



The Defend Plans

through Acuity Group.

Safe and Simple

Fixed-Cost Self-Funded Medical Coverage

Plus Refund AssistersSM

Why Self-Fund?

There's nothing wrong with traditional health care coverage. You pay a monthly fee and outsource all your medical plan needs to an insurance company or HMO. You know what you'll pay each year and your carrier does all the work. However, when claims are less than expected who keeps the savings? With traditional coverage, the answer is the insurance carrier, not you.

Fortunately, you have another option: fixed-cost, self-funded medical coverage. You pay a monthly fee and outsource all your health plan administration. You know what you'll pay each year and your third party administrator does all the work. Best of all, when claims are less than anticipated, you—not the carrier—keep the savings.

Self-funding delivers other advantages, too. You can offer the same plan to employees in different states because self-funded plans are governed by federal law. And the monthly cost is often comparable to—or less—than traditional insurance.

With great advantages comes great responsibility. With self-funded health plans, you (the plan sponsor) are responsible for claims. That's why "pure" self-insurance is better suited for extremely large companies with big pockets. For the rest of us, it makes sense to cap claims liability with stop-loss coverage.

Upside opportunity. Downside protection.

That's the beauty of self-funding with stop-loss coverage. When claims are higher than expected you're protected; when they're lower you reap the savings.



**Keep the savings
or gift it to
an insurance
company.**

**The choice
is really that
simple.**

Why the Defend Plans?

Self-funding can be complicated, but it doesn't have to be. We've designed the Defend Plans to make things easy and straightforward.

And while self-funding carries some risks, the Defend Plans keep things safe by limiting exposure to high claims, delivering comprehensive benefits, and encouraging preventive care.



Safe

Claims, billing and other operations are provided through Acuity Group, the program's highly respected third party administrator. Stop-loss coverage is provided by carriers on which you can rely.



Simple

Quality PPO plans. Quality national networks, too. Set designs for standard PPO and RBP plans. Because keeping things consistent, keeps things simple.



Fixed-Cost

Your monthly costs are determined up-front. Your responsibility for claims is capped, too. And composite rates mean you know the medical premium of new hires.



Self-Funded

You receive 100% of any surplus claim fund dollars. Unlike some self-funded programs, we don't deduct a fee from your refund. You get it all.



Plus Refund AssistersSM

Self-Funding offers the possibility of refunds when claims are lower than anticipated. The Defend Plans help you seize that potential with Refund AssistersSM: wellness, telemedicine and cost review programs that maximize your benefit dollars.



We keep things easy.

So everyone can secure the benefits – and savings – of self-funding.

What to Know

Your broker can help you determine if self-insurance is right for you. Here are some items to help your discussion.



Heads you win,
tails you don't
lose.

Terms

Just like with traditional health insurance there are certain terms you need to know when discussing fixed-cost self-funded medical coverage.

Claims Fund: the portion of your monthly payments set aside to cover claims. The rest of your monthly payments go towards stop-loss coverage, administration, operations, and to legally required fees and taxes.

Claims Fund Surplus: the unused dollars in your **claim fund** after eligible claims are paid out during the contract period.

Composite Rates: the cost of coverage is averaged over the entire group as opposed to varying by age. Each employee pays the same rate, adjusted only for the number of their dependents and location. Composite rating helps you better budget your benefit dollars.

Contract Period: the time during which eligible claims must be incurred and paid for in order to be eligible and covered by your benefit plan as shown by two numbers. The first number describes the time during which covered claims may be incurred. The second number indicates the time when claims need to be paid by.

Fixed-Cost: a self-insured arrangement in which employers pay a set amount each month towards administration, stop-loss coverage and claims expenses, with no additional charges if claims are higher than anticipated.

Plan Year: the months during your coverage in which incurred claims are covered by the plan, usually 12 months.

Run-Out: the time following the incurred period in which all claims must be submitted and paid in order to be covered by the stop-loss carrier.

Self-Funded or Self-Insurance: benefit arrangements in which the employer is responsible for claims payment instead of an insurance company. When claims are lower than anticipated, the employer gets the savings.

Stop-Loss Insurance: protects self-insured employers from excessive claims. There are two types: **specific** stop-loss steps in when any individual's claims exceed a specified amount; **aggregate** stop-loss pays eligible claims once your **claims fund** is exhausted. **Excess-loss insurance** is another name for this coverage.

Reference Based Pricing (RBP): with Reference Based Pricing providers are reimbursed based on a percentage of a specified standard, such as what Medicare pays for the same treatments and services. Programs like the Defend Plans use RBP for facilities like hospitals, clinics and hospices, along with some other services such as prosthetics, lab work and ambulance services. They may make doctors and specialists available through a physicians-only PPO, however. RBP plans sometimes have a patient advocacy component to help eliminate balance billing, negotiate charges and educate insureds. The Defend Plans uses 6 Degrees Health for this.



Getting Your Refund

**It's your refund.
You get it all.**

Getting refunds sounds good. But how do you get them? Simply.

Monthly Payments

It all begins with the plan year. Each month you'll make monthly payments that pay for administration and operating expense, stop-loss coverage, taxes, regulatory fees, and your claims fund.

The Claims Fund

Eligible claims—those covered by the benefit plan, incurred during your plan year, and submitted and paid for within the contract period—are reimbursed from your claim fund. If eligible claims exceed what's in the claims fund, it's not a problem. Stop-loss coverage pays them.

Your Refund

If claims paid out in the contract period are less than what you paid into your claims fund you receive a check for 100% of this surplus.

But what about?

Claim Timing: Not a Problem

Claims can pile up before you pay enough into the claims fund. Some programs make you pay the shortfall; an unanticipated hit to your bottom line. The Defend Plans protect you from this painful bill. We advance these claims costs, then apply future contributions to the claims fund to balance things out.

Claims Past the Plan Year

When you renew with the Defend Plans we automatically extend the payment period to cover claims incurred in the prior year. If you leave the Defend Plans, you still have a six month run-out period. Employees will need to have claims paid by the end of this six-month period. Late claims are their responsibility to pay, not yours or the stop-loss carrier.

Underwriting Matters

When it comes to self-funded coverage, assessing the health and likely claims for your group is critical.

Underwriting determines your monthly charges for expected claims. Your refund is based on the difference between actual claims and those expected claims.

That's why groups applying for self-funded coverage are fully underwritten. In the absence of claims experience, all employees and their dependents

will be asked to answer health questions—and it's critical they provide complete and accurate answers. Otherwise rates may be modified and stop-loss coverage for the members making mistatements may be rescinded. This means the plan sponsor (you) are responsible for these claims.

Consult Your Broker

The Defend Plans can deliver tremendous benefits to employers, both large and small. Simple and safe, they feature competitive rates, offer the opportunity—and provide tools—for earning refunds, all while helping employees improve and manage their health. Your broker understands your needs and the options available to you. As important, your broker can help you understand the responsibilities and obligations that come with the benefits of a fixed-cost self-funded medical plan.

The Defend Plans Deliver

Self-funding with stop-loss protection is the right choice for many businesses. The Defend Plans offer Refund AssistersSM so you can make this choice with confidence.



Refund AssistersSM

Getting benefit dollars back when claims are lower than expected is why many employers move to fixed-premium self-insurance programs. Too often, however, these programs do too little to make those refunds a reality. The Defend Plan program is different.



Wellness

The best way to reduce health care costs is to stay healthy. That's why the Defend Plans pay members to get their annual physical exam and provide easy-to-use online wellness coaching. In addition, members with specified chronic conditions are offered nurse-coaching on proven health-improving and cost-cutting regimens.



Telemedicine

Think of them as 21st century house calls: a private conversation between you and your doctor. Teladoc, one of the largest, most trusted telemedicine providers, provides convenient access to board-certified, U.S.-based doctors and pediatricians. Better still, telemedicine doctor consultations are subject to a lower co-pay.



Expense Review

Every business owner knows it's important to monitor spending. That's why we engage experienced health plan executives —independent of our administrator and stop-loss carriers—to review overall program expenses. As a result, you can expect smarter spending of benefit dollars.



Anyone can offer refunds.
Our Refund AssistersSM help deliver them.

An All-Star Team

Getting the most from your benefit dollars means working with the best team. That's why the Protect Plan program brings together best-in-class experts with the focus and skills you can count on for outstanding performance.

Reliable Plan Administration

Acuity Group, founded in 1985, is the highly regarded third party administrator for the Defend Plans. They provide seamless integration with the Defend Plans' national network of quality health care hospitals, pharmacies, doctors and other providers.

Acuity Group is responsible for:

- Membership services.
- Employer services.
- Claim payments.
- Utilization review.
- Case management.
- Run-Out management.
- Billing.
- COBRA administration.
- Production and distribution of legally required documents*
- Wellness
 - with cash rewards for members completing annual preventive exams
- Chronic condition management.
 - featuring financial rewards for members with specified conditions managing and improving their health

**This is not inclusive of all plan notice requirements to which you may be subject.*



Broad, Strong Networks

The Defend Plans standard plans delivers the extensive Cigna Choice Fund PPO network. Script Care provides prescription management services through a large, national pharmacy network.

The Defend Plans RBP plans do not use a network. Reimbursement for covered medical expenses are based on a pre-determined reference price.

Nationwide network:

Traditional PPOs: Cigna Choice Fund PPOs offering in-network access to thousands of doctors, specialists, and other physicians

Stop-Loss Coverage

Stop-loss coverage limits your exposure for eligible claim payments. It's your safety net. When self-funding, you need to be confident your stop-loss carrier will be there when you need them. Which is why the Defend Plans use A.M. Best Rated A carriers.



Refund AssistersSM
and an All-Star Team
are how we keep our
commitment to you.

DEFEND HSA PLANS

HSA-compatible plans with a wellness twist.

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance Rewards: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain receive nurse-coaching to improve outcomes and reduce costs.

Health Rewards

Plan Name

**DEFEND HSA
3000**

**DEFEND HSA
4000**

**DEFEND HSA
5000**

Maximum Lifetime In-Network Benefits

No Lifetime Maximum
(Unlimited)

Annual Deductible

In-Network / Out-of-Network

Single

\$3,000 / \$5,000

\$4,000 / \$6,000

\$5,000 / \$7,000

Family

\$6,000 / \$10,000
(Aggregate)

\$8,000 / \$12,000
(Aggregate)

\$10,000 / \$14,000
(Aggregate)

Annual Out-of-Pocket Maximum

In-Network / Out-of-Network

Single (Includes Deductible)

\$5,000 / \$7,000

\$5,500 / \$8,000

\$6,000 / \$9,000

Family (Includes Deductible)

\$10,000 / \$14,000

\$11,000 / \$16,000

\$12,000 / \$18,000

Office Visits

In-Network / Out-of-Network

In office

20% / 30%

20% / 30%

20% / 30%

Telemedicine through Teladoc

\$10 Co-pay*

\$10 Co-pay*

\$10 Co-pay*

Professional Services

In-Network / Out-of-Network

- Lab & X-Ray
- Maternity

20% / 30%

20% / 30%

20% / 30%

Hospital & Facility Services

In-Network / Out-of-Network

Hospital Inpatient

20% / 30%

20% / 30%

20% / 30%

Emergency Room Facility

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

Emergency Room Physician Services

20% / 30%

20% / 30%

20% / 30%

Urgent Care Center (Physician Services)

\$150 Co-pay* then
covered 100% / 30%

\$150 Co-pay* then
covered 100% / 30%

\$150 Co-pay* then
covered 100% / 30%

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Prescription Drug Benefit:
Covered Prescription Drug costs apply towards the
Network Out-of-Pocket Maximum

Co-pays apply only after satisfying the Annual Deductible:

Tier 1–Generic Drugs: \$10

Tier 2–Preferred Brand-Name Drugs: \$35

Tier 3–Non-Preferred Drugs (Non-Formulary): 50%

Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to \$300 Co-pay per prescription

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam:
100% Coverage

0%
Not Subject to Deductible

*Co-pays apply after meeting the annual deductible. Please Consult Summary of Benefits & Coverage for benefit details.

DEFEND CO-PAY PLANS

Comprehensive benefits with low-cost office visits.

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance Rewards: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain receive nurse coaching to improve outcomes and reduce costs.

Healthier Plans

Plan Name

Maximum Lifetime In-Network Benefits

Annual Deductible

Single

Family

Annual Out-of-Pocket Maximum

Single (Includes Deductible)

Family (Includes Deductible)

Office Visits

In office

Telemedicine through Teladoc

Professional Services

- Lab & X-Ray
- Maternity

Hospital & Facility Services

Hospital Inpatient

Emergency Room Facility

Emergency Room Physician Services

Urgent Care Center (Physician Services)

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Prescription Drug Benefit:
Covered Prescription Drug costs apply towards the Network Out-of-Pocket Maximum

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam: 100% Coverage

	DEFEND 500 CO-PAY	DEFEND 1000 CO-PAY	DEFEND 2000 CO-PAY	DEFEND 3000 CO-PAY	DEFEND 4000 CO-PAY
Maximum Lifetime In-Network Benefits	No Lifetime Maximum (Unlimited)				
Annual Deductible	In-Network / Out-of-Network				
Single	\$500 / \$2,500	\$1,000 / \$3,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$4,000 / \$6,000
Family	\$1,000 / \$5,000 (Embedded)	\$2,000 / \$6,000 (Embedded)	\$4,000 / \$8,000 (Embedded)	\$6,000 / \$8,000 (Embedded)	\$8,000 / \$12,000 (Embedded)
Annual Out-of-Pocket Maximum	In-Network / Out-of-Network				
Single (Includes Deductible)	\$1,500 / \$4,500	\$3,000 / \$5,000	\$4,000 / \$6,000	\$5,000 / \$7,000	\$6,000 / \$8,000
Family (Includes Deductible)	\$3,000 / \$9,000	\$6,000 / \$10,000	\$8,000 / \$12,000	\$10,000 / \$14,000	\$12,000 / \$16,000
Office Visits	In-Network / Out-of-Network				
In office	Primary Care \$25 Co-pay / 30% Specialty \$50 Co-pay / 30%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%
Telemedicine through Teladoc	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay
Professional Services	In-Network / Out-of-Network				
• Lab & X-Ray • Maternity	10% / 30%	20% / 40%			
Hospital & Facility Services	In-Network / Out-of-Network				
Hospital Inpatient	10% / 30%	20% / 40%			
Emergency Room Facility	10% / 30%	20% / 40%			
Emergency Room Physician Services	10% / 30%	20% / 40%			
Urgent Care Center (Physician Services)	\$150 Co-pay (Deductible waived) then covered 100% / 40%				
Prescription Drugs	Tier 1–Generic Drugs: \$10 Tier 2–Preferred Brand-Name Drugs: \$35 Tier 3–Non-Preferred Drugs (Non-Formulary): 50% Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to \$300 Co-pay per prescription				
Preventive Care (In-Network Only)	0% Not Subject to Deductible				

Please Consult Summary of Benefits & Coverage for benefit details.

DEFEND HSA PLANS - RPB

HSA-compatible plans with a wellness twist.

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance Rewards: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain who completing specified, proven steps will receive a reward of up to \$100 per year.

Health Rewards

Plan Name

**DEFEND HSA
3000 RBP**

**DEFEND HSA
4000 RBP**

**DEFEND HSA
5000 RBP**

Maximum Lifetime In-Network Benefits

No Lifetime Maximum
(Unlimited)

Annual Deductible

In-Network / Out-of-Network*

Single

\$3,000 / \$5,000

\$4,000 / \$6,000

\$5,000 / \$7,000

Family

\$6,000 / \$10,000
(Aggregate)

\$8,000 / \$12,000
(Aggregate)

\$10,000 / \$14,000
(Aggregate)

Annual Out-of-Pocket Maximum

In-Network / Out-of-Network*

Single (Includes Deductible)

\$5,000 / \$7,000

\$5,500 / \$8,000

\$6,000 / \$9,000

Family (Includes Deductible)

\$10,000 / \$14,000

\$11,000 / \$16,000

\$12,000 / \$18,000

Office Visits

In-Network / Out-of-Network*

In office

20% / 30%

20% / 30%

20% / 30%

Telemedicine through Teladoc

\$10 Co-pay*

\$10 Co-pay*

\$10 Co-pay*

Professional Services

In-Network / Out-of-Network*

- Lab & X-Ray
- Maternity

20% / 30%

20% / 30%

20% / 30%

Hospital & Facility Services

In-Network / Out-of-Network*

Hospital Inpatient

20% / 30%

20% / 30%

20% / 30%

Emergency Room Facility

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

\$250 Co-pay* (waived if admitted)

Emergency Room Physician Services

20% / 30%

20% / 30%

20% / 30%

Urgent Care Center (Physician Services)

\$150 Co-pay* then
covered 100% / 30%

\$150 Co-pay* then
covered 100% / 30%

\$150 Co-pay* then
covered 100% / 30%

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Prescription Drug Benefit:
Covered Prescription Drug costs apply towards the
Network Out-of-Pocket Maximum

Co-pays apply only after satisfying the Annual Deductible:

Tier 1–Generic Drugs: \$10

Tier 2–Preferred Brand-Name Drugs: \$35

Tier 3–Non-Preferred Drugs (Non-Formulary): 50%

Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to \$300 Co-pay per prescription

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam:
100% Coverage

0%
Not Subject to Deductible

Co-pays apply after meeting the annual deductible. Please Consult Summary of Benefits & Coverage for benefit details.
*IMPORTANT NOTE: An optional physician network is available at Employer's option. If RBP program is extended to
physicians and specialists then out-of-network references are not applicable. RBP provider payments are paid based on a
percentage of a specified reference price. 6 Degrees Health helps negotiate charges, eliminate balance billing and
educates insureds.

DEFEND CO-PAY PLANS - RPB

Comprehensive benefits with low-cost office visits.

Preventive Reward: Early detection saves lives and reduces costs. Members completing an annual preventive examination will receive a \$100 cash reward.

Chronic Condition Compliance Rewards: Effective management of chronic conditions improves quality of life and saves money. Members with asthma, COPD, diabetes, hypertension, hyperlipidemia, chronic kidney disease, congestive heart failure, coronary artery disease, and chronic pain who completing specified, proven steps will receive a reward of up to \$100 per year.

Healthier Plans

Plan Name

DEFEND 500 CO-PAY RBP	DEFEND 1000 CO-PAY RBP	DEFEND 2000 CO-PAY RBP	DEFEND 3000 CO-PAY RBP	DEFEND 4000 CO-PAY RBP
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Maximum Lifetime In-Network Benefits

No Lifetime Maximum
(Unlimited)

Annual Deductible

In-Network / Out-of-Network*

Single	\$500 / \$2,500	\$1,000 / \$3,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$4,000 / \$6,000
Family	\$1,000 / \$5,000 (Embedded)	\$2,000 / \$6,000 (Embedded)	\$4,000 / \$8,000 (Embedded)	\$6,000 / \$8,000 (Embedded)	\$8,000 / \$12,000 (Embedded)

Annual Out-of-Pocket Maximum

In-Network / Out-of-Network*

Single (Includes Deductible)	\$1,500 / \$4,500	\$3,000 / \$5,000	\$4,000 / \$6,000	\$5,000 / \$7,000	\$6,000 / \$8,000
Family (Includes Deductible)	\$3,000 / \$9,000	\$6,000 / \$10,000	\$8,000 / \$12,000	\$10,000 / \$14,000	\$12,000 / \$16,000

Office Visits

In-Network / Out-of-Network

In office	Primary Care \$25 Co-pay / 30% Specialty \$50 Co-pay / 30%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%	Primary Care \$25 Co-pay / 40% Specialty \$50 Co-pay / 40%
Telemedicine through Teladoc	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay

Professional Services

In-Network / Out-of-Network*

<ul style="list-style-type: none"> Lab & X-Ray Maternity 	10% / 30%	20% / 40%
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Hospital & Facility Services

In-Network / Out-of-Network*

Hospital Inpatient	10% / 30%	20% / 40%
Emergency Room Facility	10% / 30%	20% / 40%
Emergency Room Physician Services	10% / 30%	20% / 40%

Urgent Care Center (Physician Services)

\$150 Co-pay (Deductible waived) then covered 100% / 40%

Prescription Drugs

- 30-Day Retail Supply
- Mail Order available
- In-Network Only

Prescription Drug Benefit:
Covered Prescription Drug costs apply towards the Network Out-of-Pocket Maximum

Tier 1–Generic Drugs: \$10
Tier 2–Preferred Brand-Name Drugs: \$35
Tier 3–Non-Preferred Drugs (Non-Formulary): 50%
Tier 4–Specialty Pharmacy and Injectables: 35% Co-Insurance up to \$300 Co-pay per prescription

Preventive Care

(In-Network Only)

- Well Baby & Well Child: 100% coverage
- Adult Preventive/Wellness Exam: 100% Coverage

0%
Not Subject to Deductible

Please Consult Summary of Benefits & Coverage for benefit details.

***IMPORTANT NOTE:** An optional physician network is available at Employer's option. If RBP program is extended to physicians and specialists then out-of-network references are not applicable. RBP provider payments are paid based on a percentage of a specified reference price. 6 Degrees Health helps negotiate charges, eliminate balance billing and educates insureds.

Exclusions & Limitations

Following is an abbreviated list of exclusions and limitations. Please refer to the Summary Plan Description ("SPD") for comprehensive details. Defined terms are "Capitalized" and can be found in the SPD. Please note that in listing services or examples, we do not intend to limit a list of services or examples unless we state specifically that the list "is limited to".

- Any amounts in excess of maximum amounts stated in the SPD.
- Charges in excess of Eligible Expenses as detailed in the SPD.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the SPD.
- Alternative Treatments such as acupuncture, aromatherapy, hypnosis, Rolfing and art therapy.
- Cosmetic Procedures.
- Custodial care.
- Dental and orthodontic services except as specifically stated in the SPD.
- Devices, appliances and prosthetics except as specifically stated in the SPD. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo esophageal voice prosthetics.
- Replacement of prosthetics and Durable Medical Equipment ("DME") due to misuse, malicious damage, gross neglect or when lost or stolen.
- Domiciliary care.
- Expenses for injury or illness arising out of attempted suicide or an intentional self-inflicted injury, except if the result of a physical or mental medical condition or act of domestic violence and would normally be covered.
- Experimental or Investigational Services, except for services for persons who have been accepted into an approved clinical trial for cancer, or a life threatening Sickness or condition.
- Eye surgery performed solely for the purpose of correcting refractive errors (such as intact corneal implants). Also, Surgery that is intended to allow you to see better without glasses or other vision correction such as LASIK.
- Eyewear including the purchase cost and fitting charge for eyeglasses and contact lenses unless specifically stated in the SPD.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Foot care that is routine. Examples include the cutting and removal of corns or calluses; hygienic and preventive maintenance foot care; treatment of flat feet; shoe orthotics; shoe inserts; and arch supports. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which benefits are provided under the diabetes services in the SPD. This exclusion does not apply to preventive foot care for those who are at risk of neurological or vascular disease arising from diseases such as diabetes.
- Foreign language and sign language interpreters, except as required by law.
- Genetic testing, except as specifically stated in the SPD.
- Growth hormone therapy.
- Health club memberships.
- Infertility services (including sterilization reversal).
- Medical supplies, except as specifically listed in the SPD.
- Non-injectable medications given in an outpatient or office setting.
- Nutritional counseling except as specified listed as covered in the SPD.
- Obesity reduction services through surgical and non-surgical treatment, except as specifically stated in the SPD.
- Over-the-counter medications and treatments.
- Pain management services using multi-disciplinary pain management programs provided on an inpatient basis.
- Personal care attendant's services.
- Personal comfort items.
- Pharmaceutical products and prescription medication products beyond the specified supply limits and/or specifically excluded in the SPD.
- Pharmaceutical Products or prescription medication products for outpatient use that are filled by a prescription order or refill except as specifically stated in the SPD.
- Pregnancy through a surrogate and any services or supplies provided in connection with a surrogate Pregnancy.
- Private duty nursing.
- Psychosurgery.
- Respite care.
- Sex transformation operations.
- Smoking cessation programs that are stand-alone multi-disciplinary smoking cessation programs, except as covered in the SPD.
- Snoring treatments, both medical and surgical treatment, except as when provided as part of treatment for documented obstructive sleep apnea. Also limited is upper and lower jawbone surgery including that for obstructive sleep apnea.
- Travel or transportation expenses, even if prescribed by a Physician.
- Weight loss programs.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. This exclusion does not apply to mammography.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Health services for organ and tissue transplants, except those described under Transplantation Services in the SPD.
- Out-of-Network health services provided in a foreign country, unless as required as Emergency Health Services.
- Out-of-Network Preventive Care except as required by law.
- Medicare eligibility results in Benefit payment pursuant to Medicare rules.
- Claims submitted for health services beyond 12 months from the date of service, except as required by law.
- Services performed by a Provider who is a family member by birth or marriage or resides at same residence.
- Dental and orthodontic services except as specifically stated in the SPD.

The Defend Plans enable a partnership between you, your physicians and with the Acuity Group. Our standard plans provide discounted charges through a specified Network of Physicians, Hospitals and other Providers of medical services. At the same time we recognize that you may wish to obtain treatment from a Provider outside of this Network. Therefore, these plans provide some coverage for the Out-of-Network Providers, but much less than the coverage provided when you remain in our Network. Specifically, the Out-of-Network Benefits have separate Deductibles and Out-of-Pocket Maximums than the Network Benefits. The allowed amount for Out-of-Network Claims is equal to 110% of Medicare allowable rates. Only the allowed amount is applied to the Out-of-Network Deductible and/or Out-of-Pocket Maximum. You will be responsible for any billed charges in excess of the Medicare allowed rate. The difference in billed charges from a Network Provider compared to an Out-of-Network Provider can be substantial and these excess amounts are the responsibility of the insured. These amounts are NOT SUBJECT to any Out-of-Pocket Maximum limitations. Please be sure to verify if your Provider is in the Aetna Network prior to receiving services. Referenced Based Pricing plans reimbursements are based on a percentage of a specified standard.

For complete Benefits information visit www.DefendPlans.Info

This brochure provides abridged information about benefits, exclusions, and limitations. For costs and complete information on coverage, you must refer to the SPD about how the Defend Plans work, accessing benefits, benefit limits, service area benefit limitations, pre-service benefit confirmation, compliance rules, and eligible expenses. It is recommended that plans consult with their own experts or legal counsel to review all applicable federal and state legal requirements that may apply to their group health plan. By providing this publication and any attachments, Acuity Group is not exercising discretionary authority over the plan and is not assuming a plan fiduciary role, nor is Acuity Group providing legal advice.



The Defend Plans

Standard PPO and RBP Plans Administered by



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