

schedule of benefits

What's covered under your SummaCare plan



INDIVIDUAL PPO PLAN Q1501-80A

This plan is underwritten by the Summa Insurance Company



SUMMACARE

www.summacare.com

WELCOME TO SUMMACARE!

The following is a listing of benefits and coverage for SummaCare Individual PPO Plan Q1501-80A.

The Certificate of Insurance received upon enrollment gives further clarification of the benefits available to you under this Plan.

Below are definitions that explain some key terms used in this Schedule.

Deductible: A fixed amount of dollars that an individual or family must pay before health benefits begin.

Copay: An out-of-pocket expense an enrollee must pay to receive services. Copays are typically due at the time services are received.

Coinsurance: A percentage of costs that an enrollee must pay to receive services. Coinsurance is typically due after services are received and charges have been submitted to the Plan for payment.

Essential Health Care Benefits: Essential Benefits, as defined by HHS, include but may not be limited to the following categories of benefits: Ambulatory patient services; emergency services; hospitalization, maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness service and chronic disease management; and pediatric services including oral and vision care.

In-Network Provider (Preferred Provider): A provider who is contracted with SummaCare to supply services or supplies to enrollees.

Maximum Allowable Charge: The amount that SummaCare in-network providers have agreed to accept as full payment for their services.

Medically Necessary: A service or supply must be necessary and appropriate for the diagnosis and treatment of an illness or injury as determined by SummaCare Health Services Management Program and based on generally accepted current medical practice.

Mental Health Biologically-Based Services: These services include treatment for schizophrenia, bipolar disorder, major depressive disorder, paranoia, obsessive-compulsive disorder and other disorders as these terms are defined in the most

recent edition of the Diagnostic and Statistical Manual of Mental Health Disorders published by the American Psychiatric Association.

Mental Health Non-Biologically-Based Services: These services include treatment for substance or alcohol abuse or other disorders that do not meet the definition of Biologically-Based Services.

Out-of-Network Provider (Non-Preferred Provider): A provider who is not contracted with SummaCare to supply services or supplies to enrollees.

Prior Authorization (Approval): SummaCare requires that some services are approved before they are performed to ensure that the services are medically necessary. The most current list of these services can be viewed on www.summacare.com or attached to your Certificate of Insurance which you will receive upon enrollment.

WHAT IF I HAVE QUESTIONS?

As a SummaCare member, we want you to be informed. Maximize your benefits by knowing about your plan.

Benefits or Coverage Questions

Customer Service: 330-996-8700 or 800-996-8701 (TTY 800-750-0750)

Representatives are available to take your call from 8:30 a.m. to 5:30 p.m. Monday through Friday.

On-line: www.summacare.com

Members can go to our website and create a personalized account. You'll be able to view benefits, claims and dependent information at your convenience – 24 hours a day/seven days a week. You can also search the SummaCare PPO network, view pharmacy information and learn about SummaCare's Health & Wellness Services available to you.

Medical Questions

24 Hour Nurse Line: 800-379-5001

Registered nurses are available 24 hours a day, seven days a week to answer your medical questions and help you determine the most appropriate place to seek care if needed.

To find a doctor or hospital visit
www.summacare.com

SUMMACARE INDIVIDUAL PPO PLAN Q1501-80A

Enrollee Services	In-Network (Preferred Provider)	Out-of-Network (Non-Preferred Provider)
Individual/Family - Calendar Year Deductible (In-Network and Out-of-Network Deductibles are separate.)	\$1,500/\$3,000* (Only applies where noted)	\$3,000/\$6,000* (Only applies where noted)
Individual/Family - Calendar Year Out-of-Pocket Maximum (Includes deductible. Copays do not apply to this maximum.)	\$3,000/\$6,000	\$6,000/\$12,000
Coinsurance (What the plan pays after the deductible is met but before the out-of-pocket maximum is reached; after the out-of-pocket maximum is reached services are covered at 100% of Maximum Allowable Charge.)	80%	60% of Maximum Allowable Charge
Restricted Annual Limits Per Calendar Year (Annual limit per member per calendar year for all Essential Benefits.)	\$750,000 for Calendar Year 2011 \$1,250,000 for Calendar Year 2012 \$2,000,000 for Calendar Year 2013	
Lifetime Benefit Maximum	Unlimited	
Office Services:		Coverage Based on Maximum Allowable Charge
Primary Physician Visits	80% (Subject to deductible)	60% (Subject to deductible)
Preventive Care (Includes mammograms, immunizations, well-child care and preventive services as defined by the United States Preventive Services Task Force under grades A and B preventive services. Refer to SummaCare's Health Care Reform Rider.)	100%	60% (Subject to deductible)
Gynecological Visits	80% (Subject to deductible)	60% (Subject to deductible)
Specialist Visits	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient Services: (May Require Prior Authorization)		
X-ray, Laboratory & Other Diagnostic Services	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient Surgery	80% (Subject to deductible)	60% (Subject to deductible)
Inpatient Hospital Services: (Requires Prior Authorization)		Coverage Based on Maximum Allowable Charge
Inpatient Care	80% (Subject to deductible)	60% (Subject to deductible)
Rehabilitative Services	80% (Subject to deductible)	60% (Subject to deductible)
Maternity Services:	Not covered on this plan.	
Emergency/Urgent Care Services:		
Emergency Care (Any hospital emergency room visit inside or outside of the service area)	80% (Subject to deductible)	80% (Subject to deductible) Maximum Allowable Charge (Subject to balance billing.)
Urgent Care (Urgently needed care that is not life-or limb-threatening)	80% (Subject to deductible)	80% (Subject to deductible)

SUMMACARE INDIVIDUAL PPO PLAN Q1501-80A

Enrollee Services	In-Network (Preferred Provider)	Out-of-Network (Non-Preferred Provider)
Mental Health and Substance Abuse Services:		
Biologically Based Mental Health:		
Inpatient	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient	80% (Subject to deductible)	60% (Subject to deductible)
Non-Biologically Based Mental Health and Substance Abuse Disorders:		
Inpatient	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient	80% (Subject to deductible)	60% (Subject to deductible)
Other Services:		
Allergy Tests & Treatment	80% (Subject to deductible)	60% (Subject to deductible)
Ambulance Services	80% (Subject to deductible)	\$75 copay; Copay waived if admitted
Chiropractic Services	80% (Subject to deductible)	60% (Subject to deductible)
Durable Medical Equipment	80% (Subject to deductible)	60% (Subject to deductible)
Home Health Care	80% (Subject to deductible)	60% (Subject to deductible)
Hospice Services	80% (Subject to deductible)	60% (Subject to deductible)
Infertility Diagnosis	80% (Subject to deductible)	60% (Subject to deductible)
Outpatient Rehabilitative Services	80% (Subject to deductible)	60% (Subject to deductible)
Skilled Nursing Facility	80% (Subject to deductible)	60% (Subject to deductible)
Vision Exam	80% (Subject to deductible)	60% (Subject to deductible)
Prescription Drugs:	80% (Subject to deductible)	60% (Subject to deductible)

*Family deductible must be met before any benefits are provided on a family contract.

Benefit Plan Limitations

The following limits remain on your plan.

Non- Biologically Based Mental Health and Substance Abuse (includes \$550 per calendar year for Alcohol Abuse) limited to: (For groups of 50 or under Employees)
Inpatient (21 days per calendar year)
Outpatient (20 visits per calendar year)

Chiropractic limited to:
(10 visits per calendar year)

Home Health Care limited to:
(30 visits per calendar year)

Rehabilitative Services limited to:
Physical and Occupational Therapies (30 visits per calendar year combined)
Speech Therapy (30 visits per calendar year)
Cardiac/pulmonary (36 visits per calendar year)

Skilled Nursing Facility limited to:
(100 days per calendar year) in-network
(30 days per calendar year) out-of-network

Vision Exam
(One routine exam every 24 months)

Summa Insurance Company

Patient Protection and Affordable Care Act of 2010 Rider

This Rider amends your health benefit plan (Plan), as of the issue or renewal on or after September 23, 2010, the Effective Date. Please place this Rider with your policy for future reference.

On the Effective Date of this Rider, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

Regardless of the terms and conditions of any other provisions of your Plan, this Rider will control.

The following Definitions are added to your Plan:

“**Essential Health Benefits**” is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this Rider.

Emergency Services

“Stabilize” means, to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out of network provider. However, an out of network provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called “balance billing”). Except where your Plan provides a better benefit, your Plan will apply the same copayments and coinsurance for out of network Emergency Services as it generally requires for in network Emergency Services. A deductible may be imposed for out of network Emergency Services, only as part of the deductible that generally applies to out of network benefits. Similarly, any out-of-pocket maximum that generally applies to out of network benefits will apply to out of network Emergency Services.

Your Plan will calculate the amount to be paid for out of network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to in network providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with in network providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for out of network services (such as the usual, customary and reasonable charges), but substituting in network copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any in network copayments or coinsurance.

Lifetime Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

Annual Dollar Limits

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than \$750,000.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than \$1.25 million.
- For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than \$2 million.
- For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Preventive Health Benefits

Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services without a copayment, coinsurance or deductible when these services are delivered by a network provider. Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at www.summacare.com or 330-996-8700 or 800-996-8701, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

Dependent Coverage (for plans that make dependent coverage available)

This Plan will cover your married or unmarried child as defined Section II of this Plan until your child reaches age 26.

Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, step-child, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

Internal Claims and Appeals and External Review Process

If you are not happy with a decision about a claim, or have another complaint, you can call Customer Service at (330) 996-8700 or 800-996-8701. A Customer Service representative will ask you questions about your complaint and investigate the facts. You will receive a verbal response to your complaint within five business days.

If you are still not happy, you can pursue your complaint further through one of SummaCare's two formal complaint processes. They are the Grievance and the Appeal Process. The Appeal Process should be used whenever you disagree with SummaCare's decision to deny, reduce, or terminate a service or a claim. The Grievance Process is used for all other complaints, regarding such things as service, quality of care, or timely access to doctors and other providers. Each process is explained in detail below:

A. Grievances:

If you are not happy with the care or service you receive from SummaCare or any of our contracted providers, you may address those concerns through our formal grievance process. Some examples of a grievance are:

- A very long time on hold when calling Customer Service;
- Rude treatment by a provider or his office staff;
- You believe that the care you received from a SummaCare provider was not appropriate;
- You believe a SummaCare employee has violated your privacy rights.
- Out of Network payment issues.

To file a grievance, send your request to:

SummaCare
Grievance Department
P.O. Box 3620
Akron, Ohio 44309-3620

You may also fax your grievance to (330) 996-8545, or submit it electronically to info@Summacare.com, or you may bring your grievance to the SummaCare offices located at 10 N. Main Street, Akron, Ohio. Please be as clear as possible when describing your grievance. If you need help with your grievance, please call Customer Service for assistance. A Customer

Service Representative will help document the details of your grievance over the phone. If your complaint is about the quality or appropriateness of care, you must file your grievance within 180 days from the date you received the service.

We will investigate your grievance and respond to you in writing within 30 calendar days. Our response will inform you of our findings and any action that we have or will take as a result of your grievance.

If you are not happy with our response, you may file a second level grievance at the same address listed above. Your second level grievance will be reviewed by individuals who were not previously involved in investigating your complaint. A written response will be issued within 40 calendar days. The response will inform you of any further action we will take.

If you still are not happy, you may file a complaint with the Ohio Department of Insurance, Consumer Services Division, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215. You may also call the Ohio Department of Insurance at 800-686-1526 or 614-644-2673.

B. Urgent Benefit Determinations

You will receive notification of any benefit determination, whether adverse or not, with respect to a claim involving urgent care, as soon as possible, but not later than 24 hours after receipt of the claim.

A claim involving urgent care is one that could result in any of the following:

- Place you or your unborn child in serious jeopardy;
- Cause serious impairment to bodily functions or serious dysfunction of any organ or part;
- Place you in severe pain that cannot be adequately managed without the care or treatment in question.

To request that your benefit determination be expedited, you must call Customer Service at 330-996-8700 or 800-996-8701. If your expedited benefit determination is denied in whole or in part, you may proceed immediately with an expedited independent review (see L below).

C. Internal SummaCare Appeals:

As a member of SummaCare PPO, you have the right to appeal decisions that deny or limit your health care benefits. If a service is denied, reduced or terminated, or if payment of a claim is fully or partially denied, or if your coverage is rescinded, you may appeal that denial or rescission and your benefits will continue during the appeal. To file an appeal, send a written request to:

SummaCare
Appeals Department
P.O. Box 3620
Akron, Ohio 44309-3620

You may also fax your appeal to 330-996-8545 or submit electronically to appeals@summacare.com, or you may bring your appeal to the SummaCare offices located at 10 North Main Street, Akron, Ohio. Please be as clear as possible when describing your appeal. Any additional documentation that supports your request should be submitted with your appeal. If you need help with your appeal, please call Customer Service for assistance. A Customer Service representative will help document the details of your appeal over the phone. However, you will still need to follow-up with a signed, written appeal. You must file your appeal within 180 days from the date you first received notice of the denial you want to appeal. We may accept an appeal from you after 180 days for just cause, but we are under no obligation to do so. An authorized individual, who may be a friend, family member, doctor, or anyone you choose, may appeal for you; but we must receive a signed and dated statement from you or other legal authority authorizing that person to act on your behalf.

After we investigate the facts, your appeal will be reviewed by individuals who had no previous involvement with the decision. If your appeal is in any way related to the medical appropriateness of the care or services in question, the appeal would be reviewed by a board certified physician. We do not hire, compensate, terminate or promote any individuals based upon their likelihood to support a denial of benefits. The exact time frame for resolving your appeal depends upon a number of factors.

We must also provide you, free of charge, any new or additional evidence considered, relied upon, or generated by us in connection with your claim. Additionally, if we rely on a new or additional rationale, we must provide you, free of charge, with the rationale.

D. Post-Service Appeals:

If your appeal is about a service that you have already received, it will be handled as a post-service appeal. We will notify you in writing of the outcome to your post-service appeal within 30 calendar days from the date we received your appeal.

E. Pre-Service Appeals:

If your appeal is asking that we cover a service or medical item that you have not yet received, we will notify you in writing of the outcome within 15 calendar days. Our response will explain the basis of the decision and inform you of any action that SummaCare has or will take as a result of your appeal.

F. Expedited or Fast Appeals:

You may request an expedited appeal if you believe that waiting 15 days for a pre-service decision could result in any of the following:

- Place you or your unborn child in serious jeopardy;
- Cause serious impairment to bodily functions or serious dysfunction of any organ or part;
- Place you in severe pain that cannot be adequately managed without the care or treatment in question.

Expedited appeals are only granted in medically urgent situations. We do not have to expedite your appeal if we believe that it does not meet any of the three reasons listed above. If we determine that your appeal does not qualify for a fast/expedited review, we will still process it as a standard pre-service appeal. If a licensed physician indicates that expedition is necessary for medical reasons, we will automatically expedite your appeal. You also have the right to request a concurrent expedited external review at the same time you request an expedited appeal.

Expedite appeals will be completed within 24 hours from the time it is received or as fast as medically necessary. To request that your appeal be expedited, you must call Customer Service at 330-996-8700 or 800-996-8701. If your expedited appeal is denied in whole or in part, you may proceed immediately with an expedited independent review (see L below).

Please Note: The time frame for resolving any of the internal appeals described above may be shortened if the seriousness of your condition requires a faster review. In certain situations, we may, with your permission, choose to skip the internal appeal process and proceed directly with one of the additional external appeal processes described below.

G. Immediate External Appeals:

If we fail to adhere to our internal claims and appeals process, you may immediately request an external appeal.

H. Additional External Appeals:

If you are still not happy with SummaCare's decision, you may request a review from another source. You may appeal denials for any of the reasons listed below:

- They are not covered services
- They are not medically necessary
- They are experimental and you have a terminal illness

These additional appeals are available only after you complete our internal appeal process. The procedures for appealing denials beyond SummaCare are explained below.

I. Denial Because Services are Not Covered

If SummaCare denies a service because it is not a covered service, you may request a review from the Ohio Department of Insurance after exhausting the internal review process. You can write the Department of Insurance at 50 W. Town Street, Third Floor – Suite 300, Columbus, Ohio 43215 or call the Department at 800-686-1526.

The Department will review your contract and the type of service requested. If the Department is not able to determine that the service is a covered benefit, because deciding requires resolution of a medical issue, upon notice from the Department, we will initiate an external review. If the external review by an Independent review Organization (IRO) determines that the service is a covered benefit, we will pay for the service.

J. Denial Because Services are Not Medically Necessary

If we deny a service because it is not medically necessary and the service and related expenses are not covered and will cost you more than \$500 (the \$500 requirement does not apply to expedited cases), you may request an external review from an Independent Review Organization (IRO). The IRO is not affiliated with SummaCare.

You must request this review within 180 days of receiving notice that your appeal was denied. Your request must be in writing and include certification from the provider that the service will cost you more than \$500. Please see L below for instructions to request an external review.

The IRO will review your medical records and determine if the recommended service is medically necessary. If the IRO determines that the service is medically necessary, we must pay for the service according to the terms of the contract. If the IRO determines that the service is not medically necessary, we will not pay for the service.

K. Denial Because Services are Experimental

If you have a terminal illness you may also request an external review when services are denied because they are experimental or investigative. To qualify for this review you must meet all of the following criteria:

1. You have a terminal condition that, according to the current diagnosis, has a high probability of causing death within two years.
2. You request an external review not later than 180 days after receiving our decision denying the requested service because it is experimental.
3. Your physician certifies that one of the following situations applies to your condition:
 - a. Standard Therapies have not been effective in improving your condition;
 - b. Standard Therapies are not medically appropriate for you;

- c. There is no standard therapy covered by the policy that will benefit you more than the therapy requested by either you or your physician.
4. Your physician has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to benefit you more than standard therapies; or you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
5. You have exhausted all internal levels of appeal.
6. The drug, device, procedure, or other therapy would be covered if it were not considered to be experimental or investigative.

Please see L below for instructions to request an external review.

L. Instructions for Requesting an External Independent Review:

You must request an external review in writing within 180 days of receiving notice from us that your request for coverage is denied. You, an authorized person, the provider, or the health care facility representative may request the review. The provider and health care facility must have your signed authorization to request a review. You do not need the authorization of the provider. You are not required to pay for the review. SummaCare pays for the review.

To file a request for an external review, send a written request to:

SummaCare
Appeals Department
P.O. Box 3620
Akron, Ohio 44309-3620

You may also fax your request to 330-996-8545 or submit electronically to appeals@summacare.com, or you may bring your appeal to the SummaCare offices located at 10 North Main Street, Akron, Ohio.

The independent review organization must provide you with a response within 30 days. The decision of the IRO must include:

- a. A description of the patient's condition;
- b. The principal reason for the decision; and
- c. An explanation of the clinical rationale for the decision.

M. Expedited External Review:

When the independent review must be completed quickly because of your medical condition, you may request an external review by phone, fax or email. However, you must follow up this request with a written request within five days. The independent review organization must provide you with a response to an expedited review within seven days of your initial request.

You may request an expedited independent review if delaying the review will do any of the following:

- a. Place the health of the patient or unborn child in serious jeopardy;
- b. Cause serious impairment to bodily functions; or
- c. Cause serious dysfunction of any body organ or part.

N. Provider Reconsiderations:

Your provider has the right to request in writing, on your behalf, a review of a decision with which you disagree. We require your provider to obtain your signed statement authorizing him or her to request reconsideration. We will work with your provider to get the information needed to review the decision. We will reply to your provider's request within three business days.

No Preexisting Condition Limitations for Enrollees under age 19

The Preexisting Condition Limitations described in Section III of your Plan do not apply to enrollees who are under 19 years of age. With respect to enrollees who are under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means an enrollee under the age of 19 cannot be excluded from the plan if the exclusion is based on a preexisting condition.

This Rider takes effect on the effective date of the Plan to which it is attached. This Rider terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

Summa Insurance Company



Martin P. Hauser
President