any legislation of any governmental unit, are not covered. See SECTION X. for further information.

SECTION X. GENERAL PROVISIONS

The following general provisions apply to all benefits and exclusions described in this Agreement.

A. ISSUANCE OF AGREEMENT

SKY 100 will issue to the Group, for delivery to each
Subscriber covered under this Agreement, an Agreement that contains the benefits to which the Subscriber and their Dependents, if any, are entitled. The Agreement will tell to whom the benefits are payable, membership requirements and any family member's or Dependent's coverage.

B. ASSIGNMENT OF BENEFITS

All benefits stated in this Agreement are personal to the Participant. Neither those benefits nor Sky 100's payments to the Participant may be assigned to any person, corporation, or entity. Any attempted assignment shall be void.

C. SELECTION OF DOCTOR

Any Participant shall be free to select his or her doctor and Hospital. Sky 100 makes no guarantee as to the availability of a doctor or Hospital. Sky 100's responsibility shall be solely to make payment for the benefits described in this Agreement.

D. CHANGE TO THE AGREEMENT

SKY 100 cannot change this Agreement except
through a written endorsement signed by an officer of SKY 100 fifteen (15) days before an endorsement becomes effective. After this, the endorsement becomes part of the Agreement.

No employee of SKY 100 may change this Agreement by giving incomplete or incorrect information, or by contradicting the terms of this Agreement. Any such situation will not prevent SKY 100 from administering this Agreement in strict accordance with its terms.

E. CONTESTING AGREEMENT VALIDITY

The validity of this Agreement shall not be contested, except for nonpayment of dues, after it has been in force for two (2) years from the date of issue. No statement made by any person covered under this Agreement relating to insurability shall be used in contesting the validity of the Agreement with respect to which the statement was made after the Agreement has been in force prior to such contest for a period of two (2) years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement.

F. DISCLAIMER OF LIABILITY

SKY 100 has no control over any diagnosis, treatment,
care, or other service provided to a Participant by any provider and is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

G. DISCLOSURE OF A PARTICIPANT'S MEDICAL INFORMATION

All Protected Health Information (PHI) maintained by Sky 100 under this Agreement is confidential. Any PHI about a Participant under the Agreement obtained by SKY 100 from that Participant or from a Health Care Provider may not be disclosed to any person except:

1. Upon a written, dated, and signed authorization by the Participant or prospective Participant or by a person authorized to provide consent for a minor or an incapacitated person;
2. If the data or information does not identify either the Participant or prospective Participant or the Health Care Provider, the data or information may be disclosed upon request for use for statistical purposes or research;
3. Pursuant to statute or court order for the production or discovery of evidence; or
4. In the event of a claim or litigation between the Participant or prospective Participant and SKY 100 in which the PHI is pertinent.

This section may not be construed to prevent disclosure necessary for SKY 100 to conduct health care operations, including but not limited to utilization review or management consistent with state law, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with health care providers, or to reconcile or verify claims. This section does not apply to PHI disclosed by SKY 100 to the insurance commissioner for access to records of SKY 100 for purposes of enforcement or other activities related to compliance with state or federal laws.

H. EVIDENCE OF INSURABILITY

SKY 100 reserves the right, in accordance with the provisions of the Texas Insurance Code and the terms of this Agreement, to require any person that may otherwise be eligible for coverage under this Agreement, to furnish evidence to SKY 100 of individual insurability satisfactory to it as a condition of providing coverage hereunder. Such evidence of insurability includes, and is limited to, completing an application for insurance that contains questions pertaining to the Applicant's effective date of coverage, waiting (or affiliation) periods, late and special enrollment, eligibility for benefit packages (including rules for individuals to change their selection among benefit packages), benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), continued eligibility; and terminating coverage (including disenrollment) of any individual under the plan. The extent of coverage for benefits under the terms of this Agreement will be based upon satisfactory evidence of insurability as provided in this section.

I. EXECUTION OF PAPERS

On behalf of the Subscriber and the Subscriber's Dependents, the Subscriber must, upon request, execute and deliver any instruments and papers to SKY 100 that are necessary to carry out the provisions of this Agreement.

J. INDEPENDENT CORPORATION

The Group, on behalf of itself and its Participants, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Group and Sky 100, that SKY 100 is an independent corporation operating under a license with the First Health Network, an Organization (PPO) of contracted licensed Physicians, Hospitals, Labs, Imaging centers, Urgent Care Facilities, and all mandated medical requirements to service patients. First Health Network is the Organization permitting SKY 100 to use the First Health Network Plan. Mark in the State of Texas, and that SKY 100 is not contracting as the agent of the Organization. The Group further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than SKY 100 and that no person, entity, or organization other than SKY 100 shall be held accountable or liable to the Group for any of Sky 100's obligations to the Group created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of SKY 100 other than those obligations created under other provisions of this Agreement.

K. PAYMENT IN ERROR

If SKY 100 makes a payment in error, it may require the provider of services, the Participant, or the ineligible person to refund the amount paid in error. SKY 100 reserves the right to correct payments made in error by deducting against subsequent claims or by taking legal action, if necessary.

L. PRIVACY OF PROTECTED HEALTH INFORMATION

SKY 100 may disclose the Participant's PHI to the Group to carry out administrative functions under the terms of this Agreement, but only in accordance with applicable federal and state law. Any disclosure to and use by the Group of the Participant's PHI will be subject to and consistent with this section. SKY 100 will not disclose the Participant's PHI to the Group unless such disclosures are included in a notice of privacy practices distributed to the Participant. SKY 100 will not disclose the Participant's PHI to the Group for actions or decisions related to the Participant's employment or in connection with any other benefits made available to the Participant.

The following restricts the Group's use and disclosure of the Participant's PHI:

1. The Group will neither use nor further disclose the Participant's PHI except as permitted by the Agreement or required by law.
2. The Group will ensure that anyone who receives the Participant's PHI agrees to the restrictions and conditions of the Agreement with respect to the Participant's PHI.

3. The Group will not use or disclose the Participant's PHI for actions or decisions related to the Participant's employment or in connection with any other benefit made available to the Participant.
4. The Group will promptly report to SKY 100 any use or disclosure of the Participant's PHI that is inconsistent with the uses and disclosures allowed under this section upon learning of such inconsistent use or disclosure.
5. In accordance with federal law, the Group will make PHI available to the Participant who is the subject of the information. Such information is subject to amendment and, upon proper notice, the Group will amend the Participant's PHI where appropriate.
6. The Group will document disclosures it makes of the Participant's PHI so SKY 100 is able to provide an accounting of disclosures as required under applicable state and federal law.
7. The Group will make its internal practices, books, and records relating to its disclosure of the Participant's PHI available to SKY 100 and to the U. S. Department of Health and Human Services as necessary to determine compliance with federal law.
8. The Group will, where feasible, return or destroy all Participant's PHI in whatever form or medium received for Sky 100, including all copies of and any data or compilations derived from and allowing identification of a Participant when the Participant's PHI is no longer needed for plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Participant PHI, the Group will limit the use or disclosure of any Participant PHI to those purposes that make the return or destruction of the information infeasible.

M. PRUDENT MEDICAL CARE

SKY 100 may consider limited exceptions to the contractual provisions of this Agreement, based upon Medical Necessity and prudent medical care standards. Such decisions will be made only after establishing the cost-effectiveness, relative to alternative covered services, of medically necessary services performed on behalf of a Participant, and with the agreement of the affected Participant.

Any such decisions will not, however, prevent SKY 100 from administering this Agreement in strict accordance with its terms in other situations.

N. RESERVE FUNDS

No Participant is entitled to share in any reserve or other funds that may be accumulated or established by Sky 100, unless a right to share in such funds is granted by Sky 100's Board of Directors.

O. SENDING NOTICES

All notices to the Participant are considered to be sent to and received by the Participant when deposited in the United States Mail with postage prepaid and addressed to the Participant at the latest address appearing on Sky 100's membership records.

P. SUBSCRIBER'S LEGAL OBLIGATIONS

The Subscriber is liable for any actions which may prejudice Sky 100's rights under this Agreement. If SKY 100 must take legal action to uphold its rights, then it can require the Subscriber to pay its legal expenses, including attorney's fees and court costs, unless the court finds that the losing party's(ies') position was not frivolous or that the losing party(ies) litigated his (their) position on a reasonable basis.

Q. TERM

The term of this Agreement shall be one (1) Plan Year. This Agreement, and the membership of the Subscribers, will be renewed by SKY 100 from year to year, so long as dues are regularly prepaid as scheduled, and the required numbers and percentages are maintained.

R. STATEMENTS AND REPRESENTATIONS

All statements contained in a written application, evidence of insurability form, or other written document or instrument made by the Group or Applicant to obtain this Agreement, shall be considered representations and not warranties. No such statement made by any person insured under this Agreement shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the person's beneficiary or personal representative.

Misrepresentations, omissions, concealment of facts and incorrect or incomplete statements, As in this section shall not prevent the Agreement from remaining in effect or prevent the payment of covered benefits under this Agreement unless SKY 100 determines that either:

1. The statements and/or representations are fraudulent; or
2. The statements are material to the acceptance of the risk or coverage of the benefits provided under the Agreement; or
3. Sky 100, in good faith, if it knew the true facts as required by any application or other document as provided in this section, would not have:
    1. Entered into the Agreement or issued the membership; or
    2. Provided coverage with respect to the condition which is the basis for a claim under this Agreement.

4. Prior to rescinding coverage SKY 100 will provide a thirty (30) days advance written notice to all participants who would be affected.

S. ENTIRE AGREEMENT; CHANGES

The Group Master Agreement, with the Group application, the individual applications, if any, and any attached papers or endorsements, if any, constitute the entire Agreement between the Group, the Subscriber (as appropriate) and Sky 100. No change in this Agreement will be effective until approved by an authorized officer of Sky 100. This approval must be noted on or attached to this Agreement. No agent or representative of SKY 100 of Texas, other than an officer, may change this Agreement or waive any of its provisions.

T. PHYSICAL EXAMINATION AND AUTOPSY

Sky 100, at its own expense, has the right to examine the person of the Subscriber, or any Dependent, when and as often as it may reasonably require during the pendency or review of a claim under this Agreement and to require or make an autopsy where it is not otherwise prohibited by law.

U. SUBROGATION

For all benefits provided or paid under this Agreement, SKY 100 shall be subrogated and succeed to any rights of recovery of a Participant for expenses incurred against any person or organization. The Participant shall take action, furnish such information and assistance, and execute such papers as SKY 100 may require to facilitate enforcement of its rights, and shall take no action prejudicing the rights and interests of SKY 100 under this Agreement. The Participant shall pay Sky 100, all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of benefits provided or paid under this Agreement.

V. COORDINATION OF BENEFITS

The purpose of this Agreement is to provide certain benefits, and the rates and charges are based upon the assumption that Participants often have other coverage providing duplicate benefits. In the event of other coverage, SKY 100 will not duplicate benefits if otherwise provided for (or should have been provided had the Participant elected to claim) under any group or individual coverage by any other insurance, or government program or authorized benefits provided by private enterprise. If at any time more than one coverage shall be applicable to any benefit, the coverage first liable (primary coverage) shall pay to the full extent of its aggregate coverage. If the Agreement is determined to be secondary payor, the sum of the benefits payable by the primary payor plus the sum of the benefits payable under this Agreement shall not exceed the amount payable under this Agreement had this Agreement been determined to be the primary payor.

Determination of primary and secondary payor will be based on the following:

1. Coverage not having a coordination of benefit or non-duplication provision similar to this provision.

2. Group coverage will be primary over an individual policy with a non-duplication provision.

3. Coverage of a plan, which covers the patient as a Subscriber will be primary over a plan covering the patient as a Dependent.

4. Dependent Children: The coverage of the parent whose birth date, excluding year of birth, occurs earlier in the calendar year, will be primary payor. If a plan does not have this provision, the primary payor will be determined by the provision of the plan not having this paragraph.

5. The above applies for children, except in situations where the parents are separated or divorced.

    1. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan covering the child as a Dependent of the parent with custody shall be primary over the plan covering the child as a Dependent of the parent without custody.

    2. When the parents are divorced, and the parent with custody of the child has remarried, the benefits of the plan covering the child as a Dependent of the parent with custody shall be determined before the benefits of the plan covering the child as a Dependent of the step-parent, and the benefits of the plan covering the child as a Dependent of the parent without custody.

    3. Notwithstanding paragraphs 1 and 2 herein, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers that child as a Dependent of the parent with such responsibility shall be determined before the benefits of any other plan covering that child.

6. When the application of the above guidelines is not definitive, the benefits of a plan which has covered the patient for a longer period of time shall be primary payor.

    Except in situations of a laid-off or retired employee, or a Dependent of such employee, the plan covering the person as an active employee will be primary, over the coverage as a laid-off or retired employee, unless either coverage does not contain a provision for laid-off or retired employees, then this subparagraph shall not apply.

W. WORKERS' COMPENSATION

No benefits will be provided for services, supplies or charges for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not the Participant claims the benefits or compensation and whether or not the Participant recovers losses from a third party.

X. GENERAL INFORMATION ABOUT FILING CLAIMS

SKY 100 identification cards indicate the type of coverage Participants have. Participants should:

1. Always carry their identification card and present it to the Hospital, Facility Other Provider, Physician or Professional Other Provider whenever the Participant receives treatment.
2. Be sure to carry the *new* identification card they will receive in the event that they change coverage. The old identification card should then be destroyed.
3. Contact SKY 100 at the address below for a replacement card if the original identification card is lost.

Y. WRITTEN NOTICE OF CLAIM

1. Proof of claim must be furnished to SKY 100 at its office at 6006 N Mesa Suite 108, El Paso, TX 79912.

2. SKY 100 will not be liable under this Agreement unless proper notice (proof) is furnished to SKY 100 that Covered Services have been rendered to a Participant. Written notice must be given within ninety (90) days after completion of services that are covered under this Agreement. The notice must include the data necessary for SKY 100 to determine benefits. An expense will be considered incurred on the date the service or supply was rendered.

3. Failure to give notice to SKY 100 within the time specified above will not invalidate nor reduce any claim for benefits if it is shown it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time the proof is otherwise required.

Z. CLAIM FORMS

SKY 100 shall furnish either to the person making a claim (claimant), or to the Group, for delivery to the person making a claim, the forms it usually furnishes for filing claims for benefits. If such forms are not furnished within fifteen (15) days of the filing of notice of claim, the claimant shall be deemed to have complied with the requirements of this Agreement as to notice of claim upon submitting, within the time fixed in the Agreement for filing notice of claim, written proof covering the date(s) medical services were rendered, and the character and extent of medical services for which claim is made. SKY 100 reserves the right to request further information to make decisions whether this section is met or not.

AA. TIME OF CLAIM PAYMENT

Benefits are payable according to the terms of this Agreement not more than forty-five (30) days after receipt of written proof of the claim and supporting evidence. Such supporting evidence may include, but not be limited to, medical records required for claim analysis and payment in accordance with this Agreement. In the event SKY 100 determines that certain medical records are necessary to determine benefits under this Agreement, the 30-day claim payment time will not commence until all such necessary records are received by SKY 100 from any source.

BB. LIMITATION OF ACTIONS

No action at law or equity may be brought to recover benefits under Sky 100 prior to the expiration of sixty (60) days after written proof of a claim is furnished. No such action shall be brought later than three (3) years after the time written proof of claim for benefits is required by SKY 100 to be furnished.

CC. INTERNAL CLAIMS REVIEW PROCEDURE FOR GROUPS NOT SUBJECT TO ERISA

If a group is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) and a Participant is not satisfied with the results of the processing of his or her claim, request for pre-admission review, or request for pre-certification, the Participant may make a written appeal. When making the request for review or reconsideration, include the group, agreement and claim numbers.

1. Emergency Services

   The Participant and/or the Participant's authorized representative have up to 180 days with an additional 2 or 3 days given for holidays, Saturdays and Sundays if less than 180 days to appeal Sky 100's denial of a claim for benefits. Upon receipt of an appeal from a Participant and/or a Participant's authorized representative, SKY 100 will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 72 hours after receiving the request.

2. Pre-Admission Review, Pre-Certification and Non-emergency Services

   The Participant and/or the Participant's authorized representative have up to 180 days with an additional 2 or 3 days given for holidays, Saturdays and Sundays if less than 180 days to appeal Sky 100's denial of a Hospital admission, pre- certification of services, or claim for benefits. Upon receipt of an appeal from a Participant and/or a Participant's authorized representative, SKY 100 will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 45 days after receiving the request.

Participants should mail or hand deliver their requests to:

SKY 100
6006 N Mesa Street - Suite 108
El Paso, TX 79912

Participants have the right to be represented by an attorney or other duly authorized representative at any stage of their appeal. Participants or their representative have the right to review documents that pertain to their appeal. These documents are on file in the office of SKY 100 at the above address. SKY 100 will need at least 72 hours notice to assemble the documents pertaining to an appeal.

The adjudication committee of SKY 100 will review the appealed claim(s) and consider all information available pertaining to the appeal. Whether or not the initial decision is changed, Participants will receive a written response and explanation within 45 days of Sky 100's receiving their request for review.

DD. EXTERNAL CLAIMS REVIEW PROCEDURE FOR GROUPS NOT SUBJECT TO ERISA

If SKY 100 denies the Participant's request for the provision of, or payment for, a health care service or course of treatment on the basis that it is not medically necessary, to include a rescission of coverage, the issuer fails to strictly adhere to the requirements of the internal appeals process, or the internal appeals process has been exhausted or on another similar basis, the Participant may have a right to have the adverse determination reviewed by health care professionals who have no association with SKY 100 and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice. The Participant must submit a request for external review within 180 days with an additional 2 or 3 days given for holidays, Saturdays and Sundays if less than 180 days after receipt of the claims denial to Sky 100's appeals office. For a standard external review, a decision will be made within 45 days of receiving the request.

When filing a request for an external review, the Participant will be required to authorize the release of any medical records of the Participant that may be required to be reviewed for the purpose of reaching a decision on the external review.

1. Medical Necessity Denials

   Expedited Review: The Participant may be entitled to an expedited review when his or her medical condition or circumstances required, and in any event within 72 hours, where:

   a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
   b. The Participant's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care facility.

To request an external review or an expedited review, the Participant must submit the following completed documents that accompanied his or her claims denial: Request form, release for records, a health care professional's statement of medical necessity and any other documents necessary.

The Participant's request must be received at Sky 100, 6006 N Mesa - Suite 108, El Paso, TX 79912 within 180 days with an additional 2 or 3 days given for holidays, Saturdays and Sundays if less than 180 days of the date on the Notice of Appeal Rights. The last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

2. All Other Denials

   Expedited Review: The Participant may be entitled to an expedited review when his or her medical condition or circumstances require it, and in any event within 72 hours where:

   a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
   b. The Participant's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care facility.

The Participant's request must be made in writing and sent to Sky 100, 6006 N Mesa Suite 108, El Paso, TX 79912 within 180 days with an additional 2 or 3 days given for holidays, Saturdays and Sundays if less than 180 days of the date of the internal appeal denial. No fee will be required with submission of an external review request as noted in the Notice of Appeal Rights. The last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

EE. TEXAS INSURANCE DEPARTMENT

Participants may also have rights under Texas Insurance law. For more information about those rights, Participants may call or write the following telephone number or address:

Texas Department of Insurance
333 Guadalupe St.
Austin, TX 78701
1-800-578-4677

SECTION XI. PARTICIPANTS' RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following explanation is provided as an overview and is not intended to be legal advice or provide other specific information to the Participant as to all their rights under ERISA. Participants should consult their employer to determine whether their Group is covered under ERISA.

A. PLAN DOCUMENTS AND FINANCIAL REPORTS

Participants in an employee benefit plan are entitled to certain rights and protection under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all benefit, or plan Participants shall be entitled to:

1. Examine, without charge, at the plan Administrator's, or Employer's, offices, as applicable, and at other specified locations, such as union halls or worksites, all benefit (plan) documents including insurance contracts, and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and benefit (plan) descriptions.

2. Obtain copies of all benefit documents and other information upon written request to the plan Administrator, or Employer, as appropriate. A reasonable charge may be made for these copies.

3. Receive a summary of a benefit financial report. The plan Administrator is required by law to furnish each Participant with a copy of this summary annual report upon request.

B. FIDUCIARIES AND THEIR OBLIGATIONS

In addition to creating rights for employment benefit Participants, ERISA imposes duties upon the people who are responsible for the operation of the employment benefit plan (fiduciaries). These people have a duty to operate and/or administer Participants' employment benefits prudently and in the best interests of the Participants.

C. LEGAL RIGHTS TO BENEFITS

1. No person, including an employer, or any other person, may fire Participants or otherwise discriminate against Participants in any way to prevent Participants from obtaining an employment benefit or exercising their rights under ERISA.

2. If any claim for a benefit that Participants are legally entitled to is denied or ignored, in whole or in part, Participants must receive a written explanation of the reason for the denial. This explanation may come in various formats. Participants have the right to have SKY 100 review and reconsider their claim in accordance with the steps below.

3. Under the provisions of ERISA, there are various steps Participants can take to enforce the above rights. For instance, if Participants request materials and do not receive them within 30 days, Participants may seek assistance from the U.S. Department of Labor, or they may file a lawsuit in Federal Court. In such a case the court may require the entity from whom the Participants requested materials to provide the materials and pay the Participants up to $110.00 a day until they receive the materials, unless the materials the Participants requested were not sent because of reasons beyond the control of the entity from whom materials were requested.

4. If Participants have a claim for benefits that is denied or ignored, in whole or in part, the Participants may file a lawsuit in a state or Federal Court. If it should happen that fiduciaries misuse the plan's money, or if the Participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If the Participants are successful the court may order the person being sued to pay these costs and fees. If the Participants lose, the court may order them to pay these costs and fees; for example, if the court finds the Participants' claim is frivolous.

D. CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION

Upon receipt of a claim for benefits under this Agreement from a Participant and/or Participant's authorized representative that is conditioned on a Participant's obtaining approval in advance of obtaining the benefit or service, SKY 100 will notify the Participant and/or the Participant's authorized representative of its determination within a reasonable period of time, but no later than 15 days from receiving the claim. SKY 100 may extend this initial time period an additional 15 days if it is unable to make a determination due to circumstances beyond its control after giving the Participant and/or the Participant's authorized representative notice of the need for additional time prior to the expiration of the initial 15-day time period.

If the Participant and/or the Participant's authorized representative improperly submits a claim for benefits, SKY 100 will notify the Participant and/or the Participant's authorized representative as soon as possible, but no later than
5 days after receipt of the claim for benefits and provide the Participant and/or the Participant's authorized representative with the proper procedures to be followed when filing a Claim for benefits. SKY 100 may also request additional or specified information after receiving a claim for benefits, but any such request will be made prior to the expiration of the initial 15-day time period after receiving the claim for benefits. Upon receiving notice of an improperly filed claim for benefits or a request for additional or specified information, the Participant and/or the Participant's authorized representative has 45 days in which to properly file the Claim for benefits and submit the requested information. After receiving the properly filed claim for benefits or additional or specified information, SKY 100 shall notify the Participant and/or the Participant's authorized representative of its determination within a reasonable

period of time, but no later than 15 days after receipt of the properly filed claim for benefits and additional information.

E. CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION AND INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For services or benefits requiring pre-admission review or pre-certification and involving an ongoing course of treatment taking place over a period of time or number of treatments, SKY 100 will provide the Participant and/or the Participant's authorized representative with notice that the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Participant and/or the Participant's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a claim for benefits from a Participant and/or the Participant's authorized representative to extend such treatment, SKY 100 will notify the Participant and/or the Participant's authorized representative of its determination as soon as possible prior to terminating or reducing the benefits or services.

F. CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

Upon receipt of a claim for benefits for emergency services from a Participant and/or a Participant's authorized representative, SKY 100 will notify the Participant and/or the Participant's authorized representative of its determination as soon as possible but no later than 72 hours after receiving the claim for benefits.

If the Participant and/or the Participant's authorized representative improperly submits a claim for benefits or the claim for benefits is incomplete and SKY 100 requests additional or specified information, SKY 100 will notify the Participant and/or the Participant's authorized representative as soon as possible, but no later than 24 hours after receipt of the claim for benefits. Upon receiving notice of an improperly filed claim of benefits or the request from SKY 100 for additional or specified information, the Participant and/or the Participant's authorized representative has 48 hours to properly file the claim for benefits or to provide the requested information. After receiving the properly filed claim for benefits or requested information, SKY 100 shall notify the Participant and/or the Participant's authorized representative of its determination as soon as possible, but no later than 48 hours after receipt of the additional or specified information requested by Sky 100, or within 48 hours after expiration of the Participant's time period to respond.

G. CLAIMS FOR BENEFITS NOT REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION, BUT INVOLVING AN ONGOING COURSE OF TREATMENT OR NUMBER OF TREATMENTS

For a claim for benefits that does not require pre-admission review or pre-certification, but involves services or benefits involving an ongoing course of treatment taking place over a period of time or a number of treatments, SKY 100 will provide the Participant and/or the Participant's authorized representative with notice in a culturally and linguistically appropriate manner that

the services or benefits are being reduced or terminated at a time sufficiently in advance to permit the Participant and/or the Participant's authorized representative to request extending the course of treatment or number of treatments. Upon receiving a claim for benefits from a Participant and/or the Participant's authorized representative to extend such treatment, SKY 100 will notify the Participant and/or the Participant's authorized representative in a culturally and linguistically appropriate manner of its determination as soon as possible prior to terminating or reducing the benefits or services.

H. CLAIMS FOR ALL OTHER SERVICES OR BENEFITS

Upon receipt of a claim for benefits under the Agreement from a Participant and/or the Participant's authorized representative, SKY 100 will notify the Participant and/or the Participant's authorized representative in a culturally and linguistically appropriate manner of its determination within a reasonable period of time, but no later than 30 days from receiving the claim for benefits and only if the determination is adverse to the Participant. SKY 100 may extend this initial time period in reviewing a claim for benefits an additional 15 days if SKY 100 is unable to make a determination due to circumstances beyond its control after giving the Participant and/or the Participant's authorized representative notice of the need for additional time prior to the expiration of the initial 30-day time period.

SKY 100 may request additional or specified information after receiving a claim for benefits, but any such request will be made prior to the expiration of the initial 30-day time period after receiving the claim for benefits. Upon receiving a request for additional or specified information, the Participant and/or the Participant's authorized representative has 45 days in which to submit the requested information. After receiving the additional or specified information, SKY 100 shall notify the Participant and/or the Participant's authorized representative in a culturally and linguistically appropriate manner of its determination within a reasonable period of time, but not later than 30 days after receipt of the additional information.

I. INTERNAL APPEALS OF CLAIMS FOR BENEFITS REQUIRING PRE-ADMISSION REVIEW OR PRE-CERTIFICATION

The Participant and/or the Participant's authorized representative have up to 180 days with an additional 2 or 3 days given for holidays, Saturdays and Sundays if less than 180 days to appeal Sky 100's adverse benefit determination of a claim for benefits requiring preauthorization or prior approval of benefits or services. Upon receipt of an appeal from a Participant and/or a Participant's authorized representative, SKY 100 will notify the Participant and/or the Participant's authorized representative in a culturally and linguistically appropriate manner of its determination within a reasonable period of time, but no later than 30 days after receiving the Participant's and/or the Participant's authorized representative's request for review.

J. INTERNAL APPEALS OF CLAIMS FOR BENEFITS FOR EMERGENCY SERVICES

The Participant and/or the Participant's authorized representative have to appeal Sky 100's adverse benefit determination of a claim for benefits for emergency services. An appeal can be initiated by phone call , but a written request must be submitted. Upon receipt of an appeal from a Participant and/or the Participant's authorized representative, SKY 100 will notify the Participant and/or the Participant's authorized representative of its determination, in a culturally and linguistically appropriate manner whether adverse or not, as soon as possible, but no later than 72 hours after receiving the Participant and/or the Participant's authorized representative request for a review. A Participant and/or the Participant's authorized representative may request an appeal from a determination involving a claim for benefits for emergency services orally or in writing, and SKY 100 will accept needed materials by telephone or facsimile.

K. INTERNAL APPEALS OF CLAIMS FOR ALL OTHER SERVICES OR BENEFITS

The Participant and/or the Participant's authorized representative have to appeal Sky 100's adverse benefit determination of a claim for benefits. Upon receipt of an appeal from a Participant and/or the Participant's authorized representative, SKY 100 will notify the Participant and/or the Participant's authorized representative of its determination in a culturally and linguistically appropriate manner within a reasonable period of time, but no later than 60 days after receiving the Participant and/or the Participant's authorized representative request for review.

L. EXTERNAL CLAIMS REVIEW PROCEDURE

If SKY 100 denies the Participant's request for the provision of, or payment for, a health care service or course of treatment on the basis that it is not medically necessary, or on another similar basis, to include a rescission of coverage, the issuer fails to strictly adhere to the requirements of the internal appeals process, or the internal appeals process has been exhausted the Participant may have a right to have the adverse determination reviewed by health care professionals who have no association with SKY 100 and are not the attending health care professional or the health are professional's partner by following the procedures outlined in this notice. The Participant must submit a request for external review within 180 days with an additional 2-3 days given for holidays, Saturdays and Sundays if less than 180 days after receipt of the claims denial to Sky 100's appeals office. For a standard external review, a decision will be made within 45 days of receiving the request recipient's notice based on claimant's medical condition or circumstances is October 30th the request must be received by March 1st. If the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

When filing a request for an external review, the Participant will be required to authorize the release of any medical records of the Participant that may be required to be reviewed for the purpose of reaching a decision on the external review.

1. Medical Necessity Denials:

   Expedited Review: The Participant may be entitled to an expedited review when his or her medical condition or circumstances required, and in any event within 72 hours, where:

   a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
   b. The Participant's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care facility.

   To request an external review or an expedited review, the Participant must submit the following completed documents that accompanied his or her claims denial: Request form, release for records, a health care professional's statement of medical necessity and any other documents necessary. All Applicants within 50 States will not incur any Fees with external review requests that are submitted with all external review. Requests as noted in the Notice of Appeal Rights.

The Participant's request must be received at Sky 100, 6006 N Mesa Suite 108, El Paso, TX 79912 within 180 days with an additional 2-3 days given for holidays, Saturdays and if less than 180 days of the date on the Notice of Appeal Rights. ***Based on claimants medical condition or circumstances is October 30th the request must be received by March 1st, if the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

2. All Other Denials:

   Expedited Review: The Participant may be entitled to an expedited review when his or her medical condition or circumstances require it, and in any event within 72 hours, where:

   a. The timeframe for the completion of a standard review would seriously jeopardize the Participant's life or health or would jeopardize his or her ability to regain maximum function; or
   b. The Participant's claim concerns a request for an admission, availability of care, continued stay or health care service for which he or she received emergency services, but has not been discharged from a health care facility.

The Participant's request must be made in writing and sent to Sky 100, 6006 N Mesa Suite 108, El Paso, TX 79912 within 180 days with an additional 2-3 days given for holidays, Saturdays and Sundays if less than 180 days of the date of the internal appeal denial. Based on claimants medical condition or circumstances is October 30th the

request must be received by March 1st, if the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

No filing fee will be required with submission of an external review request as noted in the Notice of Appeal Rights.

M. TEXAS INSURANCE DEPARTMENT

Participants may also have rights under Texas Insurance law. For more information about those rights, Participants may call or write the following telephone number or address:

Texas Insurance Department
333 Guadalupe, Austin TX 78701
P.O. Box 149104, Austin, TX 78714
512-676-6000 | 800-578-4677

N. SKY 100 AS A FIDUCIARY

In accordance with the appropriate provisions of (ERISA), Sky 100, as a fiduciary or plan administrator of this health insurance agreement, may exercise in good faith any authority or control respecting the management of the operation and administration of this health insurance plan in accordance with the provisions of this Agreement.

O. ANSWERS TO QUESTIONS

1. If Participants have any questions about any of the benefits associated with this health insurance agreement or their rights under this agreement, they should contact their employer or SKY 100 at 1-800-231-0475. They can also call SKY 100 toll free at:

   Toll Free Number: 1-800-231-0475

2. If Participants have any questions about their rights under ERISA, they should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.