

SCHEDULE OF BENEFITS

These services are covered when they meet Health Plan guidelines, are provided or arranged for by a Plan Physician, deemed medically necessary and appropriate and approved by The Health Plan. Services must be deemed medically necessary and appropriate by the Plan. There may be specific limitations (see "Limitations & Exclusion").

Benefit Description	Basic Option	Standard Option
<p>Deductible: is the amount each member/family is required to pay each contract year before payment of eligible services will be paid by the Plan. To reach the family total, you can count the expenses incurred by two or more family members. However, the deductible contributed towards that total by any one family member cannot be more than the amount of a single deductible. If one family member meets the single deductible amount and again needs to use benefits, the Plan will begin to pay for that person's covered services even if the deductible for the entire family has not been met.</p> <ul style="list-style-type: none"> •For services that the deductible is waived, copays/coinsurance still apply; copays/coinsurance do not accumulate towards the deductible. •Once the deductible is met, copays/coinsurance still apply. •Deductible applies as noted 	<p>Single: \$1,000 Family: \$2,000</p>	<p>Single: \$750 Family: \$1,500</p>
<p>Inpatient Hospital Services</p>		
<ul style="list-style-type: none"> •Room and board: semi-private room, ICU/CCU, nursing care, maternity and birthing room (48 hrs. normal, 96 hrs. cesarean, if mother and physician determine that the hospital stay is to be shortened, 72 hrs. of follow-up care will be provided), nursery, operating room, therapy (oxygen and respiratory, physical, occupational and speech), laboratory, therapeutic and diagnostic x-ray, observation bed, other services and supplies •Out-of-Area Inpatient Hospitalization: defined emergency or <i>approved</i> referral to Plan tertiary facility 	<p>40% coinsurance, deductible applies</p> <p>40% coinsurance, deductible applies</p>	<p>30% coinsurance, deductible applies</p> <p>30% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Physician visits and services 	<p>40% coinsurance, deductible applies</p>	<p>30% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Rehabilitation 	<p>40% coinsurance, deductible applies</p>	<p>30% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Skilled Nursing Facility: medically necessary and in lieu of hospitalization 	<p>Not covered</p>	<p>30% coinsurance, deductible applies</p>

Benefit Description	Basic Option	Standard Option
Outpatient Services (physician's office, hospital, home setting, other Plan or approved provider)		
<ul style="list-style-type: none"> •PCP office visits: to include child health supervision services (review of physical and emotional status, birth to age nine), physical exam (one per calendar year) and well child care 	\$25 copay	\$25 copay
<ul style="list-style-type: none"> •Ob/gyn office visits: approved referral required (unless selected Ob/gyn) 	\$25 copay	\$25 copay
<ul style="list-style-type: none"> •Other office visits: approved referral required (unless selected SCP) 	\$40 copay	\$40 copay
<ul style="list-style-type: none"> •Chiropractic services 	Not covered	Not covered
<ul style="list-style-type: none"> •Podiatry 	Not covered	Not covered
<ul style="list-style-type: none"> •Maternity care: pre and post-natal care/obstetrical services •Post delivery follow-up visits: 48 hrs. normal, 96 hrs. cesarean, if mother and physician determine that the hospital stay is to be shortened, 72 hrs. of follow-up care will be provided 	\$25 copay 40% coinsurance, deductible applies	\$25 copay 30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Preventive Care: injections, immunizations (pediatric/childhood, adolescent and adult); annual mammography, Pap smear, prostate and hearing screening 	\$25 copay PCP or Ob/gyn, \$40 copay other office visits	\$25 copay PCP or Ob/gyn, \$40 copay other office visits
<ul style="list-style-type: none"> •Cardiac rehabilitation •Pulmonary rehabilitation 	Not covered Not covered	Not covered Not covered
<ul style="list-style-type: none"> •Therapy (physical, occupational and speech) 	Not covered	Not covered
<ul style="list-style-type: none"> •Laboratory, therapeutic, diagnostic and radiological services: to include ultrasound, MRI, MRA, CAT and PET scans 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Radiation and chemotherapy 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Outpatient surgery 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Oral surgical limited services: accidental or injury 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Emergency care: in-area or out-of-area 	\$110 copay, waived if admitted, see Inpatient Hospital	\$110 copay, waived if admitted, see Inpatient Hospital

Benefit Description	Basic Option	Standard Option
<ul style="list-style-type: none"> •Urgent care: in-area or out-of-area 	\$45 copay, waived if admitted, see Inpatient Hospital	\$45 copay, waived if admitted, see Inpatient Hospital
Other Services (physician's office, hospital, home setting, other Plan or approved provider)		
<ul style="list-style-type: none"> •Ambulance service: emergency transportation (medically necessary only), scheduled transportation (will be reviewed for medical necessity and appropriateness) 	\$110 copay	\$110 copay
<ul style="list-style-type: none"> •Ambulette service 	Not covered	Not covered
<ul style="list-style-type: none"> •Audiology: audiological exam (one per contract year, only if referred by a PCP or ENT physician) 	\$40 copay	\$40 copay
<ul style="list-style-type: none"> •Biofeedback therapy 	Not covered	Not covered
<ul style="list-style-type: none"> •Diabetes pharmacological agents: (members covered under prescription drug rider will receive pharmacological agents through their prescription drug rider unless the benefits supplied through the rider are at a lesser level) •Diabetes supplies: glucometers, syringes, lancets, glucose test strips, alcohol swabs, carp-u-jet, urine ketone testing strips, urine microalbumin test and penlets, supplied through pharmacies <p>Note: The Plan may require the use of specific brands of glucometers to ensure consistency of training and education services</p>	40% coinsurance, deductible applies 40% coinsurance, deductible applies	30% coinsurance, deductible applies 30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Durable medical equipment (DME) and DME supplies: rental or purchase (whichever costs less) for temporary use not to exceed a six-month period, limited to Plan's basic allowance, approved referral may be required 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Family planning: infertility services, limited to basic health care 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Hearing aid 	Not covered	Not covered
<ul style="list-style-type: none"> •Home Health: medically necessary services for intermittent skilled care only in lieu of hospitalization (home health aid not covered) 	Not covered	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Home IV therapy/infusion therapy 	Not covered	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Hospice: medically necessary in lieu of hospitalization 	Not covered	30% coinsurance, deductible applies

Benefit Description	Basic Option	Standard Option
• Orthotics	Not covered	Not covered
• Prosthetic and prosthetic supplies: for mastectomies only (coverage is included for a member receiving benefits in connection with a mastectomy who elects reconstruction for: a breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy including lymphedemas), limited to Plan's basic allowance, approved referral may be required	40% coinsurance, deductible applies	30% coinsurance, deductible applies
• Temporomandibular joint dysfunction (TMJ): non-experimental, medically necessary services, approved referral required	40% coinsurance, deductible applies	30% coinsurance, deductible applies
Mental Health/Substance Abuse Services (other mental and emotional disorders that do not qualify as biologically based will be covered at \$550 per member per calendar year, applicable copay or coinsurance and deductible will apply)		
• Inpatient biologically based mental health illnesses treatment: inpatient hospital days, intensive outpatient hospital visits, partial hospitalization visits or residential treatment programs. Treatment programs may be combined	40% coinsurance, deductible applies	30% coinsurance, deductible applies
• Outpatient biologically based mental health illnesses treatment: office visits, hospital outpatient department or licensed outpatient treatment facility	\$40 copay	\$40 copay
• Inpatient substance abuse treatment: limited to five days per member per contract year, approved referral required	Not covered	30% coinsurance, deductible applies
• Outpatient substance abuse treatment: approved referral required	Not covered	30% coinsurance, deductible applies, limited to \$550 per member per contract year
Other Information		
Prescription benefit (RX)	Not covered	\$15/20% copay/coinsurance (see enclosed RX Benefits Brochure)
• To obtain mental health services, the member may contact the Plan at 1-877-221-9295.	✓	✓

Benefit Description	Basic Option	Standard Option
<ul style="list-style-type: none"> Percentage coinsurances are based on the amount paid, allowed or negotiated by Health Plan. 	✓	✓
<ul style="list-style-type: none"> If services fall in more than one category, the higher copay shall be applicable (not to include any office visits). 	✓	✓
<ul style="list-style-type: none"> When services are limited to a maximum number of days, treatments, visits etc., each must be medically necessary and appropriate to be covered. 	✓	✓
<ul style="list-style-type: none"> Copay/coinsurance is the amount required to be paid by a member for each visit/service outlined in the Benefits Schedule. Once a single subscriber has paid \$5,000 out-of-pocket in a contract year, The Health Plan pays 100% of expenses for covered services. For a family contract, the annual limit is \$10,000 before coverage begins at 100%. Calculation of the single or family out-of-pocket maximum does not include the single and family deductible, copays or coinsurance for inpatient or outpatient mental health or substance abuse services, prescription drugs, hospice care, home health care, skilled nursing care or the voluntary and unauthorized use of a nonparticipating specialist or facility. <p>Copays/coinsurances paid by a member on any single covered basic health care service during a contract year shall not exceed 40% of the average cost to the Plan to provide the service. Total copays/coinsurances shall not exceed 200% of the average annual premium rate.</p>	✓	✓

LIMITATIONS

- Major solid organ transplants (heart, heart-lung, liver and pancreas) must be received through the Ohio Transplant Consortium. The member must also receive pre-certification by the Health Plan Medical Director. Other covered transplants-bowel, kidney, cornea and bone marrow-are not involved with the Transplant Consortium and will be covered if meeting all pre-certification criteria by Health Plan.*
- A Health Plan participating provider must be used for services unless the required specialty is not under contract with Health Plan and use of the nonparticipating provider is pre-certified by Health Plan.*
- All services must be provided by or pre-certified by the member's PCP.*
- Rental or purchase (whichever costs less) of durable medical equipment for temporary use, not to exceed a six-month period.*

When services are limited to a maximum number of days, treatments, visits, etc., each visit, treatment, etc., must be medically necessary and appropriate to be covered.

EXCLUSIONS

The following are NOT covered or are specifically limited as stated.

1. All dental, dental related services or dental related services applied to TMJ.
2. Except as stated in the benefits outline, cosmetic surgery, breast augmentation and reduction surgery and all related supplies, unless medically necessary; penile implants and related services.
3. Treatment of obesity, including diet substitutes and supplements.
4. Experimental or investigational procedures, supplies and drugs.
5. All services that are not medically necessary, except for required preventive services.
6. Examinations specifically for the purpose of obtaining employment or insurance or examination precedent to engaging in recreational activities unless obtained in the context of periodic exam.
7. Recreational, sexual or education therapy. **Speech therapy, physical therapy and occupational therapy are covered on an inpatient basis only.**
8. For foot care due to:
 - a. treatment of weak, strained or flat feet or instability or imbalance of the foot.
 - b. treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illness of similar medical seriousness.
9. Vision care benefits or orthoptics, vision training, low vision aids or any related type of service including eyeglasses and contact lenses.
10. Services rendered prior to your effective date of coverage or after your coverage terminates (unless stated otherwise regarding termination of coverage).
11. Services received from a member of the immediate family or rendered by a physician or another provider to himself/herself.
12. Services that are for any illness of injury occurring in the course of employment if whole or partial compensation is available under Workers' Compensation laws or laws of any governmental entity.
13. Any service for which the member has no legal obligation to pay in the absence of this or similar coverage.
14. Services and expenses related to all aspects of organ or tissue procurement rendered or incurred prior to the site of presentation to the donor, including all donor expenses.

15. Transportation and living expenses, except for emergency ambulance services and organ transplants performed outside of the Service Area.
16. Services received while incarcerated or in the custody of law enforcement officials when such is the financial responsibility of the applicable prison system.
17. Services of nonparticipating providers, except in an emergency or for out-of-area benefits or when authorized in advance in writing by Health Plan.
18. Services and treatment of mental retardation and other mental health services, except as otherwise provided.
19. Hearing aids and related services and supplies, except medical services required for diagnosis and treatment of diseases of, or injury to, the ears.
20. Except as stated in the benefits outline, reconstructive surgery, unless deemed medically necessary by a participating physician with the prior approval of Health Plan to restore normal physiological functioning.
21. Outpatient private duty nursing or private rooms for hospitalization.
22. Nonprescription drugs, infertility drugs, growth hormones, medications and contraceptive devices, birth control pills including, but not limited to, Norplant and similar products.
23. Personal comfort items (such as radio, television, telephone and guest meals); private rooms unless medically necessary during inpatient hospitalization.
24. Custodial or domiciliary care or convalescent care (skilled nursing care, hospice care or home health covered under the Standard Option only unless medically necessary and with prior approval by the Plan in lieu of hospitalization).
25. Out patient physical therapy and rehabilitation services.
26. Reversals of voluntary induced infertility, experimental infertility procedures and non-medically necessary procedures including, but not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).
27. Procedures, services and supplies related to sex transformations.
28. Services on which claim is based from care which is received in a veteran, marine or other federal hospital.
29. Nonmedical ancillary services and long-term rehabilitative services for the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility.
30. Except as stated in the benefits outline, orthotic and prosthetic devices.
31. Autologous bone marrow transplant, in some instances.
32. Services of chiropractor, podiatrists and optometrists.
33. Blood or blood plasma.

34. Kidney dialysis and end stage renal disease treatment after Medicare assumes responsibility.
35. Elective abortions.
36. Experimental artificial organs and related procedures.
37. Elective pre-surgery testing on an inpatient basis without pre-certification of the Health Plan Medical Director.
38. Megavitamin therapy, psychosurgery and nutritional based therapy.
39. Salabrasion, chemosurgery or other such skin abrasion procedures to remove scars, tattoos or which are performed as treatment for acne.
40. Services performed after Health Plan or a participating physician has advised the member that further services are not medically appropriate or not covered.

The subscriber/member shall be financially obligated for any and all non-covered services.

Insurance Fraud Warning: Pursuant to Ohio Revised Code Section 3999.21, "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

72 Hour Cancellation Right: Any person obligated for any part of a pre-payment may cancel such agreement within 72 hours after he/she has signed an agreement or offered to enroll. Cancellation occurs when written notice of cancellation is given to The Health Plan. Notice of cancellation shall be considered given when the prospective subscriber mails a letter to The Health Plan.

UTILIZATION REVIEW.

The Health Plan has a utilization review process in place that is designed to review the medical appropriateness and location of proposed or received health care services. The review process consists of three areas: 1.) Prospective Review, a review conducted prior to an admission or course of treatment, 2.) Concurrent Review, a review conducted during an admission or course of treatment and 3.) Retrospective Review, a review conducted after health care services have been provided. Examples of services reviewed are physical therapy, home health services, emergency services, out-of-plan care, surgeries, CT scans and MRIs.

Screening is first performed by registered nurses to evaluate whether the service and location of the service meet the Plan's criteria for medical appropriateness. For instances that do not meet review criteria, the nurses are required to involve physician reviewers. After careful review of available clinical information, the physician reviewer may authorize or not authorize the services based on medical necessity.

If you have any questions regarding utilization review, or the need for preauthorization of any service, please call The Health Plan at (740) 695-3585, 1-800-624-6961, TDD (740) 695-7919, 1-800-622-3925 or by e-mail: info@healthplan.org.

CASE MANAGEMENT.

The Case Management program is a process of coordinating resources and creating flexible, quality, cost effective health care options to result in a quality-efficient delivery of health care services. This individualized program is performed by registered nurses that focus on members with a complex illness and/or injury.

PRIVACY OF PROTECTED HEALTH INFORMATION.

The Health Plan supplies each new subscriber with a copy of the Plan's Privacy Practices in the initial enrollment packet, and each year thereafter upon renewal. Members may also obtain a copy by calling the Plan or visiting our website.

Each subscriber will be notified, in writing, 60 days in advance of any revisions to the Plan's Privacy Practices.

The Health Plan will only use and disclose the minimum amount of necessary protected health information without authorization when required for: payment, operations, treatment or as required or permitted by law. To disclose protected information for purposes other than described, the Plan will request a signed authorization from the member.

Plan members have the right to inspect or obtain copies of their medical records and offer corrections to these records in accordance with applicable federal and state laws.

Access within The Health Plan to protected health information whether oral, written, electronic, or for the use of measurement data, is limited to personnel on a "need-to-know" or "need-to-access" basis. The Plan has policies and procedures in place to ensure employees adhere to privacy/security requirements.

The Health Plan will not disclose information to employers that directly or indirectly identifies an employee or their dependents.

Any questions regarding protected health information, please contact the Plan by calling (740) 695-3585, 1-800-624-6961, TDD (740) 695-7919, 1-800-622-3925, email: info@healthplan.org.

Special Enrollment Periods under the Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires group health plans to offer two special 31-day enrollment periods for employees and dependents, who previously declined coverage to enroll, without waiting for the plan's next regular open enrollment.

1. **Loss of Group Coverage.** Plans must allow employees and dependents that lose other coverage to enroll if they have exhausted their COBRA coverage; they cease to be eligible for the other coverage or employer contributions for the other coverage cease, legal separation, divorce, death, termination of employment or reduction in hours.

The effective date of coverage will be the first of the following month upon Health Plan's receipt of the enrollment information.

2. **Change in Family Status.** Plans that offer dependent coverage must provide a special enrollment period when an employee gains dependents by reason of marriage, birth, adoption or placement for adoption.

The effective date of coverage will be the date of event.

In some instances, the enrollee will be required to provide The Health Plan with a "Certificate of Coverage".

THE HEALTH PLAN
\$15/20% COPAY
PRESCRIPTION DRUG RIDER
(STANDARD PLAN ONLY)

The Health Plan

52160 National Road East

St. Clairsville, Ohio 43950-9365

Telephone: (740) 695-3585

Toll Free: 1-800-624-6961

www.healthplan.org



\$15/20% RX

Warning: If you or your family members are covered by more than one Health Care Plan, you may not be able to collect benefits from both Plans. Each Plan may require you to follow its rules or use specific doctors and hospitals. It may be impossible to comply with both Plans at the same time. Read all the rules very carefully, including the Coordination of Benefits Section, and compare them with the rules of any other Plan that covers you or your family.

How to Use the Program

To receive maximum benefits as a Health Plan member, prescription drugs must be obtained at a participating Health Plan pharmacy. (**Prescriptions filled by nonparticipating pharmacies** will be reimbursed at 75% of the cost less the stated member copay. **The member must pay the additional balance to the pharmacy.**) For the location of a participating pharmacy, please refer to the enclosed Health Plan Pharmacy List.

To fill your prescription, just present your Health Plan ID card to the pharmacist with your prescription. You will be required to pay a copay at the time of service based on the following schedule.

\$15 or 20% copay: member pays a \$15 copay for prescriptions or refills. Prescriptions/refills costing more than \$75 the member pays a 20% copay.^{1&2}

¹ A qualified generic prescription is an order for a drug that is available from multiple sources.

² A qualified brand prescription must be available only from a single source supplier of the particular drug. **Brand names drugs are not covered if a generic equivalent exists.**

Prescriptions must not be subject to any exclusions or limitations as outlined in the Exclusions and Limitations Section of this rider.

What is Covered

The Health Plan covers "legend prescription drugs"³ and medications only if such drugs are prescribed by a participating Health Plan physician. Each prescription may be dispensed up to a 30-day supply.

Certain maintenance drugs, such as thyroid products and nitroglycerin, are covered up to a 90-day supply or 100-unit doses, whichever is greater, for a single copay.

Certain drugs require a member copay of 50%. This applies to: Tissue Plasmin Anecedent (TPA), Total Parenteral Nutrition (TPN), Azathioprine (AZT), Imuran, Retrovir, Cyclosporin, Cytoxan, Accutane, Monoclat, any: Nicotine suppression drugs, anti-rejection drugs or clotting factor preparations not mentioned above.

³ "Legend prescription drugs" are those drugs which by Federal Law can be dispensed only pursuant to a prescription and which are required to bear the legend "Caution: Federal Law prohibits dispensing without a prescription."

Out-of-Area Emergencies

In situations of emergency need for a prescription outside The Health Plan Service Area, please contact The Health Plan's Pharmacy Benefit Manager (PBM) for the location of a participating pharmacy in that area at (800) 988-2262. Present your Health Plan Identification Card with the emergency prescription and pay your copay. If no pharmacy in the area participates with the Plan's PBM, purchase the emergency prescription and send your receipt to The Health Plan. You will be reimbursed in full, less

your applicable copay or coinsurance, for the prescription provided the prescription meets the guidelines specified in this document.

Please refer to The Health Plan Pharmacy List for Participating Pharmacies and Service Area Map.

Questions? Please call The Health Plan at St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, TDD (740) 695-7919, (800) 622-3925 or Massillon area: (330) 837-6880, (800) 426-9013, TDD (877) 235-2291 or email: info@healthplan.org.

Exclusions and Limitations

The following will not be covered or paid for by The Health Plan.

1. The charge for any prescription refill other than the number set by the prescriber. No refills dispensed more than one year from the date of the original prescription.
2. The charge for any prescription oral, topical or injectable that is prescribed for cosmetic purposes.
3. The charge for any medications not FDA approved for use in the general population. Use of a FDA approved drug in the treatment of a non-FDA approved indication.
4. The charge for a drug not prescribed by a Health Plan participating provider except in true emergency/urgent situations.
5. The charge for any medication covered by any Workers' Compensation or occupational disease laws, any other group policy or government program that is not The Health Plan's program.
6. Vitamins, except for prenatal are not covered. Prenatal vitamins are covered when related to a pregnancy only.
7. Dental related prescriptions such as, but not limited to, oral fluorides, dental mouthwashes or devices used in dental therapy.
8. Nonprescription/OTCs (over the counter) drugs.
9. Prescription for drugs or devices used to promote weight loss.
10. Prescriptions used to treat sexual dysfunction (oral, topical or injectable) or devices used for impotence.
11. Prescriptions for drugs (oral, topical or injectable) for fertility, unless medically necessary.
12. Contraceptive devices. Oral contraceptives are covered.
13. Any injectable drugs except insulin, glucagon and epinephrine emergency kits (Epipen).
14. Appliances and therapeutic devices which require a prescription are not covered. These include, but are not limited to, garments, splints, bandages or braces regardless of intended use.
15. The annual limit for prescription drugs is \$1,000 for a single and \$2,500 for a family per contract year.

The Health Plan Formulary/Prior Authorization Drugs

The Health Plan formulary is a listing of prescription medications that are preferred for use. The Health Plan maintains an open formulary with certain restrictions across several therapeutic classes. In these classes, the preferred drugs will be a covered benefit when dispensed at participating pharmacies. Non-

formulary drugs are not covered without prior authorization. Prior authorization requires written medical statements of necessity by the prescribing physician. Statements of medical necessity are subject to review and approval by The Health Plan Medical Director and when necessary, the Pharmacy and Therapeutics Committee.

In cases of an emergency, a 72-hour supply of the non-formulary medication may be filled if necessary.

Restriction on choice of Providers

The Health Plan Pharmacy List and some of the providers may change from time to time.

72 Hour Cancellation Right

Any person obligated for any part of a prepayment may cancel such agreement within 72 hours after he/she has signed an agreement or offered to enroll. Cancellation occurs when written notice of cancellation is given to The Health Plan. Notice of cancellation shall be considered given when the prospective subscriber mails a letter to The Health Plan.

Insurance Fraud Warning: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."