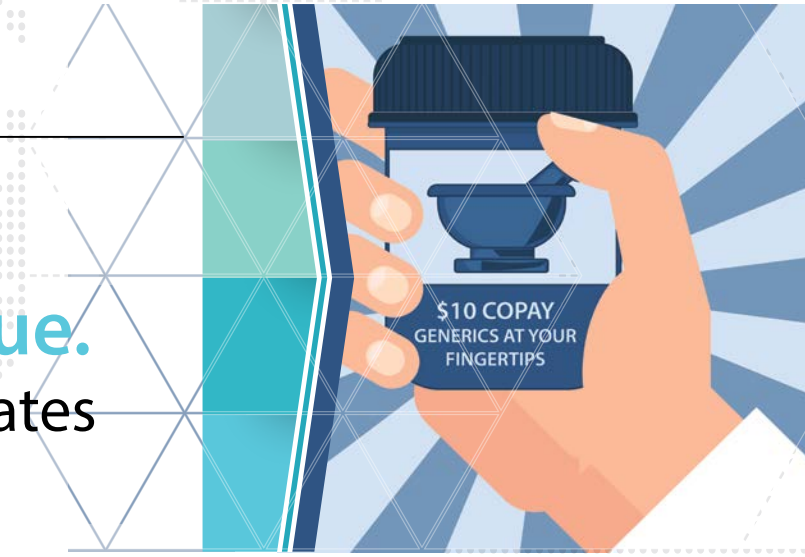
PENNSYLVANIA



Gap RX Plan[sm]
Member Driven **Value.**
Group Insurance Certificates

THESE ARE SAMPLE GROUP INSURANCE CERTIFICATES:
To download <u>your</u> group insurance certificate,
go to https://prod.pram.com

*These Sample Group Insurance Certificates are for the Gap RXPlan[sm] **purchased on or after 090717**. Any questions, you can call your Personal Member Concierge at 866.438.4274.*

Envision Insurance Company
Home Office: 2181 E. Aurora Rd., Suite 201
Twinsburg, OH 44087
A STOCK COMPANY
(Herein called the Company)

CERTIFICATE OF INSURANCE 224101-1

POLICYHOLDER:	United Business Association
EMPLOYER:	John Doe Manufacturing
POLICY NUMBER:	EX1TXUA17000397
POLICY ANNIVERSARY:	September 1, 2018

This Certificate reflects Coverage for Employees of John Doe, Manufacturing, under Policy Number EX1TXUA17000397, issued to United Business Association (hereinafter referred to as "the Association")
The Policy under which this Certificate is issued is delivered in the state of Texas and is governed by its laws.

We certify that:
1. Your coverage under the Policy begins on your Effective Date if:
   a. You are eligible; and
   b. The required premium for Your coverage has been paid.
2. If You elect spouse or Dependent coverage, the eligible spouse or Dependents You have designated are covered under the Policy as of the effective date if the required premium for such coverage has been paid.

We will pay the benefits described in the Policy for expenses incurred for Prescription Drugs, subject to all the provisions, conditions, exclusions and limitations of the Policy.

The Policy is on file with the Employer and may be examined at any reasonable time. Only an Officer of Envision Insurance Company can authorize a change to the Policy.

Signed for Envision Insurance Company by:

Signature
William C. Epling, President

Signature

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

THIS POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED PROVIDES SUPPLEMENTAL COVERAGE ISSUED ONLY TO SUPPLEMENT MEDICAL INSURANCE ALREADY IN FORCE. THIS COVERAGE WILL TERMINATE ON THE DATE THE UNDERLYING INSURANCE TERMINATES.

S

THIS IS A CERTIFICATE FOR GROUP OUTPATIENT PRESCRIPTION DRUG INSURANCE.
THIS CERTIFICATE PROVIDES LIMITED COVERAGE
PLEASE READ THIS CERTIFICATE CAREFULLY.

Administrative Office:
One Pointe Dr., Suite 120,
Brea, CA 92821-5601
Customer Service: 1-800-262-7726
1-714-671-3951

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
CERTIFICATE OF INSURANCE 224101-1

Reflecting Coverage for Employees of John Doe, Manufacturing, under Policy Number EX1TXUA17000397, issued to the Association.

MEMBER/INSURED:	John Doe
POLICY NUMBER:	EX1TXUA17000397
CERTIFICATE EFFECTIVE DATE OF COVERAGE:	September 1, 2017

SPOUSE/DEPENDENTS INSURED:	Jane Doe	**EFFECTIVE DATE OF COVERAGE:**	September 1, 2017
	Jasmine Doe	**EFFECTIVE DATE OF COVERAGE:**	September 1, 2017
	Joseph Doe	**EFFECTIVE DATE OF COVERAGE:**	September 1, 2017
		EFFECTIVE DATE OF COVERAGE:	

ELIGIBILITY WAITING PERIOD FOR NEW EMPLOYEES: As selected by the Employer

OPEN ENROLLMENT PERIOD: As selected by the Employer

PRESCRIPTION DRUG BENEFIT

Benefit Amount:	100% of Covered Expenses after any Deductible and Co-payment
Benefit Period:	12 month period beginning on the Policy Effective Date
Maximum Payable per Month	$300 per Covered Person
Maximum Payable per Benefit Period:	$3600 per Covered Person
Deductible per Benefit Period:	$0 per Covered Person

Co-payment:

Retail	
Generic:	$10
Brand Name Formulary:	
Brand Name Non-Formulary:	
Mail Order	
Generic:	$30
Brand Name Formulary:	
Brand Name Non-Formulary:	

DISPENSING LIMITS and AUTHORIZED REFILLS

Limits:

Retail:	30 day supply.
Mail:	90 day supply.

INITIAL PREMIUM RATES:

$20.68 per month, per certificate covering Employee only
$41.99 per month, per certificate covering Employee and spouse only
$38.44 per month, per certificate covering Employee and child(ren) only
$51.46 per month, per certificate covering Employee, spouse and child(ren) only

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

"Active Service" means a Covered Person is either 1) actively at work performing all regular duties on a full-time basis either at his or her employer's place of business or someplace the employer requires him or her to be; 2) employed, but on a scheduled holiday, vacation day or period of approved paid leave of absence; or 3) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

"Annual Enrollment Period" means the period agreed upon by the Employer and Us when an Eligible Person may enroll for or a Covered Person may change benefits under the Policy.

"Benefit Period" means the period of time when benefits are payable. Unless stated otherwise on the Schedule of Benefits, a Benefit Period is a Calendar Year.

"Brand Name" means a drug: 1) approved by the Food and Drug Administration; and 2) protected by the trademark registration of the pharmaceutical company which produces such drug.

"Calendar Year" means a one year period that begins on January 1 at 12:01 a.m. and ends on January 1 at 12:01 a.m. of the following year at the Employer's address.

"Co-payment" means a fixed dollar amount that the Covered Person must pay for each Prescription Drug before benefits are payable under the Policy.

"Covered Expenses" means expenses actually incurred by or on behalf of a Covered Person for outpatient Prescription Drugs covered by the Policy, provided such Drug: 1) requires a Doctor's written prescription; 2) is dispensed in the name of the Covered Person by a licensed pharmacist; 3) is approved for treatment of the Covered Person's medical condition; 4) is not specifically excluded under the terms of the Policy; 5) the Covered Person is legally obligated to pay; and 6) is not taken while in or administered by a Hospital or any other health care facility or office. A Covered Expense is deemed to be incurred on the date the Prescription Drug is filled.

"Covered Person" means any eligible person and Dependent who applies for coverage and for whom the required premium is paid.

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person before benefits are payable under the Policy. Deductibles are applied for each Benefit Period. Expenses excluded under the Policy will not be used to satisfy the Deductible.

"Dependent" means:

1. an Insured's lawful spouse or Domestic Partner under age 65; or
2. an Insured's grandchild from the moment of birth to age 25 provided the grandchild is a dependent of the Insured for federal income tax purposes at the time application for coverage of the grandchild is made; or
3. an Insured's child, from the moment of birth to age 26 .

Coverage for a full-time student will be extended:

a. for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and
b. continuously until the 10th day of instruct of the subsequent academic term, on which date coverage will end for the child if the child does not return to full-time student status before that date.

Determination of the full-time student status of a child is made in the manner provided by the educational institution at which the child enrolled.

An insured child, for eligibility purposes, includes:

1. an Insured's natural child;
2. an adopted child,
3. a child for which the Insured is a party to a suit in which the Insured seeks to adopt the child;
4. a stepchild; or
5. a child for whom e Insured must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in the state of Texas.

A Dependent may also include any person related to the Insured by blood or marriage and for whom the Insured is allowed a deduction under the Internal Revenue Code.

Insurance will continue for any Dependent child who reaches the age limit and continues to meet the following conditions:

1) is incapable of self-sustaining employment because of mental retardation or physical disability and
2) depends chiefly on the Insured for support and maintenance.

The Insured must send Us satisfactory proof that the child meets these conditions within 31 days after the child attains the limiting and, when requested thereafter. Except that, we will not ask for proof more than once a year after the second anniversary of the date the child attains the limiting age.

If the Insured has elected coverage for a Dependent child, any newly born child of the Insured will be covered from the moment of birth for 31 days. Coverage may be continued beyond this time period if the Insured notifies Us within 31 days of the child's birth and pays any required premium.

"Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality.

"Domestic Partner" means a person of the same or opposite sex of the Insured who:

1) shares the Insured's primary residence;
2) has resided with the Insured for at least 24 months prior to the date of enrollment ;
3) is financially interdependent with the Insured in each of the following ways;
    a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
    b. by owning or leasing their permanent residence as joint tenants;

c. by naming, or being named by the other as a beneficiary of life insurance or under a will;
d. by each agreeing in writing to assume financial responsibility for the welfare of the other.

4) has signed a Domestic Partner declaration with the Insured, if recognized by the laws of the state in which he or she resides with the Insured;
5) has not signed a Domestic Partner declaration with any other person within the last 24 months.
6) Is older than 18 years older, but no more than 65 years old;
7) Is not currently married to another person;
8) Is not in a position as a blood relative that.

"Employee" means a person employed by the Employer and meeting the minimum hourly requirement shown in the Employer's application. If the Employer is a sole proprietorship or partnership, the individual proprietor or each of the partners is an Employee only if engaged in the regular business of the Employer for the minimum hourly requirement shown in the Employer's application. No director of a corporate Employer is an Employee solely because of such directorship. Employee also includes a retiree, but only if a retiree class is requested by the Employer.

"Employer" means the Employer and includes any subsidiary or affiliated company wholly owned by the Employer and named in the Employer's application.

"Formulary" means a list, provided by Us, of prescription medications that are covered under the Policy. The Formulary categorizes prescription medications as: preferred Brand; non-preferred Brand; and preferred Generic.

"Full-time Employee
An Employee who works on a full-time basis and who usually works at least 30 hours a week. The term does not include an Employee who works on a part-time, temporary, seasonal, or substitute basis.

"Generic" means therapeutically equivalent drugs as determined by the Food and Drug Administration which are identical to the Brand Name drugs in strength or concentration, dosage form and route of administration.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provides organized facilities for diagnosis, treatment and surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.

"Immediate Family" means a Covered Person's parent, grandparent, spouse, child, brother, sister stepchild, grandchild, step-grandchild or in-laws.

"Insured" means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person.

“Legend Drug” means any medical substance whose label is required to bear the legend “Caution: Federal Law Prohibits Dispensing Without A Prescription”; or state restricted drug that may not require a prescription under Federal Law, but does require one under state law.

“Life Status Change” means an event recognized by the Employer and Us that qualifies an Insured to make changes in coverage at a time other than an Annual re-Enrollment Period. The following events are all considered Life Status Changes.

1) marriage;
2) divorce, annulment or legal separation;
3) birth or adoption of a child;
4) change in a Dependent child’s eligibility;
5) death of a spouse;
6) a change in the benefit plan or employment status of an Insured’s spouse that affects either person’s eligibility for benefits.

“Member” means an Employer who is a member in good standing with the Association and who has elected to participate in the benefits offered by the Association.

“Non-Participating Pharmacy” means a pharmacy that does not participate in a program used by Us to provide Prescription Drugs in accordance with the provisions of the Policy.

“Participating Pharmacy” means a pharmacy that has agreed to participate in a program used by Us to provide Prescription Drugs in accordance with the provisions of the Policy.

"Plan Year" means the 12-month period defined by an employer's Employee Benefits Plan.

“Prescription Drug” means all Outpatient Generic Legend non-injectable medications shown on the Formulary, unless otherwise specifically excluded, and any of the following:

1. Family Planning
   Oral contraceptives.
2. Nutritional Products
   Prenatal Legend Vitamins.
3. Other Legend Drugs
   a. Acne products (Retin-A only up to 24th birthday).
   b. Compounds, one ingredient must be Legend.
   c. Cough and Cold medication.
   d. Immunosuppressants.

“Outpatient” means a Prescription Drug is not taken in or administered by a Hospital or any other health care facility or office.

All over-the-counter and injectable medications are excluded unless shown above. If classifications contain both prescribed and over-the-counter, or both injectable and non-injectable products, only the non-injectable prescribed products will be covered unless shown above.

“Usual and Customary Charge” means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

“We", "Our", "Us” means the insurance company underwriting this insurance or its authorized agent.

“You”, “Your” or “Yours” means the Employee who is the Insured under the Policy.

ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the Policy is eligible to be insured on the Policy Effective Date, or the day after he or she completes the Eligibility Waiting Period, if later. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

An Insured’s Dependent is eligible on the latest of the date:
1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent ,or
3. the next Annual Enrollment Period following the date the person becomes a Dependent.

A person who is in one of the Classes of Eligible Persons and who is also eligible as a Dependent may be insured only once under the Policy. In no event will a Dependent be eligible if the Insured is not eligible.

EFFECTIVE DATE OF INSURANCE

An Eligible Person will be insured on the latest of Policy Effective Date, the first day of the month following the date he or she is eligible, or the first day of the Plan Year, if not required to contribute to the cost of this insurance.

Insurance for an Eligible Person who is required to contribute to the cost of this insurance is effective on the latest of the following dates:
1. the Policy Effective Date;
2. the first day of the month following the date he or she is eligible;
3. the date the required premium is paid;
4. the date We receive the completed enrollment form; or
5. the date payroll/account deduction is authorized for this insurance.

Insurance for an Insured or Dependent who enrolls during the enrollment period / within 31 days after he or she becomes eligible / or within 31 days after a Life Status Change becomes effective on the latest of the following dates:
1. the Policy Effective Date;
2. the first day of the month following the date he or she is eligible;
3. the date the required premium is paid;
4. the date We receive the completed enrollment form; or
5. the date payroll/account deduction is authorized for this insurance.

Insurance for any newborn Dependent child automatically becomes effective from the moment of birth. Insurance for that Dependent child automatically ends 31 days later unless the Insured has other Dependent children insured under the Policy or within 31 days, makes a request to continue coverage for that child and pays the required premium, when due.

Deferred Effective Date

If an Eligible Person or Dependent is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service. A Dependent's insurance will not be in effect prior to the date an Eligible Person is insured.

TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earliest of the date:
1. the Policy terminates;
2. the Insured is no longer eligible;
3. the Insured is no longer in Active Service;
4. the period ends for which premium is paid;

A Dependent's coverage will end on the earliest of the date:
1. he or she is no longer a Dependent;
2. the Insured's coverage ends; or
3. the period ends for which premium is paid.

Termination of insurance of any Covered Person will be without prejudice to any Covered Expense incurred before the date of termination.

CONTINUATION OF INSURANCE

If an Insured's coverage ends, he or she may be eligible to continue coverage as follows:

A. If the Insured's Active Service ends because he or she is on active duty in the armed forces, insurance will continue for an Insured and his or her insured Dependents, if the required premium is paid, until the earlier of the following dates:
   1. the end of the Benefit Period;
   2. the date the Insured fails to return to work as set forth in the Uniform Services Employment and Reemployment Rights Act of 1993, and as may be later amended.

B. If the Insured requires a family or medical leave, benefits may be continued as provided under the Family and Medical Leave Act of 1993 (FMLA). This provision applies to any Employer with 50 or more Employees.

   Insureds who have been employed by the Employer for at least 12 months and who have performed at least 1,250 hours of work during that period are entitled to 12 work weeks of leave during any 12 month period for one or more of the following reasons:
   1. the birth of an Insured's child;
   2. the placement of a child with the Insured for adoption or foster care;
   3. the care of a spouse, child or parent of the Insured if such person has a serious health condition; or
   4. a serious health condition renders the Insured unable to perform the main functions of his or her employment.

   An Insured on FMLA leave may continue benefits for the duration of that leave under the same conditions as applied prior to the leave. The terms of the FMLA supersede state

family medical leave laws for any Employer of 50 or more Employees insofar as the FMLA provides greater family or medical leave rights than those established by the state law.

Any change in benefits that occurs during a period of continuation will apply on the date the Insured returns to Active Service.

If an Insured continues coverage, he or she may also continue coverage for a Dependent if they are covered under the Policy on the date coverage would otherwise end. If a Former Insured later acquires a Dependent, he or she may elect coverage for them by submitting a request for insurance and paying the required premium.

Coverage will be effective on the date we receive the required premium payment. It will end on the earliest of the following dates.

1. The date We cancel coverage for all members of the Insured's class.
2. The end of the period for which premiums are paid subject to the Grace Period.
3. The date the Insured is age 65.
4. The date the Benefit Period for this benefit ends.

Coverage for a Dependent will end on the earliest of the following dates.

1. The date We cancel coverage for all Dependents of the Insured's class.
2. When the Insured's coverage ends.
3. The date the Benefit Period for this benefit ends.
4. The date he or she no longer qualifies as a Dependent.
5. The end of the period for which premiums are paid subject to the Grace Period.

COBRA Continuation of Benefits
(Applies to Employers with 20 or more Employees)

Applicability

Federal Law requires that Employers who employed 20 or more Employees for at least 50% of the preceding year offer temporary extension of health coverage to Qualified Employees and Qualified Beneficiaries of Employees whose coverage would otherwise end because one or more of the Qualifying Events listed below occurs. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not 1) already covered under the Policy by reason of another individual's election of COBRA Continuation Benefits, or 2) entitled to Medicare benefits under Title XVIII of the Social Security Act.

Qualifying Event

For purposes of coverage under COBRA, the term Qualifying Event means, with respect to any Insured, any of the following events that, but for the continuation coverage required under the law, would result in the loss of coverage for a Qualified Beneficiary.

Qualifying Event	Coverage Continuation Period
• Death of an Insured	36 months
• Termination of employment for any reason except gross misconduct, or the reduction in	18 months*

hours that would result in loss of coverage

- Divorce or legal separation — 36 months
- The Insured becomes eligible for Medicare — Dependents allowed 36 months
- A covered Dependent no longer meets the eligibility requirements — 36 months

* Coverage may be continued for an additional 11 months if the Qualified Beneficiary:
  1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins: and
  2. notifies the plan administrator within 60 days from determination but before the 18-month continuation period ends.

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months from all Qualifying Events.

Notice and Election

Insureds are responsible for notifying their Employer in the case of divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The Employer must notify the plan administrator of the Qualifying Event. The Employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends no earlier than 60 days after the later of 1) the date that coverage would end under the Policy by reason of a Qualifying Event, or 2) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

Premium Payment

The Qualified Beneficiary must pay to the Employer the required monthly premium. Any Grace Period applying to the Employer will also apply to the Qualified Beneficiary, except for the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of the election.

Termination of Continued Benefits

Benefits continued under COBRA will end on the first date that one of the following events occurs:

1. The premium for continued coverage is not paid within 31 days from when it is due;
2. The Qualified Beneficiary becomes covered under another group medical plan providing the same or similar benefits, if that plan does not contain any exclusion or limitation on any pre-existing conditions of the Qualified Beneficiary;
3. The Qualified Beneficiary becomes eligible for Medicare;
4. The Qualified Beneficiary, who is divorced from an insured Employee, remarries and is covered under the new spouse's medical plan; or
5. The Employer no longer provides medical benefits of any kind.

Reinstatement of Insurance

If an Insured's insurance ends because he or she is no longer in Active Service / on active duty in the armed forces, family and medical leave, or unpaid leave of absence insurance may be reinstated for an Insured and his or her insured Dependents within 31 days of his or her return to Active Service.

The following conditions must be met for insurance to be reinstated.
1. The Policy remains in force.
2. The Insured and his or her Dependents are eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to Us.
4. The required premium is paid.

Reinstated insurance will be effective on the later of the date the Insured returns to Active Service or the date the required premium and new enrollment form are received by Us. We will not pay benefits while insurance is not in force under the Policy.

DESCRIPTION OF BENEFITS

PRESCRIPTION DRUG BENEFIT

We will pay the benefit shown in the Schedule of Benefits for Covered Expenses incurred by a Covered Person for the purchase of Prescription Drugs from a Participating or Non-Participating Pharmacy. The Covered Person must satisfy any Deductible or Co-payment shown on the Schedule of Benefits for each Prescription Drug or authorized refill. All benefit amounts are subject to the maximums shown in the Schedule of Benefits.

Prescription Drugs Purchased With Drug Card

The Covered Person will be given a Prescription Drug card. The Covered Person is required to present the Prescription Drug card to the Participating Pharmacy and must pay any Deductible or Co-payment amount shown in the Schedule of Benefits, at the time each Prescription Drug is filled or refilled. When a Prescription Drug card is used at a Participating Pharmacy, benefits are assigned to the Participating Pharmacy.

Prescription Drugs Purchased Without Drug Card

If a Covered Person purchases a Prescription Drug at a Non-Participating Pharmacy or purchases a Prescription Drug at a Participating Pharmacy without the Prescription Drug card, the Covered Person must pay the full cost for the Prescription Drug at the time of purchase and complete a claim form. Reimbursement, subject to any Deductible or Co-payment shown on the Schedule of Benefits, will be made directly to the Covered Person.

Prescription Drugs Purchased By Mail Order (If Elected)

A Covered Person may choose to purchase Prescription Drugs by mailing Our approved reimbursement form to Our approved Mail Service Participating Pharmacy. The Covered Person will be required to pay any Mail Service Deductible or Co-payment amount shown in the Schedule of Benefits.

EXCLUSIONS AND LIMITATIONS

Exclusions

Prescription Drug benefits are not payable for the following items, except as set forth in the Policy:

1. Brand Name Prescription Drugs.
2. All over-the-counter products and medications unless shown in the definition of Prescription Drug. This includes, but is not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements and all other over-the-counter products and medications.
3. Blood glucose meters and insulin injecting devices.
4. Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs.
5. Biologicals (including allergy tests); blood products; growth hormones; hemophiliac factors; MS injectables; immunizations; and all other injectables unless shown in the definition of Prescription Drug.
6. All medical supplies and durable medical equipment unless shown in the definition of Prescription Drug.
7. Liquid nutritional supplements; pediatric Legend Drug vitamins; prescribed versions of Vitamins A, D, K, B12, Folic Acid and Niacin – used in treatment verses as a dietary supplement; and all other Legend Drug vitamins and nutritional supplements.
8. Anorexiants; any cosmetic drugs including, but not limited to, Renova and skin pigmentation preps; any drugs or products used for the treatment of baldness; and topical dental fluorides.
9. Refills in excess of that specified by the prescribing Doctor, or refills dispensed after one year from the original date of the prescription.
10. Any drug labeled “Caution – limited by Federal Law for Investigational Use” or experimental drugs.
11. Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
12. Drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
13. Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or any act of war; or drugs dispensed to a Covered Person while on active duty service in any armed forces.
14. Any expenses related to the administration of any drug.
15. Drugs or medicines taken while in or administered by a Hospital or any other health care facility or office.
16. Drugs covered under Worker’s Compensation, Medicare, Medicaid or other governmental program.
17. Diaphragms; erectile dysfunction Legend Drugs; and infertility Legend Drugs.
18. Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard; Glucagon-auto injection; and Imitrex-auto injection.
19. Smoking deterrents, Legend or over-the-counter drugs.
20. Replacement of lost, stolen, spilled, broken or dropped Prescription Drugs while on vacation.
21. All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of one year from such FDA approval for its intended indication.

Limitation

If a Brand Name Prescription Drug is dispensed in lieu of an available Generic Prescription Drug, then, in addition to any Deductible or Co-payment amount shown on the Schedule of Benefits, the Covered Person will be responsible for the cost of such Prescription Drug which exceeds the cost of its Generic alternative.

CLAIM PROVISIONS

Notice of Claim: A claimant must give Us or Our authorized representative written (or authorized electronic or telephonic) notice of claim within 90 days after any loss covered by the Policy occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

Claim Forms: Upon receiving written notice of claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss. We will notify the claimant of receipt of the claim and will commence investigation of the claim within 15 business days after receive of the notice of claim.

Proof of Loss: Written (or authorized electronic or telephonic) proof of loss must be sent to the agent authorized to receive it. Written (or authorized electronic or telephonic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted if it is sent later than one year from the time proof is otherwise required.

Claimant Cooperation Provision: Failure of a claimant to cooperate with Us in the administration of a claim may result in the termination of a claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Time of Payment of Claims: Any benefits due will be paid within 60 days of the date We receive written (or authorized electronic or telephonic) proof of loss.

We will notify the claimant of the acceptance or rejection of a claim not later than 15 business days from receipt of all items, statements, and forms required by us to secure final proof of loss. If we are unable to accept or reject the claim within the 15 working days, we will notify the claimant of the reasons we need additional time. We will accept or reject the claim not later than the 45th day after the date we notify the claimant under this paragraph.

Payment of Claims: If the Covered Person dies, any benefits due to the Covered Person and unpaid at the time of the Covered Person's death will be paid to the first surviving class of the following:

1. to the Covered Person's spouse;
2. to the Covered Person's children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian);

3. to the Covered Person's mother or father;
4. to the estate.

We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to the provider of covered services.

Legal Actions: No lawsuit or action in equity can be brought to recover on the Policy: (1) before 61 days following the date proof of loss was given to Us; or (2) after 3 years following the date proof of loss is required.

Recovery of Overpayment: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid, or paid in error, by any or all of the following methods.
1. A request for lump sum payment of the amount overpaid, or paid in error.
2. Reduction of any proceeds payable under the Policy by the amount overpaid, or paid in error.
3. Taking any legal action available to Us.

ADMINISTRATIVE PROVISIONS

Premiums: The premiums for the Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Payment of Premium: The first Premium is due on or before the Covered Person's Effective Date of coverage. After that, premiums will be due monthly unless We agree with the Employer on some other method of premium payment.

If any premium is not paid when due, the Covered Person's coverage will be canceled as of the Premium Due Date, except as provided in the Grace Period section.

Grace Period: If the required premium is not paid on the Premium Due Date, there is a 31-day Grace Period after each Premium Due Date after the first. If the required premium is not paid during the Grace Period, the Insured's insurance , and insurance for his or her Dependents will end on the last day of the period for which premium was paid prior to the start of the Grace Period. If a Member submits a valid claim for a loss that is covered by the Policy and incurred prior to the end of the Grace Period, the Member will be liable to Us for payment of any premium accruing prior to the end of the Grace Period.

If benefits are payable during the Grace Period, We will deduct any overdue premium from the proceeds payable under the Policy.

GENERAL PROVISIONS

Entire Contract: The Policy (including any endorsements or amendments), the signed application of the Policyholder, Employer, and any individual applications of Covered Persons, are the entire contract.

Changes: To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

Contestability: In the absence of fraud, any statements made by the Policyholder, Employer or Covered Persons will be treated as representations and not warranties.

No such statement may be used in any contest under the Policy, unless a copy of the written instrument containing the statement is or has been provided to:

a. the person making the statement; or
b. if the statement was made by the Covered Person and the Covered Person has died or become incapacitated, the Covered Person's beneficiary or personal representative.

Clerical Error: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

Conformity with State Laws: On the effective date of the Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.