

Your Benefit Plan Document

REQUIREMENTS FOR INSURANCE COVERAGE

Eligibility

A *policyholder* must indicate on the Employer Group Application the eligible classes of *employees* under this *policy*, if applicable, as defined below:

- An eligible class includes regular full-time *employees* in *active status*, if paid a salary or wage by the *employer* that meets State or Federal minimum wage requirements.

An eligible class may also include sole proprietors, partners, and corporate officers if:

- The *employer* is a sole proprietorship, partnership or corporation; and
 - The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains a livelihood from the sole proprietorship, partnership or corporation and meets the definition of *employee* as defined in the Certificate of Insurance.
- The *policyholder's group* insurance plan may also provide coverage for retired *employees* and their *dependents*.
 - Part-time *employees* and their *dependents* may be an eligible class only if the *policyholder* makes specific reference that part-time *employees* be included, and it is approved by *us*.
 - The spouse or a child of an *employee* may be included in an eligible class as a *dependent* of the *employee* only if the *employee* is covered under this *policy*.

100600

Date eligible

Each *policyholder's group* insurance plan may provide one of the following as the *eligibility date* for *employees* and *dependents* as provided by this *policy*. The *eligibility date* must be elected by the *policyholder* on the Employer Group Application. *Eligibility date* options include immediate or first of the month as outlined below.

100700

Immediate eligibility

Each *employee* included in an eligible class on, or after, the date the *employer* becomes a *policyholder* will be eligible under this *policy* on that date, provided the *employee* has completed the required *waiting period*, if any, indicated on the Employer Group Application.

100800

REQUIREMENTS FOR INSURANCE COVERAGE (continued)

First of the month eligibility

Each *employee* included in an eligible class after the date the *employer* becomes a *policyholder* will be eligible under this *policy* on the first day of the next following calendar month, or on the first day of the next following calendar month after the completion of the *waiting period*, if any, or as otherwise agreed to by the *policyholder* and *us*.

100900

Note: Any *employee* who voluntarily terminates his or her insurance must satisfy a new *waiting period* in order to become insured again under the *policyholder's* plan. However, if a person's insurance terminated because he or she was no longer considered to be in an eligible class, that person is not required to satisfy a new *waiting period* if he or she again becomes a member of an eligible class within one year from the date his or her insurance terminated.

101000

Employee enrollment

Each *employee* must complete the *employee* enrollment process to apply for coverage.

We reserve the right, based upon *our* underwriting procedures, to require an eligible *employee* and/or eligible *dependent* to submit evidence of health status. We will not use *health status-related factors* to decline medical coverage to an eligible *employee* or eligible *dependent*. We will administer this provision in a non-discriminatory manner.

101100

PARTICIPATION REQUIREMENTS

The *policyholder* is required to maintain *our* minimum underwriting, participation and contribution requirements, as specified on the Employer Group Application.

101200FL

RENEWAL AND TERMINATION PRIVILEGE

Right to not renew or terminate this policy

The *policyholder* may terminate this *policy* by giving written notice to *us* no later than 45 days prior to the desired termination date.

The *policyholder* may terminate the insurance provided under any provision of this *policy*, with *our* consent, by giving written notice to *us* as of a date mutually agreeable to the *policyholder* and *us*.
101300FL

The *policyholder* may terminate an eligible class of *covered persons*, if applicable, from the *policyholder's group* insurance plan, with *our* consent, as of a date mutually agreeable to the *policyholder* and *us*. Termination will occur only with respect to *covered persons* included in the terminated class.
101400

We may terminate this *policy*, as allowed by applicable law, by giving written notice to the *policyholder*. Written notice will be mailed no later than 45 days prior to the termination date, except as otherwise outlined under this provision.

We may refuse to renew or we may terminate the *policy* as follows:

- The *policyholder* fails to remit premium when due, except that coverage continues during the grace period applicable to the due but unpaid premium. We will provide a 45 day notice to the *policyholder* of the non-renewal or termination for non-payment of premium. This notice will be provided to the *policyholder* within 45 days after the premium due date.
- The *policyholder* has failed to comply with *our* minimum underwriting, participation and/or contribution requirements, as specified on the Employer Group Application.
- The *policyholder* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact. We may terminate the *policy* immediately, by giving written notice to the *policyholder* for instances of fraud or intentional misrepresentation of a material fact.
- If we decide to discontinue offering a particular group health policy:
 - The *policyholder* and the *employees* will be notified of such discontinuation at least 90 days prior to the date of discontinuation of such coverage; and
 - The *policyholder* will be given the option to purchase any other *group policy* providing medical benefits that are being offered by *us* at such time.
- We cease to do business in either the *small employer* or the large *employer* group medical insurance market, as applicable and as allowed by the state requirements. If we cease doing business in the *small employer* or the large *employer* group market, the *policyholders* and the *employees* covered by such policies and the Commissioner of Insurance will be notified of such discontinuation at least 180 days prior to the date of discontinuation of such coverage.

101500FL 06/06

RENEWAL AND TERMINATION PRIVILEGE (continued)

Effect of termination of this agreement

Upon termination of this *policy*, it is the *policyholder's* obligation to notify all *employees* of such termination, except for the specific situations outlined in the "Right to Not Renew or Terminate This Policy" provision. If the *policyholder* requires a contribution from the *employees* to offset a portion of the premiums, it is the responsibility of the *policyholder* to refund to those *employees* the portion of the contribution, if any, which the *policyholder* may have collected for any period of time following the termination of this *policy*.

Our obligation to offer continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to *covered persons* ends on the date the *policy* terminates. *Our* obligation to offer continuation coverage to *covered persons* under any other applicable law ends on the date this *policy* terminates or on such date as may be required under the applicable continuation of coverage law. It shall be the responsibility of the *policyholder* to secure continuation of coverage for *covered persons* whose continuation rights run beyond the termination of this *policy*.

101600

Termination of insurance

Unless otherwise agreed to by the *policyholder* and *us*, termination of insurance will occur following any of the events listed below:

- The date this *policy* terminates in accordance with its terms and conditions;
- The termination date according to the "Right to Not Renew or Terminate This Policy" provision;
- The date the *policyholder*, acting with *our* knowledge and consent, deletes an optional benefit under this *policy* (termination under this paragraph will occur only with respect to such deleted optional benefit coverage);
- The date the *policyholder*, acting with *our* knowledge and consent, deletes an eligible class of *employees*, if applicable, from the *policyholder's* group insurance plan (termination under this paragraph will occur only with respect to *covered persons* included in the terminated class); or
- The *policyholder*, acting with *our* knowledge and written consent, terminates any provision of this *policy* (termination under this paragraph will occur on a date mutually agreeable to the *policyholder* and *us*).

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RENEWAL AND TERMINATION PRIVILEGE (continued)

Rescission, reduction of insurance or increase past premium

We reserve the right to rescind this *policy* or reduce insurance coverage or increase past premium, unless prohibited by applicable law. This action may be applied to one or all *covered persons* when we have been provided incomplete or inaccurate or untimely information on any enrollment form, Employer Group Application or any other eligibility form, if such intentional misrepresentation materially affected the acceptance of the *group*, the individual, or the risk.

If on the date coverage is rescinded or reduced, no claims have been paid under this *policy*, we will return to the *policyholder* all premiums paid for such coverage.

If on the date coverage is rescinded or reduced, claims have been paid under this *policy*, we reserve the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the *policyholder*. The *policyholder* is responsible for any amount of claims in excess of premium.
101900

Reinstatement

If the *policy* terminates, it may be reinstated at *our* option. Reinstatement requests must be submitted in writing by the *policyholder*, are subject to *our* approval and are not guaranteed.

Any premium accepted in connection with a reinstatement will be applied to the period for which the premium was not previously paid.
102000

A *policyholder* that requests reinstatement will be assessed a Reinstatement Fee.
102100

PREMIUMS

Payment of premiums

Unless otherwise agreed to by *us*, the first premium is due on the *policyholder's* effective date under this *policy* and subsequent premiums are due prior to the first of each calendar month thereafter.

The required premium due on each premium due date is the sum of the premium for all *employees* in the *policyholder's group* health plan. The premiums due will be determined by applying the premium rates then in effect for each type of insurance provided by this *policy* to the amount of insurance in force.

Premiums should be sent to the designated location on the premium statement. Premiums will be recorded as paid on the date *we* receive the payment. If there are not sufficient funds in the designated bank account on the date that premiums are deducted, the *policyholder* will be assessed an Insufficient Funds Fee.

102200 10/06

Premium statement

A premium statement will be prepared in accordance with the billing method *we* arrange with the *policyholder*. This premium statement will show the premium due. It will also reflect any pro rata premium charges and credits resulting from changes in the number of *covered persons* and changes in the amounts of insurance that took place during the period following the last premium statement. In the event that notice of termination of coverage, or a decrease in coverage, for a *covered person* is received by *us* more than one month after the termination or decrease, retroactive premium credit will be limited to one month's premium.

102300FL

Premium rate change

Premium rates for this *policy* will be calculated as specified in the "Payment of Premiums" provision. *We* reserve the right to change any premium rate, including on a retrospective basis when:

- Terms of the *policy* are changed by *us*; or
- *Our* liability has been altered, in *our* opinion, because of:
 - A change in state or federal law; or
 - A substantive change in the composition of the *group*; or
 - Fraud or misrepresentation of a material fact by the *policyholder*, *employee* or an *employee's dependent*; or
- The *policyholder* changes the terms of this *policy* with *our* written or *electronically* transmitted consent; or

PREMIUMS (continued)

- We provide 45 days written or *electronic* notice to the *policyholder* that the premium rates will change, as permitted by applicable law. Such notice shall include the effective date of the change in premium rates.

102400FL 06/06

Premium charges for benefit changes or a modification of an individual's coverage

If the group health plan benefits or an individual's insurance coverage are modified other than on a premium due date, any applicable change in premium resulting from the modification will become effective as follows:

- If the change is effective on or before the 15th of the month, the change in premium will be effective on the first of the month during which the change in coverage is effective;
- If the change is effective after the 15th of the month, the change in premium will be effective on the first of the month following the effective date of the change in coverage.

The effective date of a change in premium will only vary from the above upon mutual written agreement between the *policyholder* and *us*.

102700 10/06

Notice of individual coverage terminations

Notice of any person's coverage termination should be given within 31 days of the termination date. Failure to notify *us* of a termination of coverage within 31 days will result in the *policyholder* being liable for the difference between the premiums paid and all benefits provided or claims verified and/or paid after the date of termination.

102800

Grace period

While this *policy* continues in force, a grace period of 31 days will be allowed to the *policyholder* following the premium due date, for the payment of each required premium due. This *policy* will remain in force during the grace period. If the required premium is not paid by the end of the 31 day period, this *policy* will terminate effective as of the last day of the month for which the last premium was received. Any claims incurred after the last day of the month for which premium was received are the responsibility of the *policyholder*.

102900

PREMIUMS (continued)

Unpaid premium

If the required premium is not paid by the end of the 31 day grace period, *we* reserve the right to collect the premium for the grace period.

Unpaid premium is subject to a late charge of 1.5% per month, for each late month beginning on the first day after the premium due date.

103000 12/03

DISCLOSURE

Customer service guarantee

From time to time *we* may offer prospective or renewing *policyholders* a customer service guarantee. *Policyholders* may receive a financial remuneration if *we* do not satisfactorily meet established customer service expectations. The guarantee is in no way related to health care services or medical risk.

If a customer service guarantee offer is available, a document describing the specific customer service promises included in the offer will be distributed at *group* enrollment or renewal.

104000

TABLE OF CONTENTS

Understanding your coverage
Schedule of benefits
Schedule of benefits - behavioral health
Schedule of benefits - transplant services
Covered expenses
Covered expenses - behavioral health
Covered expenses - transplant services
Limitations and exclusions
Eligibility and effective dates
Replacement of coverage
Termination provisions
Extension of benefits
Continuation
Medical conversion privilege
Coordination of benefits
Coordination of benefits for medicare eligibles
Claims
Complaint and appeals procedures
Disclosure provisions
Miscellaneous provisions
Glossary
Domestic partner benefit rider
Morbid obesity rider
Prescription drug benefit rider
Vision care rider
201000FL 04/04

UNDERSTANDING YOUR COVERAGE

As *you* read through this *certificate*, *you* will notice that certain words and phrases are printed in italics. An italicized word may have a different meaning in the context of this *certificate* than it does in general usage. Please check the "Glossary" section for the definitions of italicized words, so *you* can understand their meaning as it relates to *your* insurance coverage.

How to use your certificate

This *certificate* provides *you* with detailed information regarding *your* coverage. It explains what is covered and what is not covered. It also identifies *your* duties and how much *you* must pay when obtaining services. Although *your* coverage is broad in scope, it is important to remember that *your* coverage has limitations. Be sure to read *your* certificate carefully before using *your* benefits.

Please note the provisions and conditions of this certificate apply to *you* and to each of *your* covered dependents.

202000 04/06

Covered and non-covered expenses

Benefits are payable only if services are considered to be a *covered expense* and are subject to the specific conditions, limitations and applicable maximums of the *certificate*. The benefit payable for *covered expenses* will not exceed the *maximum allowable fee(s)*.

A *covered expense* is deemed to be incurred on the date a covered service is performed or a covered supply is furnished.

If *you* incur *non-covered expenses*, whether from a *network provider* or *non-network provider*, *you* are responsible for making the full payment to the health care provider. The fact that a *health care practitioner* has performed or prescribed a medically appropriate procedure, treatment, or supply, or the fact that it may be the only available treatment for a *bodily injury or sickness*, does not mean that the procedure, treatment or supply is covered under the *policy*.

Please refer to the "Schedule of Benefits", the "Covered Expenses" and the "Limitations and Exclusions" sections of this *certificate* for more information about *covered expenses* and *non-covered expenses*. Also, be sure to check *your certificate* for any attached amendments or supplemental benefit riders that may modify *your* benefits.

202100 04/06

How to find a network provider

An online directory of *network providers* will be made available to *you* and accessible via the Internet on *our* Website at www.humana.com at the time of *your* enrollment. This directory is subject to change. Due to the possibility of *network providers* changing status, please check the online directory of *network providers* prior to obtaining services. If *you* do not have access to the online directory, *you* may telephone *our* customer service center prior to services being rendered or to request a directory.

202400 04/04

UNDERSTANDING YOUR COVERAGE (continued)

How your policy works

Some policies may require *you* to pay a *deductible(s)* before *we* begin to share the cost of most medical services while others offer a benefit allowance before the *deductible(s)* applies.

If a *deductible* is required to be met before benefits are payable under the *policy*, when it is satisfied, *we* share the cost of *covered expenses* at the benefit percentage shown in the "Schedule of Benefits" sections, until *you* have reached any applicable *out-of-pocket limit*. After *you* have met the *out-of-pocket limit*, if any, *we* will pay *covered expenses* at 100% for the rest of the *year*, subject to the *maximum allowable fee(s)*, any maximum benefits and all other terms, provisions, limitations and exclusions of the *policy*. *You* will continue to pay benefit specific *copayments*.

Deductibles, *coinsurance* amounts, *copayments* and maximum amounts, if any, for each benefit are shown in the "Schedule of Benefits" sections. *We* calculate *deductibles* and *coinsurance* amounts by applying the dollar amount or percentage to the net charges. "Net charges" are defined as gross billed charges less any discounts or fee negotiations that may have been arranged with providers. "Gross billed charges" means the amount the provider charges without giving consideration to any discounts or other negotiated fees. The bill submitted by the provider will determine which benefit provision is applicable for payment of *covered expenses*.

202500 04/04

Preauthorization

All benefits payable under the *policy* must be for services and supplies that are *medically necessary* or for *preventive services* as stated in this *certificate*. *Preauthorization* by *us* is required for certain services and supplies. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies.

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. *You* or *your health care practitioner* must contact *us* by telephone, *electronic mail*, or in writing to obtain the appropriate authorization. *Your* identification card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not *covered expenses*.

202600 05/05

Our relationship with providers

Network providers and *non-network providers* are not *our* agents, employees or partners. *Network providers* are independent contractors. *We* do not endorse or control the clinical judgment or treatment recommendation made by *network providers* or *non-network providers*.

UNDERSTANDING YOUR COVERAGE (continued)

Nothing contained in the *policy* or any agreement or reimbursement document shall, nor is it intended to, interfere with communication between *you* and health care providers regarding *your* medical condition or treatment options. When requesting authorizations and ordering services, *health care practitioners* and other providers are acting on *your* behalf. All decisions related to patient care are the responsibility of the patient and the treating *health care practitioner*, regardless of any coverage determination(s) *we* have made or will make. *We* are not responsible for any misstatements made by any provider with regard to the scope of *covered expenses* and/or *non-covered expenses* under *your certificate*. If *you* have any questions concerning *your* coverage, please call *our* customer service center.

202700 05/05

Our financial arrangements with providers

We have agreements with *hospitals*, *health care practitioners* (including, but not limited to, physicians and other health care professionals), and other health care providers in the provider network(s) that may contain different payment arrangements.

- Many *health care practitioners* and health care providers are paid on a discounted fee-for-services basis, meaning that they are paid a mutually agreed upon amount for each *covered expense* rendered to *covered persons*. Most *hospitals* are paid on a specific Diagnosis Related Group (DRG) basis or flat fee per day basis for services provided to *covered persons* while *hospital confined*. *Outpatient* services rendered by *hospitals* and other facilities generally are reimbursed on a flat fee per service or procedure or a discount off charge basis.
- Some health care providers may have capitation agreements. This means the provider is prepaid a set dollar amount each month to care for each *covered person* regardless of how few or how many services a particular *covered person* may receive, or in some cases, whether services are provided by the primary care physician or a specialist. Stop-loss insurance protects some providers from financial loss in case the actual costs incurred in caring for patients exceed certain sums.
- Some health care providers may participate in bonus programs which impact their payments for reaching mutually agreed upon standards.

202800

Privacy and confidentiality statement

We understand the importance of keeping *your* personal and health information (PHI) private. PHI includes both medical information and individually identifiable information, such as *your* name, address, telephone number or Social Security number. *We* are required by applicable federal and state law to maintain the privacy of *your* PHI.

UNDERSTANDING YOUR COVERAGE (continued)

Under both law and *our* policies, *we* have a responsibility to protect the privacy of *your* PHI. *We*:

- Protect *your* privacy by limiting who may see *your* PHI;
- Limit how *we* may use or disclose *your* PHI;
- Inform *you* of *your* legal duties with respect to *your* PHI;
- Explain *our* privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change *our* privacy practices at any time, as allowed by applicable law, rules and regulations. *We* reserve the right to make changes in *our* privacy practices for all PHI that *we* maintain, including information *we* created or received before *we* made the changes. When *we* make a significant change in *our* privacy practices, *we* will send notice to *our* health plan subscribers. For more information about *our* privacy practices, please contact *us*.

As a *covered person*, *we* may use and disclose *your* PHI, without *your* consent/authorization in the following ways:

- **Treatment** - *we* may disclose *your* PHI to a *health care practitioner*, a *hospital* or other entity which asks for it in order for *you* to receive medical treatment; and
- **Payment** - *we* may use and disclose *your* PHI to pay claims for *covered expenses* provided to *you* by *health care practitioners*, *hospitals* or other entities.

We may also use and disclose *your* PHI to conduct other health care operations activities.

It has always been *our* goal to ensure the protection and integrity of *your* PHI. Therefore, *we* will notify *you* of any potential situations where *your* identification would be used for reasons other than treatment, payment and health plan operations.

203000

A note about this certificate - "benefit plan document"

This *certificate* is part of the insurance *policy* and describes the benefits, provisions and limitations of the *policy*. Nothing in this *certificate* waives or alters any of the terms or conditions of the *policy*. The final interpretation of any specific provision in this *certificate* is governed by the terms of the *policy*. In the event of conflict between the *policy* and this *certificate*, the provisions of the *policy* will prevail. The benefits outlined in this *certificate* are effective only if *you* are eligible for insurance, become insured and remain insured in accordance with the terms of the *policy*.

203100

SCHEDULE OF BENEFITS

Reading this "Schedule of Benefits" section will help *you* understand:

- The level of benefits generally paid for *covered expenses*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay;
- The services that require *you* to meet a *deductible*, if any, before benefits are paid; and
- *Preauthorization* requirements.

The benefits outlined in this "Schedule of Benefits" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Expenses" and "Limitations and Exclusions" sections of this *certificate*. Please refer to any applicable riders for additional coverage and/or limitations.

All services are subject to all of the terms, provisions, limitations and exclusions of the *policy*.

The benefits outlined under the "Schedule of Benefits - Behavioral Health" and "Schedule of Benefits - Transplant Services" sections are not payable under any other Schedule of Benefits of the *policy*. However, all other terms and provisions of the *policy*, including the *individual lifetime maximum benefit*, *preauthorization* requirements, annual *deductible(s)* and maximum *out-of-pocket limit(s)*, unless otherwise stated, are applicable.

SCH1-1100

Network provider verification

This *certificate* contains multiple *network provider* benefit levels. The benefits are identified as: "Level 1" and "Level 2", as follows:

Level 1 providers:

Hospitals: Shands Hospitals and facilities, Sacred Heart Hospitals
Health care practitioner: University of Florida College of Medicine Faculty Physicians;
and

Level 2 providers (Humana/ChoiceCare)

Includes Shands Employed Physicians

To know which benefit level is assigned to a *network provider*, please refer to the Online Physician Directory on *our* Website at www.humana.com. *You* may also contact *our* customer service department at the telephone number shown on *your* identification card. This list is subject to change.

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SCH1-1200

SCHEDULE OF BENEFITS (continued)

Individual lifetime maximum benefit

The total amount of benefits payable for all *covered expenses* incurred by you will not exceed the *individual lifetime maximum benefit* as follows.

Individual lifetime maximum benefit	Maximum benefit amount
<i>Individual lifetime maximum benefit</i>	\$5,000,000

SCH1-1300

Preauthorization requirements and penalty

Preauthorization by us is required for certain services and supplies. See table below or call the customer service telephone number on *your* identification card to obtain a list of services and supplies that require *preauthorization*. The list of services and supplies that require *preauthorization* is subject to change. Coverage provided in the past for services or supplies that did not receive or require *preauthorization*, is not a guarantee of future coverage of the same services or supplies.

You are responsible for informing *your health care practitioner* of the *preauthorization* requirements. You or *your health care practitioner* must contact us by telephone, electronic mail, or in writing to request the appropriate authorization. Your ID card will show the *health care practitioner* the telephone number to call to request authorization. Benefits are not paid at all for services or supplies that are not covered expenses.

If any required *preauthorization* of services or supplies is not obtained, the benefit payable for any *covered expenses* incurred for the services, will be reduced, after any applicable *deductibles* or *copayments*. If the rendered services are not covered expenses, no benefits are payable. The out-of-pocket amounts incurred by you due to these benefit reductions may not be used to satisfy any *out-of-pocket limits*. This *preauthorization* penalty will apply if you received the services from either a *network provider* or a *non-network provider* when *preauthorization* is required and not obtained.

BENEFIT	REQUIREMENTS	PENALTY
Inpatient Hospitalization	We must be notified before you are admitted. If the admission is on an emergency basis, We must be notified no later than 72 hours after you were admitted.	If the admission is not pre-authorized, benefits for the hospital or qualified treatment facility will be subject to a \$500 penalty per confinement. The penalty does not apply to the deductible, coinsurance or out-of-pocket maximums.

SCHEDULE OF BENEFITS (continued)

Skilled Nursing Facility	We must be notified before you are admitted.	Notification is required for skilled nursing facility confinement. If skilled nursing facility confinement is not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Durable Medical Equipment \$2,000 and above	We must be notified prior to services being rendered.	If durable medical equipment over \$2,000 is not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Experimental Procedures	We must be notified prior to services being rendered.	If experimental procedures are not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Abdominoplasty/Panniculectomy	We must be notified prior to services being rendered.	If abdominoplasty/panniculectomy are not pre authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out- of-pocket maximums.
Blepharoplasty	We must be notified prior to services being rendered.	If blepharoplasty is not preauthorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Cosmetic Procedures	We must be notified prior to services being rendered.	If cosmetic procedures are not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket.
Mandibular or Maxillary Osteotomy	We must be notified prior to services being rendered.	If mandibular or maxillary osteotomy is not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Morbid obesity/ Bariatric Surgery	We must be notified prior to services being rendered.	Lack of authorization will result in the benefit being Not covered.

SCHEDULE OF BENEFITS (continued)

Orthogenetic Surgery	We must be notified prior to services being rendered.	If orthogenetic surgery is not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Orthotics \$500 and above	We must be notified prior to services being rendered.	If orthotics over \$500 is not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Penile Implants and revascularization	We must be notified prior to services being rendered.	If penile implants or penile revascularization are not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Scar Revisions	We must be notified prior to services being rendered.	If scar revisions are not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Sclerotherapy	We must be notified prior to services being rendered.	If sclerotherapy is not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Septoplasty/Submucous resection with or without rhinoplasty	We must be notified prior to services being rendered.	If Septoplasty/Submucous resection with or without rhinoplasty is not pre-authorized, benefits will be subject to a \$500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Transplant services	We must be notified prior to services being rendered.	Lack of authorization will result in the benefit being Not covered.

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SCH1-1500FL

SCHEDULE OF BENEFITS (continued)

Annual deductible

An annual *deductible* is a specified dollar amount that *you* must pay for *covered expenses* per year before most benefits will be paid under the *policy*. There are individual and family *network provider* and *non-network provider deductibles*. The *deductible* amount(s) for each *covered person* and each covered family are as follows, and must be satisfied each *year*, either individually or combined as a covered family. Once the family *deductible* is met, any remaining *deductible* for a *covered person* in the family will be waived for that *year*. *Copayments* do not apply toward the annual *deductible*.

Any expense incurred by *you* for *covered expenses* that may be applied to any *deductible* under this provision will be applied equally toward the satisfaction of both *network provider* and *non-network provider deductibles*.

Deductible	Deductible amount
Level 1 Individual <i>network provider deductible</i>	\$0
Level 1 Family <i>network provider deductible</i>	\$0
Level 2 & Individual <i>non-network provider deductible</i>	\$1,000
Level 2 & Family <i>non-network provider deductible</i>	\$2,000

FL234896.3 07/09

SCH1-1600FL

Annual deductible carryover

If a *covered person* incurs *covered expenses* during the last three months of a *year* that can be applied toward the satisfaction of the individual *deductible* for that *year*, those same expenses will be applied toward the satisfaction of the individual *deductible* of the next *year*.

SCH1-1700

Out-of-pocket limit

The *out-of-pocket limit* is the amount of *covered expenses*, excluding expenses used to satisfy *deductibles* and *copayments*, that must be paid by *you*, either individually or combined as a covered family, per *year* before a benefit percentage will be increased. There are individual and family *network provider* and *non-network provider out-of-pocket limits*.

SCHEDULE OF BENEFITS (continued)

After the individual *network provider out-of-pocket limit* has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*. After the family *network provider out-of-pocket limit* has been satisfied in a *year*, the *network provider* benefit percentage for *covered expenses* will be payable at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*. Benefit specific *copayments* continue to be *your* responsibility.

After the individual *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *non-network provider* benefit percentage for *covered expenses* for that *covered person* will be payable at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*. After the family *non-network provider out-of-pocket limit* has been satisfied in a *year*, the *non-network provider* benefit percentage for *covered expenses* will be payable at the rate of 100% for the rest of the *year*, subject to any maximum benefit and all other terms, provisions, limitations and exclusions of the *policy*. Benefit specific *copayments* continue to be *your* responsibility.

Any expense incurred by *you* for *covered expenses* that may be applied to any *out-of-pocket limit* under this provision will be applied equally toward the satisfaction of both *network provider* and *non-network provider out-of-pocket limits*.

If an *out-of-pocket limit* is shown to be unlimited, *covered expenses* will be paid at the levels indicated in the Schedules of Benefits. *You* will be responsible for any out-of-pocket expenses.

If the *coinsurance* amount applied to *your* claim is waived by *your* health care provider, *you* are required to inform *us*. Any amount, thus waived and not paid by *you*, would not apply to any *out-of-pocket limit*.

Deductibles do not apply towards any *out-of-pocket limit*. Also, any expenses for chemical dependency services and mental health services as well as out-of-pocket expenses for covered organ transplants do not apply towards any *out-of-pocket limit*.

SCHEDULE OF BENEFITS (continued)

Out-of-pocket limit	Out-of-pocket limit amount
Level 1 Individual <i>network provider out-of-pocket limit</i>	\$0
Level 1 Family <i>network provider out-of-pocket limit</i>	\$0
Level 2 Individual <i>network provider out-of-pocket limit</i>	\$2,500
Level 2 Family <i>network provider out-of-pocket limit</i>	\$5,000
Individual <i>non-network provider out-of-pocket limit</i>	\$5,000
Family <i>non-network provider out-of-pocket limit</i>	\$10,000

FL234896.4 07/09

SCH1-1800

SCHEDULE OF BENEFITS (continued)

Preventive services

Preventive services are limited to a maximum benefit of \$500 per year. (Does not include expenses for Pap smear, prostate specific antigen PSA testing, mammogram or routine endoscopic services.)

Preventive services office visits for covered persons 26 years of age or over

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

Preventive services office visits for covered persons under 26 years of age

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	80% benefit payable

Preventive immunizations for covered persons under 26 years of age

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	80% benefit payable

SCHEDULE OF BENEFITS (continued)

Preventive immunizations for covered persons 26 years of age or over

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

Preventive screenings for covered persons under 26 years of age

Excludes preventive endoscopic services, including but not limited to colonoscopy, proctosigmoidoscopy and sigmoidoscopy, vision and hearing services.

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

Preventive screenings for covered persons 26 years of age or over

Excludes preventive endoscopic services, including but not limited to colonoscopy, proctosigmoidoscopy and sigmoidoscopy, vision and hearing services.

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

SCHEDULE OF BENEFITS (continued)

Preventive endoscopic services

Includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy.

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

Routine hearing services

Exam

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

Testing (Administered by audiologist for diagnostic purposes)

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Routine vision services

Exam (Refraction is not covered)

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

Tonometry

Level 1 <i>network health care practitioner</i>	80% benefit payable after <i>network provider deductible</i>
Level 2 <i>network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Health care practitioner office visit services

Health care practitioner office visit

Excludes diagnostic laboratory and radiology services, *advanced imaging* and *outpatient surgery*.

Level 1 <i>network health care practitioner*</i>	100% benefit payable
Level 2 <i>network health care practitioner*</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

**Network health care practitioner* office visits for prenatal care are covered at 100% after the initial visit.

Diagnostic laboratory and radiology services

Excludes *advanced imaging*

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable

Advanced imaging when performed in a health care practitioner's office

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Allergy serum when received in the health care practitioner's office

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable

Allergy testing when received in the health care practitioner's office

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable

Allergy injections when received in a health care practitioner's office

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Injections other than routine received in a health care practitioner's office

<i>Level 1 network health care practitioner</i>	100% benefit payable
<i>Level 2 network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable

Surgery performed in the office and billed by the health care practitioner

<i>Level 1 network health care practitioner</i>	100% benefit payable
<i>Level 2 network health care practitioner</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network health care practitioner</i>	60% benefit payable

Anesthesia in a clinic (including medical surgical supplies)

<i>Level 1 network health care practitioner</i>	100% benefit payable
<i>Level 2 network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Second medical opinion

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	100% benefit payable
<i>Non-network health care practitioner</i>	100% benefit payable

Hospital services

Hospital inpatient services

Level 1 <i>Network hospital</i>	100% benefit payable
Level 2 <i>Network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	60% benefit payable after <i>non-network provider deductible</i>

Health care practitioner inpatient services when provided in a hospital

(Includes surgery, anesthesia and *hospital visit*)

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Health care practitioner pathology and radiology services when provided in a hospital

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

Pre-admission testing

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	80% benefit payable after <i>non-network provider deductible</i>

Hospital outpatient surgical services

Must be performed in a *hospital's outpatient* department.

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Health care practitioner outpatient services when provided in a hospital

Includes *outpatient surgery*

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable

Hospital outpatient non-surgical services

Must be performed in a *hospital's outpatient* department. Excludes radiology, pathology and *advanced imaging*.

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	60% benefit payable

Hospital outpatient advanced imaging

Must be performed in a *hospital's outpatient* department.

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Health care practitioner radiology and pathology outpatient services when provided in a hospital

Must be performed in a *hospital's outpatient* department.

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	60% benefit payable

Pregnancy and newborn benefit

Birth center

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	60% benefit payable

Maternity laboratory and radiology

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	80% benefit payable

SCHEDULE OF BENEFITS (continued)

Emergency services

Hospital emergency room services*

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	80% benefit payable

Hospital emergency room health care practitioner services*

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

***Emergency care provided by a *non-network hospital* or *non-network health care practitioner* will be covered at the network level(s).**

Hospital emergency room pathology, radiology and anesthesiology services

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

SCHEDULE OF BENEFITS (continued)

Ambulance

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	80% benefit payable

Ambulatory surgical center services

Ambulatory surgical center for outpatient surgery

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable

Health care practitioner outpatient services provided in an ambulatory surgical center

Includes *outpatient surgery*.

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Durable medical equipment

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable

Prosthesis

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	80% benefit payable after <i>non-network provider deductible</i>

Free standing facility services

Free standing facility surgical center services

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Free standing facility outpatient non-surgical services

Excludes *advanced imaging*.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable

Health care practitioner outpatient non-surgical services provided in a free standing facility

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	80% benefit payable

Free standing facility advanced imaging

Level 1 <i>network hospital</i>	100% benefit payable
Level 2 <i>network hospital</i>	80% benefit payable
<i>Non-network hospital</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Home health care

Limited to a combined maximum of 60 visits per year up to 4 hours per visit.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable after <i>network provider deductible</i>
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Hospice

Limited to a combined maximum of \$10,000.

Inpatient and outpatient

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable after <i>network provider deductible</i>
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Bereavement

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable after <i>network provider deductible</i>
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Jaw joint benefit

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable

Splint and appliances

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	80% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Physical medicine and rehabilitative services

Physical therapy, occupational therapy, speech therapy, vision therapy, respiratory therapy and cognitive rehabilitation services

Office

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Facility

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Radiation and chemotherapy services

Office and facility

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Cardiac rehabilitation

Limited to phases I and II. Phase III is typically not covered because it is a maintenance program and may not be medically supervised. At this point, the intensive program has been completed and the patient should have developed a personal fitness program for life. If medical supervision is not needed for maintenance, then the fitness program would be no different than a program followed by a person without cardiac disease.

Phase I

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Phase II

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	80% benefit payable after <i>non-network provider deductible</i>

Acupuncture

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Massage therapy

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Chiropractic care

Exams

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Laboratory and radiology

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable

SCHEDULE OF BENEFITS (continued)

Manipulations and therapy

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Skilled nursing facility

Limited to a combined maximum of 60 days per *year*.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable

Urgent care services

Urgent care facility services

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	80% benefit payable

SCHEDULE OF BENEFITS (continued)

Birth control devices

Injections and implant devices

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i>
<i>Non-network provider</i>	80% benefit payable

Sexual dysfunction/ impotence

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Wigs

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	80% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Sterilization in a clinic

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Oral surgeries

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Dental osteotomies/ dental injuries

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	100% benefit payable after \$30 <i>copayment</i> per visit
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS (continued)

Private duty nursing

Limited to inpatient *hospital* only.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable after <i>network provider deductible</i>
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

Infertility counseling and treatment

Same as any other sickness depending on type of service and place of treatment.

Morbid obesity

If medically necessary, same as any other sickness depending on type of service and place of treatment.

Additional covered expenses

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

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SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH

Reading this "Schedule of Benefits - Behavioral Health" section will help *you* understand:

- The level of benefits generally paid for the *mental health services* and *chemical dependency* services under the *policy*;
- The amounts of *copayments* and/or *coinsurance* *you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits - Behavioral Health" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Expenses - Behavioral Health" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all the terms and provisions, limitations and exclusions of the *policy*.

Mental Health Services

Acute inpatient services and partial hospitalization

All *acute inpatient services* for *mental health services* are limited to a maximum of 90 days per *year*.

Acute inpatient services

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Health care practitioner inpatient visits

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

Partial hospitalization

Covered expenses for acute inpatient services and partial hospitalization combined will not exceed the cost of 90 days of inpatient hospitalization for mental health services. Two days partial hospitalization equals one day inpatient services.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH (continued)

Outpatient therapy and office therapy

Outpatient therapy and office therapy individual and group sessions for *mental health services* are limited to a combined maximum of 52 visits per year. A session will not exceed one hour.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	80% benefit payable

Chemical Dependency Services

All *inpatient* and *outpatient* care for *chemical dependency services* is limited to a combined maximum of 90 days per year.

Acute inpatient services

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH
(continued)

Health care practitioner inpatient visits

Level 1 <i>network health care practitioner</i>	100% benefit payable
Level 2 <i>network health care practitioner</i>	80% benefit payable
<i>Non-network health care practitioner</i>	60% benefit payable after <i>non-network provider deductible</i>

Partial hospitalization

Covered expenses for acute inpatient services and partial hospitalization combined will not exceed the cost of 90 days of inpatient hospitalization for mental health services. Two days partial hospitalization equals one day inpatient services.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	60% benefit payable after <i>non-network provider deductible</i>

SCHEDULE OF BENEFITS - BEHAVIORAL HEALTH
(continued)

Outpatient therapy and office therapy

All *outpatient* care for alcoholism and *chemical dependency services* is limited to a maximum of 52 visits per year.

Level 1 <i>network provider</i>	100% benefit payable
Level 2 <i>network provider</i>	80% benefit payable
<i>Non-network provider</i>	80% benefit payable

SCH-BHFL 04/04

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES

Reading this "Schedule of Benefits - Transplant Services" section will help *you* understand:

- The level of benefits generally paid for the transplant services covered under the *policy*;
- The amounts of *copayments* and/or *coinsurance you* are required to pay; and
- The services that require *you* to meet a *deductible* before benefits are paid.

The benefits outlined in this "Schedule of Benefits - Transplant Services" are a summary of coverage and limitations provided under the *policy*. A more detailed explanation of *your* coverage and its limitations and exclusions for these benefits are provided in the "Covered Expenses - Transplant Services" and "Limitations and Exclusions" sections of this *certificate*. Please refer to this *certificate* and any applicable riders for additional coverage and/or limitations.

All services are subject to all of the terms, provisions, limitations and exclusions of the *policy*.

Organ transplant benefit

Medical Services

Limited to a combined maximum of \$300,000 per year.

- *Hospital services*

Hospital benefits as shown in the "Schedule of Benefits" section under the "Hospital Services" provision of the *certificate* will be payable as follows:

Level 1 <i>network hospital</i> designated by <i>us</i> as an approved transplant facility	Same as any other <i>sickness</i> based on location of services and type of provider
Level 2 <i>network hospital</i> designated by <i>us</i> as an approved transplant facility	Same as any other <i>sickness</i> based on location of services and type of provider
<i>Non-network hospital</i>	Same as any other <i>sickness</i> based on location of services and type of provider to the <i>transplant non-network provider out-of-pocket limit</i>

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES (continued)

- *Health care practitioner services*

Health care practitioner benefits as shown in the "Schedule of Benefits" section under the "Health Care Practitioner Services" provision of the *certificate* will be payable as follows:

Level 1 <i>network health care practitioner</i> designated by <i>us</i> as an approved transplant <i>health care practitioner</i>	Same as any other <i>sickness</i> based on location of services and type of provider
Level 2 <i>network health care practitioner</i> designated by <i>us</i> as an approved transplant <i>health care practitioner</i>	Same as any other <i>sickness</i> based on location of services and type of provider
<i>Non-network health care practitioner</i>	Same as any other <i>sickness</i> based on location of services and the type of provider to the <i>transplant non-network provider out-of-pocket limit</i>

Direct, non-medical costs

Limited to a combined maximum of \$10,000 per covered *organ transplant*.

- Transportation

Level 1 <i>network hospital</i> designated by <i>us</i> as an approved transplant facility	100% benefit payable
Level 2 <i>network hospital</i> designated by <i>us</i> as an approved transplant facility	100% benefit payable
<i>Non-network hospital</i>	100% benefit payable

SCHEDULE OF BENEFITS - TRANSPLANT SERVICES
(continued)

- Temporary lodging

Level 1 <i>network hospital</i> designated by <i>us</i> as an approved transplant facility	100% benefit payable
Level 2 <i>network hospital</i> designated by <i>us</i> as an approved transplant facility	100% benefit payable
<i>Non-network hospital</i>	100% benefit payable

SCHFL-OT 10/07

COVERED EXPENSES

The "Covered Expenses" section describes the services that will be considered *covered expenses* under the *policy*. Benefits will be paid for such covered medical services for a *bodily injury* or *sickness*, or for specified *preventive services*, on a *maximum allowable fee* basis and as shown on the Schedules of Benefits subject to any applicable:

- *Deductible*;
- *Copayment*;
- *Coinsurance* percentage; and
- Maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy*, including the *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.

204000 05/05

Preventive services

Preventive services office visit

Covered expenses include charges incurred for an office visit made to a *health care practitioner* for examinations and physicals to detect or prevent *sickness* as recommended by the U.S. Preventive Services Task Force.

Covered expenses include child health supervision services from the moment of birth to age 16 years. The periodic visits include a history, a physical examination, a developmental assessment and anticipatory guidance, appropriate immunizations and laboratory tests, and newborn hearing screening including any necessary follow-up care. Minimum benefits may be limited to one visit payable to one *health care practitioner* for all of the services provided at each visit. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. These services are not subject to the annual *deductible*.

Preventive screenings and immunizations

Covered expenses include charges incurred by *you* for the following *preventive services* as recommended by the United States Preventive Services Task Force:

- Laboratory, radiology and/or endoscopic services to detect or prevent *sickness*.
- An annual mammogram for a female *covered person* or more frequently based on your physician's recommendation. One or more mammograms each year for any female *covered person* at risk. Annual mammograms may be performed with or without a physician's recommendation if the mammogram is obtained in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative Services for breast cancer screening;

COVERED EXPENSES (continued)

- Annual Routine pap smear.
- A prostate specific antigen (PSA) test for a male.
- Routine immunizations. TB tine tests and allergy desensitization injections are not considered routine immunizations.
- Immunizations against influenza and pneumonia.
- Routine hearing.
- Routine vision screening (not including refractions).

FL234896.8 07/09

204200FL 02/08

Health care practitioner office services

We will pay the following benefits for *covered expenses* incurred by you for *health care practitioner* office visit charges. You must incur the *health care practitioner's* charges as the result of a *sickness* or *bodily injury*.

Health care practitioner office visit

Covered expenses include:

- Office visits for the diagnosis and treatment of a *sickness* or *bodily injury*.
- Office visits for prenatal care and post-delivery care.
- Office visits for *diabetes self-management training*.
- Diagnostic laboratory and radiology.
- Allergy testing.
- Allergy serum.
- Allergy injections.
- Injections other than allergy.
- *Surgery*, including anesthesia.
- Second surgical opinions.

204400FL 07/07

Hospital services

We will pay benefits for *covered expenses* incurred by you while *hospital confined* or for *outpatient* services. A *hospital confinement* must be ordered by a *health care practitioner*.

COVERED EXPENSES (continued)

For *emergency care* benefits provided in a *hospital*, refer to the "Emergency Services" provisions of the "Covered Expenses" section.

Hospital inpatient services

Covered expenses include:

- Daily semi-private, ward, intensive care or coronary care *room and board* charges for each day of *confinement*. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient.
- Services and supplies, other than *room and board*, provided by a *hospital* to a registered bed patient.

Health care practitioner inpatient services when provided in a hospital

Services which are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- Medical services furnished by an attending *health care practitioner* to you while you are *hospital confined*.
- *Surgery* performed on an *inpatient* basis. If several *surgeries* are performed during one operation, we will pay the *maximum allowable fee* for the most complex procedure.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.
- Consultation charges requested by the attending *health care practitioner* during a *hospital confinement*. The benefit is limited to one consultation by any one consultant per specialty during a *hospital confinement*.
- Services of a pathologist.
- Services of a radiologist.
- Services performed on an emergency basis in a *hospital* if the *sickness* or *bodily injury* being treated results in a *hospital confinement*.

COVERED EXPENSES (continued)

Hospital outpatient services

Covered expenses include *outpatient* services and supplies, as outlined in the following provisions, provided in a *hospital's outpatient* department.

Covered expenses provided in a *hospital's outpatient* department will not exceed the average semi-private room rate when you are in *observation status*.

Hospital outpatient surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in a hospital

Services which are payable as a *hospital* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. If several *surgeries* are performed during one operation, we will pay the *maximum allowable fee* for the most complex procedure.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.
- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant for a *surgery*.
- Services of a pathologist.
- Services of a radiologist.
- Post-delivery care including services rendered in an *outpatient* maternity center.

Hospital outpatient non-surgical services

Covered expenses include services provided in a *hospital's outpatient* department in connection with non-surgical services.

Covered expenses for *hospital* non-surgical services do not include *advanced imaging*.

Hospital outpatient advanced imaging

We will pay benefits for *covered expenses* incurred by you for *outpatient advanced imaging* in a *hospital's outpatient* department.

205450FL 07/07

COVERED EXPENSES (continued)

Pregnancy and newborn benefit

We will pay benefits for *covered expenses* incurred by a *covered person* for a pregnancy.

Covered expenses include:

- A minimum stay of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section. If an earlier discharge is consistent with the most current protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics and is consented to by the mother and the attending *health care practitioner*, a post-discharge office visit to the *health care practitioner* or a home health care visit within the first 48 hours after discharge is also covered, subject to the terms of this *certificate*
- For a newborn, *hospital confinement* during the first 48 hours or 96 hours following birth, as applicable and listed above for:
 - *Hospital charges for routine nursery care;*
 - *The health care practitioner's charges for circumcision of the newborn child; and*
 - *The health care practitioner's charges for routine examination of the newborn before release from the hospital.*
- If the covered newborn must remain in the *hospital* past the mother's *confinement*, services and supplies received for:
 - *A bodily injury or sickness;*
 - *Care and treatment for premature birth; and*
 - *Medically diagnosed birth defects and abnormalities.*

Covered expenses also include *cosmetic surgery* specifically and solely for:

- Reconstruction due to *bodily injury*, infection or other disease of the involved part; or
- Congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect.

Covered expenses also include those services rendered in licensed birth centers.

The newborn will not be required to satisfy a separate *deductible* and/or *copayment* for *hospital* facility charges for the *confinement* period immediately following birth. A *deductible* and/or *copayment*, if applicable, will be required for any subsequent *hospital admission*.

205500FL 07/07

Emergency services

We will pay benefits for *covered expenses* incurred by you for *emergency care*, including the treatment and stabilization of an emergency medical condition. *Covered expenses* include medical screening examinations provided in a *hospital* emergency facility to determine whether a medical emergency condition exists.

COVERED EXPENSES (continued)

Emergency care provided by a *non-network hospital* or a *non-network health care practitioner* will be covered at the same benefit level as a *network provider*, subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us*.

Covered expenses also include *health care practitioner* services for *emergency care*, including the treatment and stabilization of an emergency medical condition, provided in a *hospital* emergency facility. These services are subject to the terms, conditions, limitations, and exclusions of the *policy*.
205700FL 02/09

Ambulance

We will pay benefits for *covered expenses* incurred by *you* for professional *ambulance* service to, from or between medical facilities for *emergency care*. *We* will also pay benefits for a newborn *dependent's* transportation to and from the nearest available facility staffed and equipped to treat the newborn's condition if the transportation is certified by the attending physician as necessary to protect the health and safety of the newborn *dependent*.

Ambulance service for *emergency care* provided by a *non-network* provider will be covered at the same benefit level as a *network provider*, subject to the *maximum allowable fee*. *Non-network providers* have not agreed to accept discounted or negotiated fees, and may bill *you* for charges in excess of the *maximum allowable fee*. *You* may be required to pay any amount not paid by *us*.
205750FL 02/09

Ambulatory surgical center

We will pay benefits for *covered expenses* incurred by *you* for services provided in an *ambulatory surgical center* for the utilization of the facility and ancillary services in connection with *outpatient surgery*.

Health care practitioner outpatient services when provided in an ambulatory surgical center

Services which are payable as an *ambulatory surgical center* charge are not payable as a *health care practitioner* charge.

Covered expenses include:

- *Surgery* performed on an *outpatient* basis. If several *surgeries* are performed during one operation, *we* will pay the *maximum allowable fee* for the most complex procedure.
- Services of a surgical assistant and/or assistant surgeon when *medically necessary*.
- Services of a physician assistant (P.A.), registered nurse (R.N.) or a certified operating room technician when *medically necessary*.

COVERED EXPENSES (continued)

- Anesthesia administered by a *health care practitioner* or certified registered anesthetist attendant to a *surgery*.
 - Services of a pathologist.
 - Services of a radiologist.
- 205800 07/07

Durable medical equipment and diabetes equipment

We will pay benefits for *covered expenses* incurred by you for *durable medical equipment* and *diabetes equipment*. At our option, *covered expense* includes the purchase or rental of *durable medical equipment* or *diabetes equipment*. If the cost of renting the equipment is more than you would pay to buy it, only the cost of the purchase is considered to be a *covered expense*. In either case, total *covered expenses* for *durable medical equipment* or *diabetes equipment* shall not exceed its purchase price. In the event we determine to purchase the *durable medical equipment* or *diabetes equipment*, any amount paid as rent for such equipment will be credited toward the purchase price.

We do not pay for equipment or devices not specifically designed and intended for the care and treatment of a *sickness* or *bodily injury*.

The following are not considered *covered expenses*:

- Repair or maintenance of the *durable medical equipment* or *diabetes equipment*; or
- Duplicate or similar rentals or purchases of *durable medical equipment* or *diabetes equipment* as determined by *us*.

205900FL 05/05

Free-standing facility services

Free-standing outpatient non-surgical services

We will pay benefits for *covered expenses* for services provided in a *free-standing facility* for the utilization of the facility and ancillary services.

Covered expenses for *outpatient* non-surgical services do not include *advanced imaging*.

Health care practitioner services provided in a free-standing facility

We will pay benefits for *outpatient* non-surgical services provided by a *health care practitioner* in a *free-standing facility*.

COVERED EXPENSES (continued)

Free-standing outpatient advanced imaging

We will pay benefits for *covered expenses* incurred by you for *advanced imaging* in a *free-standing facility*.

206250 07/07

Home health care

We will pay benefits for *covered expenses* incurred by you in connection with a *home health care plan*. All home health care services and supplies must be provided on a part-time or intermittent basis to you in conjunction with the approved *home health care plan*.

The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a *home health care agency*, if any. A visit by any representative of a *home health care agency* of two hours or less will be counted as one visit.

Home health care *covered expenses* include:

- Care provided by a *nurse*;
- Physical, occupational, respiratory or speech therapy, medical social work and nutrition services; and
- Medical appliances, equipment and laboratory services.

Home health care *covered expenses* do not include:

- Charges for mileage or travel time to and from the *covered person's* home;
- Wage or shift differentials for any representative of a *home health care agency*;
- Charges for supervision of *home health care agencies*;
- Charges for services of a home health aide;
- *Custodial care*; or
- The provision or administration of *self-administered injectable drugs*.

206300 05/05

Hospice

We will pay benefits for *covered expenses* incurred by you for a *hospice care program*. A *health care practitioner* must certify that the *covered person* is terminally ill with a life expectancy of 18 months or less.

If the above criteria is not met, no benefits will be payable under the *policy*.

COVERED EXPENSES (continued)

Hospice care benefits are payable as shown on the "Schedule of Benefits" for the following hospice services, subject to the *individual lifetime maximum benefit* and any other maximum(s):

- *Room and board* at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;
- Counseling for the terminally ill *covered person* and his/her immediate covered family members by a licensed:
 - Clinical social worker; or
 - Pastoral counselor.

This counseling is limited to a total of 5 family sessions. This counseling must be provided within six months following the *covered person's* death.

- Medical social services provided to the terminally ill *covered person* or his/her immediate covered family members under the direction of a *health care practitioner*, including:
 - Assessment of social, emotional and medical needs, and the home and family situation; and
 - Identification of the community resources available.
- Psychological and dietary counseling;
- Physical therapy;
- Part-time home health aide services for up to eight hours in any one day, and
- Medical supplies, drugs, and medicines prescribed by a *health care practitioner* for *palliative care*.

Hospice care *covered expenses* do not include:

- A *confinement* not required for acute pain control or other treatment for an acute phase of chronic symptom management;
- Services by volunteers or persons who do not regularly charge for their services;
- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
- Bereavement counseling services for family members not covered under this policy.

206400 07/07

COVERED EXPENSES (continued)

Jaw joint benefit

We will pay benefits for *covered expenses* incurred by *you* during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit level shown on the "Schedule of Benefits", if any.

The following are *covered expenses*:

- A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;
- Therapeutic injections;
- Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the *maximum allowable fee* for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and
- Surgical procedures.

Covered expenses do not include charges for:

- Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;
- Electronic diagnostic modalities;
- Occlusal analysis; or
- Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures.

206500 05/05

COVERED EXPENSES (continued)

Physical medicine and rehabilitative services benefit

We will pay benefits for *covered expenses* incurred by *you* for the following physical medicine and/or rehabilitative services for a documented loss of physical function, pain, or developmental defect as ordered by a *health care practitioner* and performed by a *health care practitioner*:

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations, adjustments and modalities performed in a *health care practitioner's* office or on an *inpatient* or *outpatient* basis or in a *rehabilitation facility*;
- Speech therapy or speech pathology services;
- Acupuncture;
- Cognitive rehabilitation services;
- Respiratory or pulmonary therapy services;
- Cardiac rehabilitation services;
- Chemotherapy; and
- Massage therapy.

The "Schedule of Benefits" shows the maximum number of visits for physical medicine and/or rehabilitative services, if any.

206600FL 07/07

Skilled nursing facility

We will pay benefits for *covered expenses* incurred by *you* for charges made by a *skilled nursing facility* for *room and board*, and services and supplies. *Your confinement* to a *skilled nursing facility* must be based upon a written recommendation of a *health care practitioner*.

The "Schedule of Benefits" shows the maximum length of time for which *we* will pay benefits for charges made by a *skilled nursing facility*, if any.

206800 05/05

Urgent care services

We will pay benefits for *covered expenses* incurred by *you* for charges made by an *urgent care center* for *urgent care* services. *Covered expense* also includes *health care practitioner* services for *urgent care* provided at and billed by an *urgent care center*.

206900 07/07

COVERED EXPENSES (continued)

Additional covered expenses

We will pay benefits for *covered expenses* incurred by *you* based upon the location of the services and the type of provider for:

- Blood and blood plasma which is not replaced by donation; administration of the blood and blood products including blood extracts or derivatives.
- Oxygen and rental of equipment for its administration.
- Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. Replacement is a *covered expense* if due to pathological changes or growth.
- Cochlear implants, when approved by *us*, for a *covered person*:
 - 18 years of age or older with bilateral severe to profound sensorineural deafness; or
 - 12 months to 17 years of age with profound bilateral sensorineural deafness.

Replacement or upgrade of a cochlear implant and its external components may be a *covered expense* if:

- The existing device malfunctions and cannot be repaired;
 - Replacement is due to a change in the *covered person's* condition that makes the present device non-functional; or
 - The replacement or upgrade is not for cosmetic purposes.
- Casts, splints, trusses, crutches, orthotics and braces. Orthotics must be custom made or custom fit and made of rigid or semi-rigid material.

Regardless of indication, no coverage is provided for:

- Fabric supports;
 - Replacement orthotics and braces;
 - Oral splints and appliances; or
 - Dental splints and dental braces.
- The following special supplies, dispensed up to a 30-day supply, when prescribed by *your* attending *health care practitioner*:
 - Surgical dressings;
 - Catheters;
 - Colostomy bags, rings and belts; and
 - Flotation pads.

COVERED EXPENSES (continued)

- The initial pair of eyeglasses or contacts needed due to cataract *surgery* or an *accident* if the eyeglasses or contacts were not needed prior to the *accident*.
- Dental treatment only if:
 - The charges are incurred for treatment of a *dental injury* to a *sound natural tooth*; and
 - The *pre-existing condition* exclusion period, if applicable, has been satisfied; and
 - The treatment begins within 90 days after the date of the *dental injury*; and
 - The treatment is completed within 12 months after the date of the *dental injury*.

However, benefits will be paid only for the least expensive service that will, in *our* opinion, produce a professionally adequate result.

- Hospitalization services and general anesthesia for dental treatment or *surgery* when provided to a *covered person* who is under 8 years of age and who is determined by a licensed dentist and the child's physician to require necessary dental treatment in a *hospital* or *ambulatory surgical center* due to significantly complex dental condition or a developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk in the course of treatment delivery if not rendered in a *hospital* or *ambulatory surgical center*.
- Certain oral surgical operations as follows:
 - Excision of partially or completely unerupted impacted teeth;
 - Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations;
 - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - Reduction of fractures and dislocation of the jaw;
 - External incision and drainage of cellulitis;
 - Incision of accessory sinuses, salivary glands or ducts;
 - Frenectomy (the cutting of the tissue in the midline of the tongue); and
 - Orthognathic surgery for a congenital anomaly causing a functional defect.
- Elective vasectomy or tubal ligation.
- For a *covered person*, who is receiving benefits in connection with a mastectomy, service for:
 - Reconstructive *surgery* of the breast on which the mastectomy has been performed;
 - *Surgery* and reconstruction on the non-diseased breast to achieve symmetrical appearance;
 - Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas; and
 - Post-surgical follow-up care.

COVERED EXPENSES (continued)

- Enteral formulas for use at home by a *covered person* that are prescribed or ordered by a *health care practitioner* and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU), unless otherwise covered in the Prescription Drug Benefit, if any, attached to this *policy*. Coverage shall include food products modified to be low protein for a *covered person* through the age of 24.
- Private duty nursing while you are *hospital confined*.
- *Covered expenses* for treatment of cleft lip and cleft palate for a covered *dependent* under the age of eighteen. This coverage includes medical, dental, speech therapy, audiology, and nutrition services when prescribed by the treating *health care practitioner*. The *health care practitioner* must certify that such services are *medically necessary* and consequent to treatment of the cleft lip or palate. This benefit is subject to all other terms and conditions applicable to other benefits.
- Services for the *medically necessary* diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.
- Any medically necessary treatment, including surgical procedures for *morbid obesity*.

FL234896.9 07/09

207000FL 07/07

COVERED EXPENSES - BEHAVIORAL HEALTH

The "Covered Expenses - Behavioral Health" section describes the services that will be considered *covered expenses* for *mental health services* and *chemical dependency services* under the *policy*. Benefits for *mental health services* and *chemical dependency services* will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits - Behavioral Health" subject to:

- The *deductible*, if applicable;
- Any *copayment*, if applicable;
- Any *coinsurance* percentage; and
- Any maximum benefit.

Refer to the "Limitations and Exclusions" section listed in this *certificate*. All terms and provisions of the *policy*, including *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.

208000

Acute inpatient services

We will pay benefits for *covered expenses* incurred by you for *acute inpatient services* for *mental health services* and *chemical dependency services* provided in a *hospital* or *health care treatment facility*.

Covered expense does not include charges for services rendered in a *residential treatment facility*.

The "Schedule of Benefits - Behavioral Health" reflects benefit limitations for *acute inpatient services* care for *mental health services* and *chemical dependency services*, if any.

208100

Acute inpatient facility services

We will pay benefits for *covered expenses* incurred by you for a *confinement* in a *hospital* or *health care treatment facility* for *mental health services* and *chemical dependency services*.

208200

Acute inpatient health care practitioner services

We will pay benefits for *covered expenses* incurred by you for *mental health services* and *chemical dependency services* provided by a *health care practitioner* in a *hospital* or *health care treatment facility*.

208300

COVERED EXPENSES - BEHAVIORAL HEALTH (continued)

Outpatient care and office therapy services

We will pay benefits for *covered expense* incurred by you for *mental health services* and *chemical dependency services* while not *confined* in a *hospital* or *health care treatment facility* for *outpatient services*, including *outpatient services* provided as part of an *intensive outpatient program*.

Covered expense does not include charges for *outpatient services* rendered in or by a *residential treatment facility*.

The "Schedule of Benefits - Behavioral Health" reflects the benefit limitations for *outpatient care*, including *outpatient services* provided as part of an *intensive outpatient program*, for *mental health services* and *chemical dependency services*, if any.

208500

COVERED EXPENSES - TRANSPLANT SERVICES

The "Covered Expenses - Transplant Services" section describes the services that will be considered *covered expenses* for transplant services under the *policy*. Benefits for transplant services will be paid on a *maximum allowable fee* basis and as shown in the "Schedule of Benefits - Transplant Services" subject to any applicable:

- *Deductible*;
- *Copayment*; and
- *Coinsurance* percentage.

Refer to the "Exclusions" provision in this section and the "Limitations and Exclusions" section listed in this *certificate* for transplant services not covered by the *policy*. All terms and provisions of the *policy*, including *preauthorization* requirements specified in this *certificate*, are applicable to *covered expenses*.
210000FL 10/07

Organ transplant benefit

We will pay benefits for *covered expenses* incurred by you for an *organ transplant*. The *organ transplant* must be approved in advance by us, and is subject to the terms, conditions and limitations described below and contained in the *policy*. Please contact our Transplant Management Department or our designee when in need of these services.

For an *organ transplant* to be considered fully approved, *preauthorization* from us is required in advance of the *organ transplant*. You or your *health care practitioner* must notify us in advance of your need for an initial evaluation for the *organ transplant* in order for us to determine if the *organ transplant* will be covered. For approval of the *organ transplant* itself, we must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once coverage for the *organ transplant* is approved, we will advise your *health care practitioner*. Benefits are payable only if the pre-transplant services, the *organ transplant* and post-discharge services are approved by us. Coverage for post-discharge services and treatment of complications after transplantation are limited to the *organ transplant treatment period*.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the *policy*.
210100 10/06

Covered expenses

Covered expense for an *organ transplant* includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

COVERED EXPENSES - TRANSPLANT SERVICES (continued)

- Heart;
- Lung(s);
- Liver;
- Kidney;
- *Bone marrow*;
- Intestine;
- Pancreas;
- Auto islet cell;
- Any combination of the above listed organs; and
- Any organ not listed above required by state or federal law.

The following are *covered expenses* for approved *organ transplants* and all related complications:

- *Hospital and health care practitioner services.*
- Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition.
- Direct, non-medical costs for:
 - The *covered person* receiving the *organ transplant*, if he or she lives more than 100 miles from the transplant facility; and
 - One designated caregiver or support person (two, if the *covered person* receiving the organ transplant is under 18 years of age), if they live more than 100 miles from the transplant facility.

Direct, non-medical costs include:

- Transportation to and from the *hospital* where the *organ transplant* is performed; and
- Temporary lodging at a prearranged location when requested by the *hospital* and approved by *us*.

All direct, non-medical costs for the *covered person* receiving the *organ transplant* and the designated caregiver(s) or support person(s) are limited to a combined maximum coverage per *organ transplant* as specified in the "Schedule of Benefits - Transplant Services" section in this *certificate*.

210200FL 10/07

Exclusions

No benefit is payable for, or in connection with an *organ transplant* if:

- It is *experimental or investigational*, or for *research purposes* unless the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to 627.4236 (3), F.S.

COVERED EXPENSES - TRANSPLANT SERVICES (continued)

- The expense relates to storage of cord blood and stem cells, unless it is an integral part of an *organ transplant* approved by *us*.
- *We* do not approve coverage for the *organ transplant*, based on *our* established criteria.
- Expenses are eligible to be paid under any private or public research fund, government program except *Medicaid*, or another funding program, whether or not such funding was applied for or received.
- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *policy*.
- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by *us*.
- The expense relates to an *organ transplant* performed outside of the United States and any care resulting from that *organ transplant*.
- A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and expenses related to complications of such transplant.
- *You* have not met pre-transplant criteria as established by *us*.

210300FL 10/07

LIMITATIONS AND EXCLUSIONS

Pre-existing condition limitation

Health insurance benefits are limited to the first \$2,000 of covered expenses incurred for a *pre-existing condition* for 12 consecutive months following *your enrollment date*, 18 months for *late applicants*.

The exclusion does not apply to:

- Pregnancy;
- Genetic information in the absence of a diagnosis of the condition related to the information;
- Newborn children or children adopted before the age of 18 if they are covered under the *policy* within 60 days of the date of birth or date of placement for adoption; or
- Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer.

The *pre-existing condition* limitation shall not be applied to *you* if *you* were continuously covered for an aggregate period of 12 months under *creditable coverage*.

Portability of creditable coverage

You are eligible for portability of *creditable coverage* if *your* coverage was continuous without a break of more than 63 days between the termination of coverage under *creditable coverage* and the *enrollment date* under the *policy*. The *pre-existing condition* exclusion period will be reduced by the number of days of coverage that *you* had under the *creditable coverage*.

The waiting period for a plan or policy is counted as *creditable coverage* and will not be counted toward determining whether there has been a 63-day break in coverage. For those eligible for trade adjustment assistance (TAA) under the 2002 Trade Act, the lapse between the loss of group coverage and the second COBRA election period will not be counted toward determining whether there has been a 63-day break in coverage.

If on a particular day *you* have *creditable coverage* from more than one source, all the *creditable coverage* on that day will be counted as one day.

Notice

You must submit certification of *creditable coverage* to us. Upon request and authorization from *you*, we can contact *your* prior health plan(s) for *your* *creditable coverage* certification.

FL234896.10 07/09

211100FL 02/09

LIMITATIONS AND EXCLUSIONS (continued)

Other limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

211200 07/07

- Treatments, services, supplies or *surgeries* that are not *medically necessary*, except for the specified routine *preventive services* as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of this *certificate*.
- A *sickness* or *bodily injury* for which benefits are paid or received under any Workers' Compensation or similar law.
- Care and treatment given in a *hospital* owned or run by any government entity, unless *you* are legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to *covered persons* who are armed services retirees and their *dependents* are not excluded.

211600FL 02/08

- Any service furnished while *you* are confined in a *hospital* or institution owned or operated by the United States government or any of its agencies for any military service-connected *sickness* or *bodily injury*.
- Any service *you* would not be legally required to pay for in the absence of this insurance.
- *Sickness* or *bodily injury* for which *you* are in any way paid or entitled to payment or care and treatment by or through a government program.
- Any service not ordered by a *health care practitioner*.

212000 07/07

- Services rendered by a standby physician or certified operating room technician unless *medically necessary*.
- Any service which is not rendered or not substantiated in the medical records.
- Any expense incurred for services received outside of the United States while *you* are residing outside of the United States for more than six months in a *year* except as required by law for *emergency care* services.
- Education or training, except for *diabetes self-management training*.
- Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.

212600FL 07/07

LIMITATIONS AND EXCLUSIONS (continued)

- Medical services provided by a *covered person's family member*.
- *Ambulance* services for routine transportation to, from or between medical facilities and/or a *health care practitioner's office*.
- Any drug, biological product, device, medical treatment, or procedure which is *experimental*, or *investigational* or *for research purposes*.
- Vitamins, dietary supplements, and dietary formulas (except enteral formulas for the treatment of genetic metabolic diseases, e.g. phenylketonuria (PKU), unless otherwise covered by a Prescription Drug Benefit attached to the *policy*).

- Over the counter, non-prescription medications.

213250 07/07

- Immunizations required for foreign travel for a *covered person* of any age.
- Growth hormones (medications, drugs or hormones to stimulate growth) unless there is a laboratory confirmed diagnosis of growth hormone deficiency, or as otherwise determined by *us*.
- Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
- Prescription drugs and *self-administered injectable drugs*, unless administered to *you*:
 - While an *inpatient* in a *hospital*, *skilled nursing facility*, or *health care treatment facility*;
 - By a *health care practitioner* during an office visit; or
 - By a *home health care agency* as part of a covered *home health care plan* when approved by *us*.

213700 07/07

- Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants as otherwise stated in this *certificate*.
- Services received in an emergency room, unless the services are *emergency care*.
- Weekend non-emergency *hospital admissions*, specifically *admissions* to a *hospital* on a Friday or Saturday at the convenience of the *covered person* or his or her *health care practitioner* when there is no cause for an emergency *admission* and the *covered person* receives no *surgery* or therapeutic treatment until the following Monday.
- *Hospital inpatient* services when *you* are in *observation status*.

LIMITATIONS AND EXCLUSIONS (continued)

- In-vitro fertilization; any medical or surgical treatment of infertility; gamete intrafallopian transfer (GIFT) procedures; zygote intrafallopian transfer (ZIFT) procedures; embryo transport surrogate parenting, donor semen and related costs including collection and preparation; non-medically necessary circumcision ,genetic counseling; or reversal of elective sterilization.

FL234896.11 07/09

214100FL 02/09

- Sex change services, regardless of any diagnosis of gender role or psychosexual orientation problems.
- No benefits will be provided for:
 - Immunotherapy for recurrent abortion;
 - Chemonucleolysis;
 - Biliary lithotripsy;
 - Home uterine activity monitoring;
 - Sleep therapy;
 - Light treatments for Seasonal Affective Disorder (S.A.D.);
 - Immunotherapy for food allergy;
 - Prolotherapy;
 - Cranial banding, unless otherwise determined by us;
 - Hyperhydrosis surgery;
 - Lactation therapy; or
 - Sensory integration therapy.
- *Cosmetic surgery* and cosmetic services or devices, unless for reconstructive *surgery*:
 - Resulting from a *bodily injury*, infection or other disease of the involved part, when functional impairment is present; or
 - Resulting from congenital disease or anomaly of a covered *dependent* child which resulted in a functional impairment.

A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense incurred for reconstructive *surgery* performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.

- Hair prosthesis, hair transplants or implants.
214400 07/07
- Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any *oral surgery* or *periodontic surgery* and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a *bodily injury* or *sickness* unless otherwise stated in this *certificate*.
- The following types of care of the feet:
 - Shock wave therapy of the feet;
 - The treatment of weak, strained, flat, unstable or unbalanced feet;

LIMITATIONS AND EXCLUSIONS (continued)

- Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses, or hyperkeratoses;
 - The treatment of tarsalgia, metatarsalgia, or bunion, except surgically;
 - The cutting of toenails, except the removal of the nail matrix;
 - The provision of heel wedges, lifts, or shoe inserts; and
 - The provision of arch supports or orthopedic shoes, unless *medically necessary* because of diabetes or hammer toe.
- *Custodial care and maintenance care.*
 - Any loss contributed to, or caused by:
 - War or any act of war, whether declared or not;
 - Insurrection; or
 - Any conflict involving armed forces of any authority.
 - *Sickness or bodily injury caused by the covered person's:*
 - Engaging in an illegal occupation; or
 - Commission of or an attempt to commit a criminal act.
- 214900 07/07
- Expenses for any membership fees or program fees paid by *you*, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or surgical programs, and any materials or products related to these programs.
 - Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss *surgery*.
 - Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a *health care practitioner*) and certain medical devices including, but not limited to:
 - Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;
 - Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles;
 - Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes;
 - Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas;
 - Medical equipment including blood pressure monitoring devices, breast pumps, PUVA lights and stethoscopes;
 - Communication system, telephone, television or computer systems and related equipment or similar items or equipment;
 - Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

LIMITATIONS AND EXCLUSIONS (continued)

- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment unless such therapy or testing is approved by:
 - The American Academy of Allergy and Immunology; or
 - The Department of Health and Human Services or any of its offices or agencies.

- Lodging accommodations or transportation.
215300 07/07

- Communications or travel time.

- Any treatment for obesity, unless qualified as *morbid obesity*.

- *Sickness or bodily injury* for which medical payment or expense coverage benefits are paid or payable under any homeowners, premises or any other similar coverage.

- Elective medical or surgical abortion unless:
 - The pregnancy would endanger the life of the mother; or
 - The pregnancy is a result of rape or incest; or
 - The fetus has been diagnosed with a lethal or otherwise significant abnormality.

- *Alternative medicine*.
215800FL 10/07

- Services rendered in a premenstrual syndrome clinic or holistic medicine clinic.

- Services of a midwife, unless provided by a Certified Nurse Midwife.

- Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy, refractive keratoplasty or any other *surgery* or procedure to correct myopia, hyperopia or stigmatic error; or, the purchase or fitting of eyeglasses or contact lenses (except as the result of an *accident* or following cataract *surgery* as stated in this *certificate*).
216300FL 07/07

- Services and supplies which are:
 - Rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services, or
 - Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

- Marriage counseling.

LIMITATIONS AND EXCLUSIONS (continued)

- Services for pervasive development disorder.
- *Court-ordered behavioral health services.*
- Expenses for employment, school, sport or camp physical examinations or for the purposes of obtaining insurance.
- Expenses for care and treatment of non-covered procedures or services.
216650 07/07
- Expenses for treatment of complications of non-covered procedures or services.
- Expenses incurred for services prior to the *effective date* or after the termination date of *your* coverage under the *policy*. Coverage will be extended as described in the "Extension of Benefits" section, if such coverage is required by state law.
- *Pre-surgical/procedural testing duplicated during a hospital confinement.*
- Expenses for nicotine habit or addiction.
FL234896.6 *216880FL 07/07*

These limitations and exclusions apply even if a *health care practitioner* has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent *your health care practitioner* from providing or performing the procedure, treatment or supply; however, the procedure, treatment or supply will not be a *covered expense*.
216900 04/04

ELIGIBILITY AND EFFECTIVE DATES

Eligibility date

Employee eligibility date

The *employee* is eligible for coverage if the following conditions are met:

- The employee meets the eligibility requirements of the Group; and
- The *employee* is in an *active status*.

The *employee's* eligible effective date is the first day of employment with the *policyholder*.

The *employee's* eligible for coverage include *employee's* who must be appointed at .50 FTE or above.

Clinical M.D. and Clinical Ph.D. faculty, ranked Instructor/Lecturer and above and Associate and Assistant Deans and Vice Presidents as designated by the Fringe Benefit Committee, the Executive Committee and the Dean of the College of Medicine.

Visiting clinical M.D. or clinical Ph.D., Faculty, ranked Instructor/Lecturer and above, appointed for one year or more and receiving other than OPS salary.

Housestaff, Disabled employees, dependents of deceased employees, grandfathered retirees.
FL234896.12 07/09 217000

Dependent eligibility date

Each *dependent* is eligible for coverage on:

- The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date;
- The date of the *employee's* marriage for any *dependents* (spouse or child) acquired on that date;
- The date of birth of the *employee's* natural-born child or adopted child;
- The date of birth of a child born to an *employee's* covered *dependent* child;
- The date a foster child is placed in the *employee's* home
- The date of placement of the child for the purpose of adoption by the *employee*; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the *employee* to provide coverage for a child or spouse as specified in such orders.

ELIGIBILITY AND EFFECTIVE DATES (continued)

The *employee* may cover his or her *dependents* only if the *employee* is also covered.

A *dependent* child who enrolls for other group coverage through any employment is no longer eligible for group coverage under the *policy*. If a *dependent* child becomes an *employee* of the *employer*, he or she is no longer eligible as a *dependent* and must make application as an eligible *employee*.

FL234896.22

217100FL 10/06

Enrollment

Employee enrollment

The *employee* must enroll as agreed by the *policyholder* and *us*. Depending on the total number of *employees* covered by the *employer's policy*, *we* may require any *employee* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations. This information will not be used for declination purposes. The insurer will administer this provision in a non-discriminatory manner in regards to eligibility or on the basis of premium.

If the *employee* enrolls more than 31 days after the *employee's eligibility date* or more than 31 days after the *employee's special enrollment date*, the *employee* is a *late applicant*.

217200FL

Dependent enrollment

Check with the *employer* immediately on how to enroll for *dependent* coverage. The *employee* must enroll for *dependent* coverage and enroll additional *dependents* as agreed by the *policyholder* and *us*.

Depending on the total number of *employees* covered by the *employer's policy*, *we* may require any *dependent* to provide evidence of health status whenever enrolling as permitted by laws, rules, or regulations. This information will not be used for declination purposes. The insurer will administer the provision in a non-discriminatory manner in regards to eligibility or on the basis of premium.

A *dependent* enrolled more than 31 days after the *dependent's eligibility date* or the *special enrollment date* will be a *late applicant*.

217300FL

Newborn dependent enrollment

An *employee* who already has *dependent* child coverage in force prior to the newborn's date of birth is not required to complete an enrollment form for the newborn child. However, the *employee* must notify *us* of the birth.

ELIGIBILITY AND EFFECTIVE DATES (continued)

An *employee* who does not have *dependent* child coverage must enroll the newborn *dependent*, as agreed by the *policyholder* and *us*, within 60 days after the date of birth. The newborn will be effective from the moment of birth.

217400FL

Special enrollment

Loss of other coverage

If you are an *employee* or *dependent* who was previously eligible for coverage under the *policy* and had waived coverage, you may be eligible for the "Special Enrollment" provision.

You will not be considered a *late applicant*, if the following applies:

- You declined enrollment under the *policy* at the time of initial enrollment because:
 - You were covered under a group health plan or other *health insurance coverage* at the time of eligibility and your coverage terminated as a result of:
 - Termination of employment or eligibility;
 - Reduction in number of hours of employment;
 - Divorce, legal separation or death of a spouse; or
 - Termination of your employer's contribution for the coverage; or
 - You had COBRA continuation coverage under another plan at the time of eligibility and such coverage has since been exhausted; and
 - You stated, at the time of the initial enrollment, that coverage under the group health plan, other *health insurance coverage* or COBRA continuation was your reason for declining enrollment; and
 - You were covered under an alternate plan provided by the *employer* and you are replacing coverage with the *policy*;
- You apply for coverage within 31 days after termination of coverage under the group health plan or other *health insurance coverage* or COBRA.

217500

Dependent special enrollment period

The *dependent* Special Enrollment Period is a 31-day period from the *special enrollment date*.

ELIGIBILITY AND EFFECTIVE DATES (continued)

If *dependent* coverage is available under the *employer's policy* or added to the *policy*, an *employee* who is a *covered person* can enroll eligible *dependents* during the Special Enrollment Period. An *employee*, who is otherwise eligible for coverage and had waived coverage under the *policy* when eligible, can enroll himself/herself and eligible *dependents* during the Special Enrollment Period. The *employee* or *dependent* enrolling within 31 days from the *special enrollment date* will not be considered a *late applicant*.
217600

Effective date

Employee effective date

The *employee's effective date* provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the *waiting period* or the *special enrollment date*.

If the *employee* enrolls more than 31 days after his or her *eligibility date* or *special enrollment date*, he or she is a *late applicant*. The *effective date* of coverage will be the first of the month following the receipt of the enrollment form.
217700

Employee delayed effective date

If the *employee* is not in *active status* on the *eligibility date*, coverage will be effective the day after the *employee* returns to *active status*. The *employer* must notify *us* in writing of the *employee's* return to *active status*.
217800

Dependent effective date

The *dependent's effective date* will be determined as follows:

- If we receive enrollment on, prior to, or within 31 days of the *dependent's eligibility date* that *dependent* is covered on the date he or she is eligible.
- If we receive enrollment on, prior to, or within 31 days of the *dependent's special enrollment date*, that *dependent's* coverage is effective on the *special enrollment date*.
- If we receive enrollment more than 31 days after the *dependent's eligibility date*, or the *special enrollment date*, that *dependent* is considered a *late applicant*. The *effective date* of coverage will be the first of the month following the receipt of the enrollment form.

However, no *dependent's effective date* will be prior to the *employee's effective date* of coverage.
219800

ELIGIBILITY AND EFFECTIVE DATES (continued)

Newborn dependent effective date

If *we* receive enrollment on, prior to, or within 60 days of the newborn's date of birth, *dependent* coverage is effective on the newborn's date of birth. If notice is given within 31 days after the birth, *we* will not charge additional subscription fees for coverage of the newborn child for the first 31 days of coverage. The applicable subscription fee for the child will be charged after the initial 31 days of coverage. If notice is not given within the 31-day period referenced above, premium will be charged from the date of birth.

If notice is given within 60 days of the birth of the child, *we* may not deny coverage for a child due to the failure of the insured to timely notify *us* of the birth of the child. If notice is not given within the 60-day period, *you* must wait until the *group's* next open enrollment period to enroll the child.

If the *employee* already has *dependent* child coverage, and enrollment is not required, *dependent* coverage is effective on the newborn's date of birth. However, the *employee* must notify *us* of the birth.

Adopted child dependent effective date

Notice of the birth or placement of an adopted child must be given to *us*, in writing, no later than 31 days after the occurrence. If timely notice is given, no additional premium will be charged for coverage of the adopted child for the duration of the 31-day notice period. If timely notice is not given, *we* will charge the applicable premium from the date of birth for an adopted newborn or the date of placement for an adopted child. The applicable premium for the child will be charged after the initial 31-day period in either case.

If notice is given within 60 days of birth or placement of a child, coverage will not be denied for the child due to the *employee's* failure to provide timely notice as stated above. The *pre-existing condition* limitation does not apply to an adopted child.

In the case of a newborn adopted child, the *effective date* of coverage will be the birth date of the child if a written agreement for adoption has been entered into by the *covered person*. Otherwise, the effective date of coverage will be the date child's placement in the home of the *covered person*. No coverage will be provided under this provision for a child who is not ultimately placed in the *covered person's* home.

Foster child dependent effective date

Notice of the placement of a foster child must be given to *us*, in writing, no later than 31 days after the occurrence. If timely notice is given, no additional premium will be charged for coverage of the foster child for the duration of the 31-day notice period. If timely notice is not given, *we* will charge the applicable premium from the date of placement of the foster child. The applicable premium for the child will be charged after the initial 31-day period in either case.

If notice is given within 60 days of placement of the child, coverage will not be denied for the child due to the *covered person's* failure to provide timely notice as stated above. *Pre-existing condition* limitations may apply to a foster child.

ELIGIBILITY AND EFFECTIVE DATES (continued)

The *effective date* of coverage for the foster child will be the date of placement in the home of the *covered person*. Coverage for the foster child will terminate the date the *covered person* no longer has legal custody of the child.

21900FL

Benefit changes

Benefit changes will become effective on the date specified by *us*.

220000

Retired employee coverage

If you are an early retired *employee* with at least 10 years of continuous service, you may continue coverage under this *policy* with benefits for you and your eligible *dependents* until you reach age 65, provided such coverage was effective at the time of the *employee's* retirement. Please see your *employer* for more details.

If you are retired *employee* age 65 or over you may continue coverage under the *policy* with benefits for you and any of your eligible *dependents* provided such coverage was effective at the time of your retirement. Any *dependents* acquired through marriage after retirement may be added by timely enrollment. Please see your *employer* for more details.

FL234896.13 07/09

220400

REPLACEMENT OF COVERAGE

Applicability

The "Replacement of Coverage" section applies when an *employer's* previous group health plan not offered by *us* or *our* affiliates (Prior Plan) is terminated and replaced by coverage under the *policy* and:

- *You* are eligible to become insured for medical coverage on the effective date of the *policy*; and
- *You* were covered under the *employer's* Prior Plan on the day before the effective date of the *policy*.

Benefits available for *covered expense* under the *policy* will be reduced by any benefits payable by the Prior Plan during an extension period.

221000

Delayed effective date

If any delayed *effective date* provision described in this *certificate* applies to *you* on the effective date of the *policy*, *we* will waive the provision. Medical coverage as set forth in this *certificate* is then provided to *you* until the date *your* medical coverage would otherwise terminate according to the Termination of Coverage provision stated in this certificate.

221100FL 10/07

Deductible and Out-of-Pocket Expense Limit Credit

Medical expense incurred while *you* were covered under the Prior Plan may be used to satisfy *your network provider deductible* or maximum out-of-pocket expense limit amount under the *policy* if:

- The expense incurred was applied to the *deductible* or *out-of-pocket expense limit* amount under the Prior Plan; and
- The expense incurred qualifies as a *covered expense* under the *policy*; and
- The expense incurred would have served to partially or fully satisfy the *deductible* or *out-of-pocket expense limit* amount under the *policy* for the *year* in which *your* coverage becomes effective.

221200FL 10/07

Waiting period credit

If the *employee* had not completed the initial *waiting period* under the *policyholder's* Prior Plan on the day that it ended, any period of time that the *employee* satisfied will be applied to the appropriate *waiting period* under the *policy*, if any. The *employee* will then be eligible for coverage under the *policy* when the balance of the *waiting period* has been satisfied.

221300 10/07

REPLACEMENT OF COVERAGE (continued)

Pre-existing conditions

If a *sickness* or *bodily injury* is a *pre-existing condition* as stated in the "Pre-Existing Condition Limitation" provision of this *certificate* but would not have been a *pre-existing condition* under the Prior Plan had it remained in force, it will not be a *pre-existing condition* under the *policy*. If a *sickness* or *bodily injury* is a *pre-existing condition* under both the Prior Plan and the *policy*, any benefits payable are applicable only to medical expenses which were incurred after the date such *sickness* or *bodily injury* would no longer have been a *pre-existing condition* under the Prior Plan had it remained in force.

There is a \$2,000 pre-existing benefit that may be used during the pre-existing condition waiting period. Once the pre-existing waiting period is fully satisfied, full benefits for the pre-existing condition will be provided under the *policy*.

However, this does not apply to any *sickness* or *bodily injury* for which *you* are entitled to receive benefits during any extension period provided by the Prior Plan.

221500 10/07

TERMINATION PROVISIONS

Termination of insurance

The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by *your employer* on the Employer Group Application.

When *we* receive notification of a change in eligibility status in advance of the effective date of the change, insurance will terminate on the actual date specified by the *employer* and/or *employee* or at the end of that month, as selected by *your employer* on the Employer Group Application.

222000

Otherwise, insurance terminates on the earliest of the following:

- The date the *group policy* terminates;
- The end of the period for which required premium was due to *us* and not received by *us*;
- For the *employee*, the date that he or she has terminated employment with the *employer*;
- For the *employee*, the date that he or she is no longer qualified as an *employee*;
- The date *you* fail to be in an eligible class of persons as stated in the Employer Group Application;
- The date *you* entered full-time military, naval or air service.
- The date the *employee* retired, except if the Employer Group Application provides coverage for a retiree class of *employees* and the retiree is in an eligible class of retirees, selected by the *employer*;
- The date of an *employee* request for termination of insurance for the *employee* or *dependents*;
- For a *dependent*, the date the *employee's* insurance terminates;
- For a *dependent*, the date the *employee* ceases to be in a class of *employees* eligible for *dependent* insurance.
- For a *dependent*, the date he or she no longer qualifies as a *dependent*;
- For a newborn child born to an *employee's* covered *dependent* child, the date he or she is 18 months of age.
- For a *retiree's* surviving spouse and his or her *dependent* children the date the spouse becomes Medicare eligible or remarries, or the *dependent* child reaches a limiting age, whichever is earlier;
- For any benefit, the date the benefit is deleted from the *policy*; or
- The date *we* determine that fraud or an intentional misrepresentation of a material fact has been committed by *you*.

FL234896.14 07/09

222100FL 10/07

You and the employer are responsible to notify us of any change in eligibility, including the lack of eligibility, of any covered person.

222200 12/03

TERMINATION PROVISIONS (continued)

Termination for cause

We will terminate *your* coverage for cause under the following circumstances:

- If *you* allow an unauthorized person to use *your* identification card or if *you* use the identification card of another *covered person*. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying *us* the *maximum allowable fee* for those services.
- If *you* or the *policyholder* perpetrate fraud and/or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication and/or alteration of a claim, identification card or other identification.

222300

EXTENSION OF BENEFITS

Extension of health insurance for total disability

We extend limited health insurance benefits if:

- The *policy* terminates while you are *totally disabled* due to a *bodily injury* or *sickness* that occurs while the *policy* is in effect.

223000FL

Benefits are payable only for those expenses incurred for the same *sickness* or *bodily injury* which caused you to be *totally disabled*. Insurance for the disabling condition continues but not beyond the earliest of the following dates:

- The date your *health care practitioner* certifies you are no longer *totally disabled*; or
- The date any maximum benefit or your *individual lifetime maximum benefit* is reached; or
- The last day of a 12 consecutive month period following the date the *policy* terminated.

No insurance is extended to a child born as a result of a *covered person's* pregnancy.

For pregnancy, when not covered by the succeeding carrier, maternity benefits will continue until the date of delivery, provided the pregnancy began after your effective date and prior to the termination of the *policy*. This extension will not be based on *total disability*.

The "Extension of Health Insurance for Total Disability" provision does not apply to covered retired persons.

223100FL 11/08

CONTINUATION

Continuation options in the event of termination

If health insurance terminates:

- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

224000FL 11/08

CONTINUATION OF COVERAGE FOR ACTIVE MILITARY SERVICE

Coverage and premium

Continuation of coverage is available for an *employee* and their covered dependents while the *employee* is called to active duty or state active duty. The *employee* will have the same premium in effect for other insureds under the same *policy*.

Notification

The *employee*, or an appropriate military authority, must notify the *employer* that the *employee* wishes to continue coverage before reporting for active duty or state active duty.

This notice is not required if impossible or unreasonable (such as an immediate call-up in a natural disaster emergency) or if military necessity precludes it.

Reinstatement of coverage

The *employee* is not required to continue coverage while on active duty or state active duty. If coverage is not continued, the *employee* will have 63 days to request reinstatement upon returning to work with the same *employer*. There will be no waiting period, nor may any condition existing at the time of call-up prevent them from reinstatement.

Continuation

If health insurance terminates:

- It may be continued as described in the Uniformed Services Employment and Reemployment Rights Act (USERRA);
- It may be continued as described in the "State Continuation of Health Insurance" provision; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

Definitions

The following terms are used in this provision:

Active duty: full-time duty in the active military service of the United States.

State active duty: those periods when the Governor orders the National Guard into service, typically in response to natural disasters or civic disorders.

3019000FL 09/05

MEDICAL CONVERSION PRIVILEGE

Eligibility

Subject to the terms below, if *your* medical coverage under the *policy* terminates, a Conversion Policy is available without medical examination. *You* must have been continuously covered under the *policy* or any group health plan it replaced for at least 90 days and:

- *Your* coverage ends;
- *You* are a covered *dependent* whose coverage ends due to the *employee's* marriage ending via legal annulment, dissolution of marriage or divorce;
- *You* are the surviving covered *dependent*, in the event of the *employee's* death or at the end of any survivorship continuation as provided by the *policy*; or
- *You* have been a covered *dependent* child but no longer meet the definition of *dependent* under the *policy*; and
- *Your* coverage under the *policy* is not terminated because of fraud or material intentional misrepresentation.

Only persons covered under the *policy* on the date coverage terminates are eligible to be covered under the Conversion Policy.

The Conversion Policy may be issued covering each former *covered person* on a separate basis or it may be issued covering all former *covered persons* together. However, if conversion is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be a *dependent* of the *employee* are eligible to exercise the medical conversion privilege.

This privilege does not apply when the *employer's* participation in the *policy* terminates and medical coverage is replaced within 31 days by another group insurance plan.

A state pool plan may be available in lieu of a Conversion Policy. Please contact *us* for details.
225000FL 11/08

Overinsurance - duplication of coverage

Where overinsurance does not exist but other insurance is in force, benefits payable under the Conversion Policy may be reduced by the amount of any benefits payable under the group *policy* after the termination of coverage under the *policy*.

225100FL

Conversion policy

The Conversion Policy which *you* may select and apply for will be the Conversion Policy customarily offered by *us* as a conversion from group coverage or as mandated by state law.

MEDICAL CONVERSION PRIVILEGE (continued)

The Conversion Policy is a new policy and not a continuation of *your* terminated coverage. The Conversion Policy benefits will differ from those provided under *your group* coverage. An election and premium notice along with the benefits that may be available to you will be described in an Outline of Coverage provided to *you* when *you* request an application for conversion from *us*. This information will be provided to *you* within 14 days after such request is received.

225200FL

Effective date and premium

You have 63 days after the date *your* coverage terminates under the *policy* to apply and pay the required premium for *your* Conversion Policy. The premium must be paid in advance. *You* may obtain application forms from *us* via the internet or by request in writing. The Conversion Policy will be effective on the day after *your group* medical coverage ends, if *you* enroll and pay the first premium within 63 days after the date *your* coverage ends. If termination of *your group* coverage was the result of non-payment of premium faulted by the *employer* or *policyholder*, written application and the first premium must be paid to *us* no later than 63 days after notice of termination is received.

The premium for the Conversion Policy will be the premium charged by *us* as of the effective date based upon the Conversion Policy form, classification of risk, age and benefit amounts selected. The premium may change as provided in the Conversion Policy.

225300FL

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one *plan*. The order of benefit determination rules below determine which *plan* will pay as the *primary plan*. The *primary plan* pays first without regard to the possibility another *plan* may cover some expenses. A *secondary plan* pays after the *primary plan* and may reduce the benefits it pays so that payments from all *plans* do not exceed 100% of the total *allowable expense*.

226000

Definitions

The following definitions are used exclusively in this provision.

Plan means any of the following that provide benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered part of the same *plan* and there is no COB among those separate contracts.

Plan includes:

- Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured);
- Hospital indemnity benefits in excess of \$200 per day;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- Homeowners coverage
- Medical benefits under group or individual automobile contracts, including "No Fault" and Medical Payments coverages; and
- *Medicare* or other governmental benefits, as permitted by law.

Plan does not include:

- Individual or family insurance;
- Closed panel or other individual coverage (except for group-type coverage);
- Hospital indemnity benefits of \$200 or less per day;
- School accident type coverage;
- Benefits for non-medical care components of group long-term care contracts;
- Medicare supplement policies;
- A state plan under *Medicaid*; and
- Coverage under other governmental plans, unless permitted by law.

Each contract for coverage is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

Notwithstanding any statement to the contrary, for the purposes of COB, prescription drug coverage under a Prescription Drug Benefit Rider, if applicable, will be considered a separate *plan* and will therefore only be coordinated with other prescription drug coverage.

COORDINATION OF BENEFITS (continued)

Primary/secondary means the order of benefit determination stating whether this *plan* is *primary* or *secondary* covering the person when compared to another *plan* also covering the person.

When this *plan* is *primary*, its benefits are determined before those of any other *plan* and without considering any other *plan's* benefits. When this *plan* is *secondary*, its benefits are determined after those of another *plan* and may be reduced because of the *primary plan's* benefits.

Allowable expense means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of services (e.g. an HMO), the reasonable cash value of each service will be considered an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plans* is not an *allowable expense*. The following are examples of expenses or services that are not *allowable expenses*:

- If a *covered person* is confined in a private *hospital* room, the difference between the cost of a semi-private room in the *hospital* and the private room, (unless the patient's stay in a private *hospital* room is medically necessary in terms of generally accepted medical practice, or one of the *plans* routinely provides coverage for *hospital* private rooms) is not an *allowable expense*.
- If a person is covered by two or more *plans* that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest usual and customary fees for a specific benefit is not an *allowable expense*.
- If a person is covered by two or more *plans* that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an *allowable expense*.
- If a person covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment arrangement shall be the *allowable expense* for all *plans*.
- The amount a benefit is reduced by the *primary plan* because a *covered person* does not comply with the *plan* provisions. Examples of these provisions are second surgical opinions, precertification of *admissions* and preferred provider arrangements.

Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this *plan*, or before the date this COB provision or a similar provision takes effect.

Closed panel plan is a *plan* that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the *plan*, and that limits or excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member.

Custodial parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

226100FL 06/06

COORDINATION OF BENEFITS (continued)

Order of determination rules

General

When two or more *plans* pay benefits, the rules for determining the order of payment are as follows:

- The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.
- A *plan* that does not contain a COB provision that is consistent with applicable promulgated regulation is always *primary*. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base *plan* hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.
- A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.

226200

Rules

The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.

- **Non-dependent or dependent.** The *plan* that covers the person other than as a *dependent*, for example as an *employee*, member, subscriber or retiree is *primary* and the *plan* that covers the person as a *dependent* is *secondary*. However, if the person is a *Medicare* beneficiary and, as a result of federal law, *Medicare* is *secondary* to the *plan* covering the person as a *dependent*; and *primary* to the *plan* covering the person as other than a *dependent* (e.g. retired *employee*); then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an *employee*, member, subscriber or retiree is *secondary* and the other *plan* is *primary*.
- **Child covered under more than one plan.** The order of benefits when a child is covered by more than one *plan* is:
 - The *primary plan* is the *plan* of the parent whose birthday is the earlier in the year if:
 - The parents are married;
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one part has the responsibility to provide health care coverage.
 - If both the parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

COORDINATION OF BENEFITS (continued)

- If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. This rule applies to *claim determination periods* or plan years commencing after the *plan* is given notice of the court decree.
- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - The *plan* of the *custodial parent*;
 - The *plan* of the spouse of the *custodial parent*;
 - The *plan* of the non-*custodial parent*; and then
 - The *plan* of the spouse of the non-*custodial parent*.
- **Active or inactive employee.** The *plan* that covers a person as an *employee* who is neither laid off nor retired, is *primary*. The same would hold true if a person is a *dependent* of a person covered as a retiree and an *employee*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
- **Continuation coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another *plan*, the *plan* covering the person as an *employee*, member, subscriber or retiree (or as that person's *dependent*) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
- **Longer or shorter length of coverage.** The *plan* that covered the person as an *employee*, member, subscriber or retiree longer is *primary*.

If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan* under this provision. In addition, this *plan* will not pay more than it would have had it been *primary*.

226300

Effects on the benefits of this plan

When this *plan* is *secondary*, benefits may be reduced to the difference between the *allowable expense* (determined by the *primary plan*) and the benefits paid by any *primary plan* during the *claim determination period*. Payment from all *plans* will not exceed 100% of the total *allowable expense*.

The difference between the benefit payments that this *plan* would have paid had it been the *primary plan*, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the *covered person* and used by this *plan* to pay an *allowable expense*, not otherwise paid during the *claim determination period*. As each claim is submitted, this *plan* will:

- Determine its obligation to pay or provide benefits under its contract;
- Determine whether a benefit reserve has been recorded for the *covered person*; and
- Determine whether there are any unpaid *allowable expenses* during the *claims determination period*.

COORDINATION OF BENEFITS (continued)

If there is a benefit reserve, the *secondary plan* will use the *covered person's* benefit reserve to pay up to 100% of total *allowable expenses* incurred during the *claim determination period*. At the end of the *claim determination period*, the benefit reserve returns to zero. A new benefit reserve must be created for each new *claim determination period*.

If a *covered person* is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and the other *closed panel plan*.

226400 03/07

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give us any facts we need to apply those rules and determine benefits payable.

226500

Facility of payment

A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this *plan*. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means a reasonable cash value of the benefits provided in the form of services.

226600

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

226700

COORDINATION OF BENEFITS FOR MEDICARE ELIGIBLES

Definitions

Medicare Part A means the *Medicare* program that provides hospital insurance benefits.

Medicare Part B means the *Medicare* program that provides medical insurance benefits.

Medicare Part D means the *Medicare* program that provides prescription drug benefits.

227000 06/06

General coordination of benefits with Medicare

If *you* are covered under both *Medicare* and this *certificate*, federal law mandates that *Medicare* is the secondary plan in most situations. But when permitted by law, this plan is the secondary plan. In all cases, coordination of benefits with *Medicare* will conform to federal statutes and regulations. If *you* are enrolled in *Medicare*, *your* benefits under this *certificate* will be coordinated to the extent benefits are payable under *Medicare*, as allowed by federal statutes and regulations.

You are considered to be eligible for *Medicare* on the earliest date coverage under *Medicare* could have become effective for *you*.

227100 06/06

Coordination of benefits with Medicare Part B

If *you* are eligible for *Medicare Part B*, but are not enrolled, *your* benefits under the *policy* may be coordinated as if *you* were enrolled in *Medicare Part B*. We may not pay benefits to the extent that benefits would have been payable under *Medicare Part B*, if *you* had enrolled. Therefore, it is important that *you* enroll in *Medicare Part B* if *you* are eligible to do so.

227200 06/06

CLAIMS

Notice of claim

Network providers will submit claims to *us* on *your* behalf. If *you* utilize a *non-network provider* for *covered expenses*, *you* must submit a notice of claim to *us*. Notice of claim must be given to *us* in writing or by *electronic mail* as required by *your* plan, or as soon as is reasonably possible thereafter. Notice must be sent to *us* at *our* mailing address shown on *your* identification documentation or *our* Website at www.humana.com.

228000

Claims must be complete. At a minimum a claim must contain:

- Name of the *covered person* who incurred the *covered expenses*;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

The forms necessary for filing proof of loss are available via the internet at *our* Website. When requested by *you*, *we* will send *you* the forms for filing proof of loss. If the requested forms are not sent to *you* within 15 days, *you* will have met the proof of loss requirements by sending *us* a written or *electronic* statement of the nature and extent of the loss containing the above elements within the time limit stated in the "Proof of Loss" provision.

228100FL

Proof of loss

You must give written or *electronic* proof of loss within 90 days after the date of loss. *Your* claims will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written or *electronic* notice must be given within one year after the date proof of loss is otherwise required, except if *you* were legally incapacitated.

228200

Right to require medical examinations

We have the right to require a medical examination on any *covered person* as often as *we* may reasonably require. If *we* require a medical examination, it will be performed at *our* expense. *We* also have a right to request an autopsy in the case of death, if state law so allows.

228300 05/05

CLAIMS (continued)

To whom benefits are payable

If *you* receive services from a *network provider*, we will pay the provider directly for all *covered expenses*. *You* will not have to submit a claim for payment.

Except for *emergency care*, all benefit payments for services rendered by a *non-network provider* are due and owing solely to the *covered person*. Assignment of benefits is prohibited; however, *you* may request that *we* direct a payment of selected medical benefits to the health care provider on whose charge the claim is based. If *we* consent to this request, *we* will pay the health care provider directly. Such payments will not constitute the assignment of any legal obligation to the *non-network provider*. If *we* decline this request, *we* will pay *you* directly, and *you* are then responsible for all payments to the *non-network provider(s)*.

If any *covered person* to whom benefits are payable is a minor or, in *our* opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her parent or legal guardian. However, if no request for payment has been made by the parent or legal guardian, *we* may, at *our* option, make payment to the person or institution appearing to have assumed his or her custody and support.
228400FL 05/05

Time of payment of claims

Payments due under the *policy* will be paid no more than 30 days after receipt of written or *electronic* proof of loss.
228500

Right to request overpayments

We reserve the right to recover any payments made by *us* that were:

- Made in error; or
- Made to *you* and/or any party on *your* behalf, where *we* determine that such payment made is greater than the amount payable under the *policy*; or
- Made to *you* and/or any party on *your* behalf, based on fraudulent or misrepresented information; or
- Made to *you* and/or any party on *your* behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the *deductible* or *out-of-pocket limit*.
228700

Right to collect needed information

You must cooperate with *us* and when asked, assist *us* by:

CLAIMS (continued)

- Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;
- Obtaining medical information and/or records from any provider as requested by *us*;
- Providing information regarding the circumstances of *your sickness, bodily injury or accident*;
- Providing information about other insurance coverage and benefits, including information related to any *bodily injury or sickness* for which another party may be liable to pay compensation or benefits; and
- Providing information *we* request to administer the *policy*.

If *you* fail to cooperate or provide the necessary information, *we* may recover payments made by *us* and deny any pending or subsequent claims for which the information is requested.

228800 05/05

Exhaustion of time limits

If *we* fail to complete a claim determination or appeal within the time limits set forth in the *policy*, the claim shall be deemed to have been denied and *you* may proceed to the next level in the review process outlined under the "Complaint and Appeal Procedures" section of this *certificate* or as required by law.

228900

Recovery rights

You as well as *your dependents* agree to the following, as a condition of receiving benefits under the *policy*.

229000

Duty to cooperate in good faith

You are obligated to cooperate with *us* and *our* agents in order to protect *our* recovery rights. Cooperation includes promptly notifying *us* that *you* may have a claim, providing *us* relevant information, and signing and delivering such documents as *we* or *our* agents reasonably request to secure *our* recovery rights. *You* agree to obtain *our* consent before releasing any party from liability for payment of medical expenses. *You* agree to provide *us* with a copy of any summons, complaint or any other process served in any lawsuit in which *you* seek to recover compensation for *your* injury and its treatment.

You will do whatever is necessary to enable *us* to enforce *our* recovery rights and will do nothing after loss to prejudice *our* recovery rights.

You agree that *you* will not attempt to avoid *our* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

CLAIMS (continued)

In the event that *you* fail to cooperate with *us*, *we* shall be entitled to recover from *you* any payments made by *us*.

229100

Duplication of benefits/other insurance

We will not provide duplicate coverage for benefits under the *policy* when a person is covered by *us* and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay *your* medical expenses, except another "plan", as defined in the "Coordination of Benefits" section (e.g. group health coverage), in which case priority will be determined as described in the "Coordination of Benefits" section.

Where there is such coverage, *we* will not duplicate other coverage available to *you* and shall be considered secondary, except where specifically prohibited. Where double coverage exists, *we* shall have the right to be repaid from whomever has received the overpayment from *us* to the extent of the duplicate coverage.

We will not duplicate coverage under the *policy* whether or not *you* have made a claim under the other applicable coverage.

When applicable, *you* are required to provide *us* with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

229200 05/05

Workers' Compensation

If benefits are paid by *us* and *we* determine that the benefits were for treatment of *bodily injury* or *sickness* that arose from or was sustained in the course of, any occupation or employment for compensation, profit or gain, *we* have the right to recover as described below. *We* will exercise *our* right to recover against *you*.

The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;

CLAIMS (continued)

- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier, or
- Medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the *policy*, *you* will notify *us* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse *us* as described above.
229300

Right of subrogation

As a condition to receiving benefits from *us*, *you* agree to transfer to *us* any rights *you* may have to make a claim, take legal action or recover any expenses paid under the *policy*. *We* will be subrogated to *your* rights to recover from any funds paid or payable as a result of a personal injury claim or any reimbursement of expenses by:

- Any legally liable person or their carrier;
- Any uninsured motorist or underinsured motorist coverage;
- Medical payments/expense coverage under any automobile, homeowners, premises or similar coverages;
- No-fault or other similar coverage.

We may enforce *our* subrogation rights by asserting a claim to any coverage to which *you* may be entitled.

If *we* are precluded from exercising *our* rights of subrogation, *we* may exercise *our* right of reimbursement.
229400

Right of reimbursement

If benefits are paid under the *policy* and *you* recover from any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, no-fault, or other similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.

You shall notify *us*, in writing or by *electronic mail*, within 31 days of any settlement, compromise or judgment. Any *covered person*, who waives, abrogates or impairs *our* right of reimbursement or fails to comply with these obligations, relieves *us* from any obligation to pay past or future benefits or expenses until all outstanding lien(s) are resolved.

If, after the inception of coverage with *us*, *you* recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, no-fault, or other similar insurer from liability for future medical expenses relating to a *sickness* or *bodily injury*, *we* shall have a continuing right to reimbursement from *you* to the extent of the benefits *we*

CLAIMS (continued)

provided with respect to that *sickness* or *bodily injury*. This right, however, shall apply only to the extent of such payment and only to the extent not limited or precluded by law in the state whose laws govern the *policy*, including any made whole or similar rule.

The obligation to reimburse *us* in full exists, regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.
229500

Assignment of recovery rights

The *policy* contains an exclusion for *sickness* or *bodily injury* for which there is medical payment/expenses coverage provided under any automobile, homeowner's, premises or other similar coverage.

If *your* claim against the other insurer is denied or partially paid, *we* will process *your* claim according to the terms and conditions of the *policy*. If payment is made by *us* on *your* behalf, *you* agree to assign to *us* the right *you* have against the other insurer for medical expenses *we* pay.

If benefits are paid under the *policy* and *you* recover under any automobile, homeowner's, premises or similar coverage, *we* have the right to recover from *you* an amount equal to the amount *we* paid.
229600

Cost of legal representation

The costs of *our* legal representation in matters related to *our* recovery rights shall be borne solely by *us*. The costs of legal representation incurred by *you* shall be borne solely by *you*, unless *we* were given timely notice of the claim and an opportunity to protect *our* own interests and *we* failed or declined to do so.
229700

COMPLAINT AND APPEAL PROCEDURES

There are situations when *covered persons* have questions about their coverage or are dissatisfied with *policy services*. Any *covered person* who has an inquiry or complaint regarding a matter arising under a *covered person's policy* should contact 1-866-500-2548. Such inquiries and complaints will be handled in a timely manner.

230040FL 08/07

Exhaustion of remedies

You must complete all levels of the appeal process available to *you* under state or federal law, including external review, before filing a lawsuit. This assures that both *you* and *we* have a full and fair opportunity to complete the record and resolve the dispute. Contact *us* if *you* believe *your* condition requires the use of the shorter time lines applicable to emergency health conditions.

The appeal process, however, does not preclude *you* from pursuing other appropriate remedies, including injunctive relief or equitable relief, if the requirement of exhausting the process for appeal, including the emergency appeal process, would place *your* health in serious jeopardy.

A coverage denial does not mean that *your* provider cannot provide the service or supply, *Our* denial only means *we* will not pay for the service or supply, unless *our* decision is reversed on appeal or in a subsequent lawsuit.

230100FL 08/07

Legal actions and limitations

No legal action may be brought to recover on this *policy* within 60 days after written proof of loss has been given as required by this *policy*. No such action may be brought after the expiration of the applicable statute of limitations from time written proof of loss is required to be given.

230200FL

DISCLOSURE PROVISIONS

Discount programs

From time to time, *we* may offer or provide access to discount programs to *you*. In addition, *we* may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers to provide discounts on goods and services to *you*. Some of these third party service providers may make payments to *us* when *covered persons* take advantage of these discount programs. These payments offset the cost to *us* of making these programs available and may help reduce the costs of *your* plan administration. Although *we* have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under the *policy*. The third party service providers are solely responsible to *you* for the provision of any such goods and/or services. *We* are not responsible for any such goods and/or services, nor are *we* liable if vendors refuse to honor such discounts. Further, *we* are not liable to *covered persons* for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

231000

Shared savings program

As a member of a Preferred Provider Organization Plan, *you* are free to obtain services from providers participating in the Preferred Provider Organization network (*network providers*), or providers not participating in the Preferred Provider Organization network (*non-network providers*). If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

We have a Shared Savings Program that may allow *you* to share in discounts *we* have obtained from *non-network providers*.

Although *our* goal is to obtain discounts whenever possible, *we* cannot guarantee that services rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

In most cases, to maximize *your* benefit design and minimize *your* out-of-pocket expense, please access *network providers* associated with *your* plan.

If *you* choose to obtain services from a *non-network provider*, it is not necessary for *you* to inquire about a provider's status in advance. When processing *your* claim, *we* will automatically determine if that provider is participating in the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. *Your* Explanation of Benefits statement will reflect any savings with a remark code used to reference the Shared Savings Program.

DISCLOSURE PROVISIONS (continued)

However, if *you* would like to inquire in advance to determine if a *non-network provider* participates in the Shared Savings Program, please contact *our* customer service department at the telephone number shown on *your* identification card. Please note provider arrangements in the Shared Savings Program are subject to change without notice. *We* cannot guarantee that the provider from whom *you* received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.
231100 12/03

MISCELLANEOUS PROVISIONS

Entire contract

The entire contract is made up of the *policy*, the application of the *policyholder*, incorporated by reference herein, and the applications of the *employees*, if any. All statements made by the *policyholder* or by an *employee* are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the *policy*, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written or *electronic* application signed by the *policyholder* or *covered person* and a copy is furnished to the person making such statement or his or her beneficiary.

232000FL

Additional policyholder responsibilities

In addition to responsibilities outlined in the *policy*, the *policyholder* is responsible for:

- Collection of premium; and
- Providing access to:
 - Benefit plan documents;
 - Renewal notices and policy modification information;
 - Product discontinuance notices; and
 - Information regarding continuation rights.

No *policyholder* has the power to change or waive any provision of the *policy*.

232100 06/06

Certificates of insurance

We will furnish to the *policyholder*, for delivery to each *employee* or *covered person* of the *group*, a certificate containing the group number and setting forth the essential features of the insurance coverage of such *employee* or *covered person* and those to whom benefits are payable. If *dependents* are included in the coverage, only one certificate need be issued for each family unit.

232200FL

This *certificate* is part of the *policy* that controls *our* obligations regarding coverage. No document that is viewed as being not consistent with the *policy* shall take precedence over it. This is true, also, when this *certificate* is incorporated by reference into a summary description of plan benefits prepared and distributed by the administrator of a group health plan subject to ERISA. This *certificate* is not subject to the ERISA style and content conventions that apply to summary plan descriptions. So if the terms of a summary plan description appear to differ with the terms of this *certificate* respecting coverage, the terms of this Certificate of Insurance will control.

232300 04/04

MISCELLANEOUS PROVISIONS (continued)

Incontestability

After two years from the effective date of the *policy*, no misstatement made by the *policyholder*, except a fraudulent misstatement made in the application may be used to void the *policy*.

After *you* are insured without interruption for two years, *we* cannot contest the validity of *your* coverage except for:

- Nonpayment of premium; or
- Any fraudulent misrepresentation made by *you*.

At any time, *we* may assert defenses based upon provisions in the *policy* which relate to *your* eligibility for coverage under the *policy*.

No statement made by *you* can be contested unless it is in a written or *electronic* form signed by *you*. A copy of the form must be given to *you* or *your* beneficiary.

An independent incontestability period begins for each type of change in coverage or when a new Employee Enrollment Form is completed.

232400

Fraud

Health insurance fraud is a criminal offense that can be prosecuted. Any person(s) who willingly and knowingly engages in an activity intended to defraud *us* by filing a claim or form that contains a false or deceptive statement may be guilty of insurance fraud.

If *you* commit fraud against *us* or *your employer* commits fraud pertaining to *you* against *us*, as determined by *us*, *your* coverage ends automatically, without notice, as of the date fraud is committed or as of the date otherwise determined by *us*.

232500

Clerical error, misstatement of age or gender

If it is determined that information about the age or gender of *you* or *your dependents* was omitted or misstated in error, the amount of insurance for which *you* are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to *you* and to *us*.

232600

MISCELLANEOUS PROVISIONS (continued)

Modification of policy

The *policy* may be modified at any time by agreement between *us* and the *policyholder* without the consent of any *covered person* or any beneficiary. No modification will be valid unless approved by *our* President, Secretary or Vice-President. The approval must be endorsed on or attached to the *policy*. No agent has authority to modify the *policy*, waive any of the *policy* provisions, extend the time of premium payment, or bind *us* by making any promise or representation.

The *policy* may be modified by *us* at anytime without prior consent of, or notice to, the *policyholder* when the changes are:

- Allowed by state or federal law or regulation;
- Directed by the state agency that regulates insurance;
- Benefit increases that do not impact premium; or
- Corrections of clerical errors or clarifications that do not reduce benefits.

Modifications due to reasons other than those listed above, may be made by *us*, upon renewal of the *policy*, in accordance with state and federal law. The *policyholder* will be notified in writing or *electronically* at least 31 days prior to the effective date of such changes.

232700 06/06

Premium contributions

Your employer must pay the required premiums to *us* as they become due. *Your employer* may require *you* to contribute toward the cost of *your* insurance. Failure of *your employer* to pay any required premium to *us* when due may result in the termination of *your* insurance.

232800

Premium rate change

We reserve the right to change any premium rates in accordance with applicable law upon notice to the *employer*. *We* will provide notice to the *employer* of any such premium changes. Questions regarding changes to premium rates should be addressed to the *employer*.

232900

Assignment

The *policy* and its benefits may not be assigned by the *policyholder*.

233200

MISCELLANEOUS PROVISIONS (continued)

Conformity with statutes

Any provision of the *policy* which is not in conformity with applicable state law(s) or other applicable law(s) shall not be rendered invalid, but shall be construed and applied as if it were in full compliance with the applicable state law(s) and other applicable law(s).

233300

GLOSSARY

Terms printed in italic type in this *certificate* have the meaning indicated below. Defined terms are printed in italic type wherever found in this *certificate*.

234000

A

Accident means a sudden event that results in a *bodily injury* or *dental injury* and is exact as to time and place of occurrence.

Active status means the *employee* is performing all of his or her customary duties whether performed at the *employer's* business establishment, some other location which is usual for the *employee's* particular duties or another location when required to travel on the job:

- On a regular full-time basis or for the number of hours per week shown on the Employer Group Application;
- For 48 weeks a year; and
- Is maintaining a bona fide *employer-employee* relationship with the *policyholder* of the *group policy* on a regular basis.

Each day of a regular vacation and any regular non-working holiday is deemed *active status*, if the *employee* was in *active status* on his or her last regular working day prior to the vacation or holiday. An *employee* is deemed to be in *active status* if an absence from work is due to a *sickness* or *bodily injury*, provided the individual otherwise meets the definition of *employee*.

Acute inpatient services means care given in a *hospital* or *health care treatment facility* which:

- Maintains permanent full-time facilities for *room and board* of resident patients;
- Provides emergency, diagnostic and therapeutic services with a capability to provide life-saving medical and psychiatric interventions;
- Has physician services, appropriately licensed behavioral health practitioners and skilled nursing services available 24-hours a day;
- Provides direct daily involvement of the physician; and
- Is licensed and legally operated in the jurisdiction where located.

Acute inpatient services are utilized when there is an immediate risk to engage in actions which would result in death or harm to self or others or there is a deteriorating condition in which an alternative treatment setting is not appropriate.

Admission means entry into a facility as a registered bed patient according to the rules and regulations of that facility. An *admission* ends when *you* are discharged, or released, from the facility and are no longer registered as a bed patient.

Advanced imaging, for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT), and Computed Tomography (CT) imaging.

GLOSSARY (continued)

Alternative medicine, for the purposes of this definition, includes, but is not limited to: acupressure, aromatherapy, ayurveda, biofeedback, faith healing, guided mental imagery, herbal medicine, holistic medicine, homeopathy, hypnosis, macrobiotics, massage therapy, naturopathy, ozone therapy, reflexotherapy, relaxation response, rolfing, shiatsu and yoga.

Ambulance means a professionally operated vehicle, provided by a licensed ambulance service, equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's *sickness* or *bodily injury*. Use of the *ambulance* must be *medically necessary* and/or ordered by a *health care practitioner*.

Ambulatory surgical center means an institution which meets all of the following requirements:

- It must be staffed by physicians and a medical staff which includes registered *nurses*.
- It must have permanent facilities and equipment for the primary purpose of performing *surgery*.
- It must provide continuous physicians' services on an *outpatient* basis.
- It must admit and discharge patients from the facility within a 24-hour period.
- It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be operated as an ambulatory surgical center as defined by those laws.
- It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

234800 07/07

B

Behavioral health means *mental health services* and *chemical dependency services*.

Bodily injury means bodily damage other than a *sickness*, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a *sickness* and not a *bodily injury*.

Bone marrow means the transplant of human blood precursor cells which are administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving an *organ transplant* of *bone marrow*, the term *bone marrow* includes the harvesting, the transplantation and the chemotherapy components.

235100FL 11/08

C

Certificate means this benefit plan document which outlines the benefits, provisions and limitations of the *policy*.

GLOSSARY (continued)

Chemical dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Coinsurance means the amount expressed as a percentage of the *covered expense* that *you* must pay. The percentage of the *covered expense* that *we* pay is shown in the "Schedule of Benefits" sections.

Confinement or **confined** means *you* are admitted as a registered bed patient as the result of a *health care practitioner's* recommendation. It does not mean detainment in *observation status*.

Copayment means the specified dollar amount that *you* must pay to a provider for certain *covered expenses* regardless of any amounts that may be paid by *us* as shown in the "Schedule of Benefits" sections.

Cosmetic surgery means *surgery* performed to reshape normal structures of the body in order to improve or change *your* appearance or self-esteem.

Court-ordered means involuntary placement in *behavioral health* treatment as a result of a judicial directive.

Covered expense means *medically necessary* services or routine *preventive services* which are:

- Ordered by a *health care practitioner*;
- For the benefits described herein, subject to any maximum benefit and all other terms, provisions limitations and exclusions of the *policy*; and
- Incurred when *you* are insured for that benefit under the *policy* on the date that the service is rendered.

Covered person means the *employee* and/or the *employee's dependents* who are enrolled for benefits provided under the *policy*.

Creditable coverage means a *covered person's* prior coverage under any of the following:

- A group health plan, including church and governmental plans;
- *Health insurance coverage*;
- *Medicare* or *Medicaid*;
- The health plan for active military personnel, including TRICARE;
- The Indian Health Services or other tribal organization program;
- A state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- A non-federal, public health plan;
- A health benefit plan under section 5(e) of the Peace Corps Act;
- State Children's Health Insurance Program; or
- Foreign health care.

GLOSSARY (continued)

Creditable coverage does not include any of the following:

- Accident only coverage, disability income insurance, or any combination thereof;
- Supplemental coverage to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on site medical clinics;
- Benefits if offered separately:
 - Limited scope dental and vision;
 - Long-term care, nursing home care, home health care, community based care, or any combination thereof; and
 - Other similar, limited benefits;
- Benefits if offered as independent, non-coordinated benefits:
 - Specified disease or illness coverage; and
 - Hospital indemnity or other fixed indemnity insurance;
- Benefits offered as a separate policy:
 - *Medicare* supplement insurance;
 - Supplemental coverage to the health plan for active military personnel, including TRICARE; and
 - Similar supplemental coverage provided to group health plan coverage.
- A health Flexible Spending Account (FSA), if it meets the Internal Revenue Service definition of a health FSA, and:
 - *You* have other coverage available under a group health plan; and
 - *Your* maximum benefit payable under the FSA does not exceed two times *your* salary election. If *your* maximum benefit payable under the FSA is greater than two times *your* salary election, it must not exceed more than \$500 plus *your* salary election.

Custodial care means services given to *you* if:

- *You* need services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or
- The services *you* require are primarily to maintain, and not likely to improve, *your* condition; or
- The services involve the use of skills which can be taught to a layperson and do not require the technical skills of a *nurse*.

GLOSSARY (continued)

Services may still be considered *custodial care* by us even if:

- You are under the care of a *health care practitioner*;
- The *health care practitioner* prescribed services are to support or maintain *your* condition; or
- Services are being provided by a *nurse*.

236100 07/07

D

Deductible means the amount of *covered expenses* that *you*, either individually or combined as a covered family, must pay per *year* before *we* pay benefits for certain specified services.

Note: Some plans may have a *network provider* benefit allowance prior to the applicability of the *deductible*. Please refer to the "Schedule of Benefits" section for more information.

Dental injury means an injury to a *sound natural tooth* caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

Dependent means a covered *employee's*:

- Legally recognized spouse;
- Natural born child, step-child, foster child, legally adopted child, or child placed for adoption whose age is less than the limiting age; or
- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
 - Such QMCSO or NMSN is no longer in effect; or
 - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *policy*.
- Child in court-ordered temporary or other custody
- Newborn child of a covered *dependent* child. Coverage for such child terminates 18 months after the date of birth or the date as determined by the Termination of Coverage provision, whichever is earliest.

Under no circumstances shall *dependent* mean a great-grandchild including where the great-grandchild meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

GLOSSARY (continued)

The coverage for each *dependent* child is subject to the following limiting age(s):

- The end of the calendar year in which the child reaches age 25, if the following conditions are met:
 - a. the child is fully dependent upon *you* and living in *your* home; or
 - b. the child is fully dependent upon *you* and is enrolled and actively attending an accredited learning institution as a part-time or full-time student. Semester breaks do not jeopardize a child's dependent status. However, if the child is not enrolled and attending an institution as a part-time or full-time student for the semester following the break, the child will no longer be considered a dependent for the purpose of insurance and insurance will end.

You must furnish satisfactory proof to *us*, upon *our* request, that the above conditions continuously exist. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who becomes an employee eligible for other group coverage through employment is no longer eligible as a *dependent* for coverage under the *policy*.

A covered *dependent* child who attains the limiting age while insured under the *policy* remains eligible if the covered *dependent* child is:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the *employee* or spouse for support and maintenance.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while insured under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under the *policy*. Please refer to the "Replacement of Coverage" section of this *certificate*.

You must furnish satisfactory proof to *us* upon *our* request that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

Dependent adult child

If the covered *employee* has an adult child who meets the following requirements, coverage may be available for that adult child until the end of the calendar year in which they reach age 30.

To be eligible for coverage, an adult child must satisfy the following requirements:

- The adult child is unmarried and does not have *dependents* of his or her own;
- The adult child is a resident of Florida, or a full-time or part-time student; and
- The adult child does not have coverage as a *covered person* under any other *health insurance coverage* or individual health benefits plan, or *Medicare*.

GLOSSARY (continued)

If an adult child is covered under this provision after the end of the year in which the adult child reaches age 25 and that coverage terminates, the adult child is not eligible to again be covered under the *policy* unless the adult child has *creditable coverage* without a gap of more than 63 days.

An adult child, as defined in the bulleted items above, ceases to be eligible for coverage under this provision:

- on the last day of the calendar year following the adult child's attainment of the limiting age; or
- when the adult child no longer meets the requirements listed above.

Diabetes equipment means blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes self-management training means the training provided to a *covered person* after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of diabetes equipment and supplies. It also includes training when changes are required to the self-management regime and when new techniques and treatments are developed.

Diabetes supplies means test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; glucagon emergency kits; and alcohol swabs.

Durable medical equipment means equipment, defined by *Medicare Part B*, that meets all of the following criteria:

- It can stand repeated use;
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- It is usually not useful to *you* in the absence of *sickness* or *bodily injury*;
- It is appropriate for home use;
- It is related to *your* physical disorder;
- It is not typically furnished by a *hospital* or *skilled nursing facility*; and
- It is provided in the most cost effective manner required by *your* condition, including, at *our* discretion, rental or purchase.

236800FL 10/08

E

Effective date means the date *your* coverage begins under the *policy*.

Electronic or electronically means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

GLOSSARY (continued)

Electronic mail means a computerized system that allows a user of a network computer system and/or computer system to send and receive messages and documents among other users on the network and/or with a computer system.

Electronic signature means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

Eligibility date means the date the *employee* or *dependent* is eligible to participate in the plan.

Emancipated minor means a child who has not yet attained full legal age, but who has been declared by a court to be emancipated.

Emergency care means services provided in a *hospital* emergency facility for a *bodily injury* or *sickness* manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of that individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency care does not mean services for the convenience of the *covered person* or the provider of treatment or services.

Employee means a person who is in *active status* for the *employer* on a *full-time* basis. The *employee* must be paid a salary or wage by the *employer* that meets the minimum wage requirements of *your* state or federal minimum wage law for work done at the *employer's* usual place of business or some other location which is usual for the *employee's* particular duties.

Employee also includes a sole proprietor, partner or corporate officer where:

- The *employer* is a sole proprietorship, partnership or corporation; and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, and gains their livelihood from the sole proprietorship, partnership or corporation and is in an *active status* at the *employer's* usual place of business or some other location which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

If specified on the Employer Group Application and approved by *us*, *employee* includes retirees of the *employer*. A retired *employee* is not required to be in *active status* to be eligible for coverage under this *policy*.

Employer means the sponsor of this *group* insurance plan, or any subsidiary or affiliate described in the Employer Group Application.

GLOSSARY (continued)

Enrollment date means:

- If you are not a *late applicant*, your *enrollment date* is the earlier of the following:
 - The first day your coverage is effective under the *policy*; or
 - The first day of the *waiting period* for enrollment, if any *waiting period* is applicable.
- Your *enrollment date* is the first day your coverage is effective under the *policy*, if:
 - You are a *late applicant*; or
 - You are enrolled on a *special enrollment date*.

The term *enrollment date* in this *certificate* is used for the determination and application of the *pre-existing condition* limitation and/or *creditable coverage*.

Experimental or investigational or for research purposes means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by *us*:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, or (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law;
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase; or
- Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision, except as required by state or federal law.

238000 07/07

GLOSSARY (continued)

F

Family member means *you* or *your* spouse, or *your* or *your* spouse's child, brother, sister, or parent.

Free-standing facility means any licensed public or private establishment other than a *hospital* which has permanent facilities equipped and operated to provide laboratory and diagnostic laboratory, *outpatient* radiology, *advanced imaging*, chemotherapy, inhalation therapy, radiation therapy, lithotripsy, physical, cardiac, speech and occupational therapy, or renal dialysis services. An appropriately licensed birthing center is also considered a *free-standing facility*.

Full-time, for an *employee*, means a work week of at least 20 hours.
238300FL 07/07

G

Group means the persons for whom this insurance coverage has been arranged to be provided.
238400

H

Health care practitioner means a practitioner professionally licensed by the appropriate state agency to diagnose or treat a *sickness* or *bodily injury* and who provides services within the scope of that license.

Health care treatment facility means a facility, institution or clinic, duly licensed by the appropriate state agency to provide medical services or *behavioral health* services, and is primarily established and operating within the scope of its license. *Health care treatment facility* does not include a *residential treatment facility*.

Health insurance coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization (HMO) contract offered by a health insurance issuer. "Health insurance issuer" means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to the state law that regulates insurance.

Health status-related factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;
- Claims experience;
- Receipt of health care;
- Genetic information;
- Disability; or
- Evidence of insurability, including conditions arising out of acts of domestic violence.

GLOSSARY (continued)

Home health care agency means a *home health care agency* or *hospital* which meets all of the following requirements:

- It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses;
- It must be operated according to established processes and procedures by a group of professional medical people, including physicians and *nurses*;
- It must maintain clinical records on all patients; and
- It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home health care.

Home health care plan means a plan of care and treatment for *you* to be provided in *your* home. To qualify, the *home health care plan* must be established and approved by a *health care practitioner*. The services to be provided by the plan must require the skills of a *nurse*, or another *health care practitioner* and must not be for *custodial care*.

Hospice care program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual and social needs of a terminally ill *covered person* and his or her immediate covered family members, by providing *palliative care* and supportive medical, nursing and other services through at-home or *inpatient* care. A hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their *sickness* and, as estimated by their physicians, are expected to live 18 months or less as a result of that *sickness*.

Hospital means an institution that meets all of the following requirements:

- It must provide, for a fee, medical care and treatment of sick or injured patients on an *inpatient* basis;
- It must provide or operate, either on its premises or in facilities available to the *hospital* on a pre-arranged basis, medical, diagnostic and surgical facilities. The requirement for provision or operation of surgical facilities does not apply to a hospital that is primarily for the rehabilitation of physical disability;
- Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24-hour basis and must be given by or supervised by registered nurses;
- It must be licensed by the laws of the jurisdiction where it is located. It must be operated as a hospital as defined by those laws;
- It must not be primarily a:
 - Convalescent, rest or nursing home; or
 - Facility providing custodial, educational care.

GLOSSARY (continued)

The *hospital* must be accredited by one of the following:

- The Joint Commission on the Accreditation of Hospitals;
- The American Osteopathic Hospital Association; or
- The Commission on the Accreditation of Rehabilitative Facilities.

239200FL 07/07

I

Individual lifetime maximum benefit means the maximum amount of benefits payable by *us* for all *covered expenses* incurred by *you*. Once the *individual lifetime maximum benefit* is reached, benefits are not payable and will not be reinstated.

Inpatient means *you* are *confined* as a registered bed patient.

Intensive outpatient program means *outpatient* services providing:

- Group therapeutic sessions greater than one hour a day, three days a week;
- *Behavioral health* therapeutic focus;
- Group sessions centered on cognitive behavioral constructs, social/occupational/educational skills development and family interaction;
- Additional emphasis on recovery strategies, monitoring of participation in 12-step programs and random drug screenings for the treatment of *chemical dependency*; and
- Physician availability for medical and medication management.

Intensive outpatient program does not include services that are for:

- *Custodial care*; or
- Day care.

239600 07/07

J

K

L

Late applicant means an *employee* or *dependent* who enrolls more than 31 days after his/her *eligibility date*, or more than 31 days after the *special enrollment date*.

239700

GLOSSARY (continued)

M

Maintenance care means services and supplies furnished mainly to:

- Maintain, rather than improve, a level of physical or mental function; or
- Provide a protected environment free from exposure that can worsen the *covered person's* physical or mental condition.

Maximum allowable fee for a *covered expense* is the lesser of:

- The fee charged by the provider for the services;
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
- The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
- The fee based upon rates negotiated by *us* or other payors with one or more *network providers* in a geographic area determined by *us* for the same or similar services;
- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available *Medicare* cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
- The fee based on a percentage determined by *us* of the fee *Medicare* allows for the same or similar services provided in the same geographic area.

Note: The bill *you* receive for services from *non-network providers* may be significantly higher than the *maximum allowable fee*. In addition to *deductibles*, *copayments* and *coinsurance*, *you* are responsible for the difference between the *maximum allowable fee* and the amount the provider bills *you* for the services. Any amount *you* pay to the provider in excess of the *maximum allowable fee* will not apply to *your out-of-pocket limit* or *deductible*.

Medicaid means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

Medically necessary means the required extent of health care service, treatment or product that a *health care practitioner* would provide to his or her patient for the purpose of diagnosing, palliating or treating a *sickness* or *bodily injury*, or its symptoms. Such health care service, treatment or product must be:

- In accordance with nationally recognized standards of medical practice and identified as safe, widely used and generally accepted as effective for the proposed use;
- Clinically appropriate in terms of type, frequency, intensity, toxicity, extent, setting, and duration;

GLOSSARY (continued)

- Not primarily for the convenience of the patient, physician or other health care provider;
- Clearly substantiated and supported by the medical records and documentation concerning the patient's condition;
- Performed in the most cost effective setting required by the patient's condition; and
- Supported by the preponderance of nationally recognized peer review medical literature, if any, published in the English language as of the date of service.

Medicare means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

Mental health services means those diagnoses and treatments related to the care of a *covered person* who exhibits a mental, nervous or emotional condition classified in the Diagnostic and Statistical Manual of Mental Disorders.

Morbid obesity (clinically severe obesity) means a body mass index (BMI) as determined by a *health care practitioner* as of the date of service of:

- 40 kilograms or greater per meter squared (kg/m^2); or
- 35 kilograms or greater per meter squared (kg/m^2) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

240300FL 02/09

N

Network health care practitioner means a *health care practitioner* who has signed a direct agreement with *us* as an independent contractor or who has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network health care practitioner* designation by *us* may be limited to specified services.

Network hospital means a *hospital* which has signed a direct agreement with *us* as an independent contractor or has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network hospital* designation by *us* may be limited to specified services.

Network provider means a *hospital*, *health care treatment facility*, physician, or any other health services provider who has signed an agreement with *us* as an independent contractor or who has been designated by *us* as an independent contractor to provide services to all *covered persons*. *Network provider* designation by *us* may be limited to specified services.

Non-network health care practitioner means a *health care practitioner* who has not been designated as a *network health care practitioner* by *us*.

Non-network hospital means a *hospital* which has not been designated as a *network hospital* by *us*.

GLOSSARY (continued)

Non-network provider means a *hospital, health care treatment facility*, physician, or any other health services provider who has not been designated as a *network provider* by *us*.

Nurse means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

241000 07/07

O

Observation status means a stay in a *hospital* or *health care treatment facility* for less than 24 hours if:

- *You* have not been admitted as a resident *inpatient*;
- *You* are physically detained in an emergency room, treatment room, observation room or other such area; or
- *You* are being observed to determine whether *confinement* will be required.

Oral surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include, but are not limited to, the following:

- Surgical removal of full bony impactions;
- Mandibular or maxillary implant;
- Maxillary or mandibular frenectomy;
- Alveolectomy and alveoplasty;
- Orthognathic surgery;
- Surgery for treatment of temporomandibular joint syndrome/dysfunction; and
- Periodontal surgery, including gingivectomies.

Organ transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified in the "Covered Expenses - Transplant Services" section, which are determined by *us* to be *medically necessary* services and which are not *experimental*, or *investigational*, or *for research purposes*. Transplantation of multiple organs, when performed simultaneously, is considered one organ transplant.

Organ transplant treatment period means 365 days from the date of discharge from the *hospital* following an *organ transplant* received while *you* were covered by *us*.

Out-of-pocket limit means the amount of *covered expenses* that must be paid by a *covered person*, either individually or combined as a covered family, per *year* before a benefit percentage will be increased.

Outpatient means *you* are not *confined* as a registered bed patient.

Outpatient surgery means surgery performed in a health care practitioner's office, ambulatory surgical center, or the outpatient department of a hospital.

241600FL 07/07

GLOSSARY (continued)

P

Palliative care means care given to a *covered person* to relieve, ease, or alleviate, but not to cure, a *bodily injury* or *sickness*.

Partial hospitalization means services provided by a *hospital* or *health care treatment facility* in which patients do not reside for a full 24-hour period:

- For a comprehensive and intensive interdisciplinary psychiatric treatment for minimum of 5 hours a day, 5 days per week;
- That provides for social, psychological and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents who must have a treatment program designed to meet the special needs of that age range; and
- That has physicians and appropriately licensed behavioral health practitioners readily available for the emergent and urgent needs of the patients.

The *partial hospitalization* program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered *partial hospitalization* services.

Partial hospitalization does not include services that are for:

- *Custodial care*; or
- Day care.

Periodontics means the branch of dentistry concerned with the study, prevention, and treatment of diseases of the tissues and bones supporting the teeth.

Policy means the document describing the benefits *we* provide as agreed to by *us* and the *policyholder*.

Policyholder means the legal entity identified as the *policyholder* on the face page of the *policy* who establishes, sponsors and endorses an employee benefit plan for insurance coverage.

Pre-surgical/procedural testing means:

- Laboratory tests or radiological examinations done on an *outpatient* basis in a *hospital* or other facility accepted by the *hospital* before *hospital confinement* or *outpatient surgery* or procedure;
- The tests must be accepted by the *hospital* or *health care practitioner* in place of like tests made during *confinement*; and
- The tests must be for the same *bodily injury* or *sickness* causing *you* to be *hospital confined* or to have the *outpatient surgery* or procedure.

GLOSSARY (continued)

Preauthorization means approval by *us*, or *our* designee, of a service prior to it being provided. Certain services require medical review by *us* in order to determine eligibility for coverage.

Preauthorization is granted when such a review determines that a given service is a *covered expense* according to the terms and provisions of the *policy*.

Pre-existing condition means a *sickness* or *bodily injury* for which *you* have received medical attention during the six months prior to *your enrollment date*. For the purposes of this definition, medical attention means care, advice, examination, treatment, services, medication, procedures, tests, consultation, referral or diagnosis.

Preventive services means services determined to be effective and accepted for the detection and prevention of disease in persons with no symptoms as recommended by the U.S. Preventive Services Task Force.

242500 07/07

Q

R

Rehabilitation facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily to render physical and occupational therapies, diagnostic services and other therapeutic services.

Residential treatment facility means an institution which:

- Is licensed as a 24-hour residential facility for *behavioral health* treatment, although not licensed as a *hospital*;
- Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a physician or a Ph.D. psychologist; and
- Provides programs such as social, psychological, and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Room and board means all charges made by a *hospital* or other *health care treatment facility* on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

GLOSSARY (continued)

Routine nursery care means the charges made by a *hospital* or licensed birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. *Health care practitioner* visits are not considered *routine nursery care*. Treatment of a *bodily injury, sickness, birth abnormality, congenital defect* following birth and care resulting from prematurity is not considered *routine nursery care*.

242900 07/07

S

Self-administered injectable drugs means an FDA approved medication which a person may administer to himself or herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and prescribed for use by *you*.

Sickness means a disturbance in function or structure of the body which causes physical signs or physical symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of the body. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) *behavioral health*.

Skilled nursing facility means a licensed institution (other than a *hospital*, as defined) which meets all of the following requirements:

- It must provide permanent and full-time bed care facilities for resident patients;
- It must maintain, on the premises and under arrangements, all facilities necessary for medical care and treatment;
- It must provide such services under the supervision of physicians at all times;
- It must provide 24-hours-a-day nursing services by or under the supervision of a registered nurse; and
- It must maintain a daily record for each patient.

A *skilled nursing facility* is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of *chemical dependency*.

Small employer means, in connection with a health benefit plan with respect to a calendar *year* and plan *year*, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in Florida, employed an average of at least one but not more than 50 eligible *employees* on business days during the preceding calendar *year* the majority of whom were employed in Florida, employs at least one *employee* on the first day of the plan *year*, and is not formed primarily for purposes of purchasing insurance. In determining the number of eligible *employees*, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single *employer*. A sole proprietor, independent contractor, or self-employed individual is considered a *small employer* only if all of the conditions and criteria established in this section are met.

GLOSSARY (continued)

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth, (for example a tooth that has not been previously broken, chipped, filled, cracked or fractured).

Special enrollment date means:

- The date of change in family status after the initial *eligibility date* as follows:
 - Date of marriage;
 - Date of divorce;
 - Date specified in a Qualified Medical Child Support Order (QMCSO);
 - Date specified in a National Medical Support Notice (NMSN);
 - Date of birth of a natural born child; or
 - Date of adoption of a child or date of placement of a child with the *employee* for the purpose of adoption; or
- The date of termination of coverage under a group health plan or other *health insurance coverage*, as specified under the "Special Enrollment" provision.

Surgery means services categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term *surgery* includes, but is not limited to: excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening; insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and treatment of fractures.

243800FL 08/08

T

Total disability or **totally disabled** means *your* continuing inability, as a result of a *bodily injury* or *sickness*, to perform the material and substantial duties of any job for which *you* are or become qualified by reason of education, training or experience.

The term also means a *dependent's* inability to engage in the normal activities of a person of like age. If the *dependent* is employed, the *dependent* must be unable to perform his or her job.

244000 07/07

GLOSSARY (continued)

U

Urgent care means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires attention without delay but that does not pose a threat to life, limb or permanent health of the *covered person*.

Urgent care center means any licensed public or private non-hospital free-standing facility which has permanent facilities equipped to provide *urgent care* services on an *outpatient* basis.

244200 07/07

V

Vision therapy means trainings consisting of a series of eye exercises aimed at stabilizing various subsystems of the mind/body through biofeedback mechanisms, "brain training." Vision training has been used in the treatment of eye disorders such as hyperopia (farsightedness), myopia (nearsightedness), and extropia (cross eyes). Vision training has also been used as a neuro-physiological based intervention for attention deficit disorder in children. Vision training has not been supported in large scale, controlled clinical studies.

FL234896.15 07/09

244300

W

Waiting period means the period of time, elected by the *policyholder*, which must pass before an *employee* is eligible for coverage under the *policy*.

We, us or our means the offering company as shown on the cover page of the *policy* and *certificate*.

244400 07/07

X

Y

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *policy*, the first *year* begins for *you* on the effective date of *your* insurance and ends on the following December 31st.

You or your means any *covered person*.

244600 07/07

Z

DOMESTIC PARTNER BENEFIT RIDER

This rider is made part of the *policy* to which it is attached. The effective date of this change is the latter of the effective date of the *certificate* or the date this benefit is added to the *policy*.

This rider modifies the *policy* as follows:

1200000

- By adding the definition of *domestic partner* to the "Glossary" section of the *certificate* as follows:

Domestic partner means an individual of the same or opposite gender who resides with the covered *employee* in a long-term relationship of indefinite duration; and, there is an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. The *domestic partner* must be more than 18 years of age, competent to contract, and may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside. We reserve the right to require an affidavit from the *domestic partners* attesting that the domestic partnership has existed for a minimum period of 12 months and, periodically thereafter, to require proof that the *domestic partner* relationship continues to exist.

1200100 05/05

- By deleting the definition of *dependent* in the "Glossary" section of the *certificate* and replacing it with the following:

Dependent means a covered *employee's*:

- Legally recognized spouse or *domestic partner*;
- Natural born child, step-child, foster child, legally adopted child, or child placed for adoption whose age is less than the limiting age;
- Child whose age is less than the limiting age and for whom the *employee* has received a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) to provide coverage, if the *employee* is eligible for family coverage until:
 - Such QMCSO or NMSN is no longer in effect; or
 - The child is enrolled for comparable health coverage, which is effective no later than the termination of the child's coverage under the *policy*; or
- *Domestic partner's* natural born child, step-child, foster child, legally adopted child, or child placed for adoption whose age is less than the limiting age, subject to the following conditions:
 - The *domestic partner's* child must live in the *employee's* household;
 - The *domestic partner's* child is not covered by any other medical plan; and
 - The *domestic partner's* child is not entitled to coverage through another medical plan because of a QMCSO or NMSN.

DOMESTIC PARTNER BENEFIT RIDER (continued)

Note: The *domestic partner's* child cannot qualify as a *dependent* prior to the *employee's* *domestic partner* becoming a qualified *dependent*.

- Child in court-ordered temporary or other custody
- Newborn child of a covered *dependent* child. Coverage for such child terminates 18 months after the date of birth or the date as determined by the Termination of Coverage provision, whichever is earliest.

Under no circumstances shall *dependent* mean a great-grandchild including where the great-grandchild meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The coverage for each *dependent* child is subject to the following limiting age(s):

- The end of the calendar year in which the child reaches age 25 if the following conditions are met:
 - a. The child is fully dependent upon *you* and living in *your* home; or
 - b. The child is fully dependent upon you and is enrolled and actively attending an accredited learning institution as a part-time or full-time student. Semester breaks do not jeopardize a child's dependent status. However, if the child is not enrolled and attending an institution as a part-time or full-time student for the semester following the break, the child will no longer be considered a dependent for the purpose of insurance and insurance will end.

You must furnish satisfactory proof to *us*, upon *our* request that the above conditions continuously exist. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who becomes an employee eligible for other group coverage through employment is no longer eligible as a *dependent* for coverage under the *policy*.

A covered *dependent* child who attains the limiting age while insured under the *policy* remains eligible if the covered *dependent* child is:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the *employee* or spouse for support and maintenance.

In order for the covered *dependent* child to remain eligible as specified above, *we* must receive notification within 31 days prior to the covered *dependent* child attaining the limiting age.

A handicapped *dependent* child, as defined in the bulleted items above, who attained the limiting age while insured under the *employer's* previous group medical plan (Prior Plan) is eligible for coverage under the *policy*. Please refer to the "Replacement of Coverage" section of this *certificate*.

DOMESTIC PARTNER BENEFIT RIDER (continued)

You must furnish satisfactory proof to *us* upon *our* request that the conditions, as defined in the bulleted items above, continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, *we* may not request such proof more often than annually. If satisfactory proof is not submitted to *us*, the child's coverage will not continue beyond the last date of eligibility.

Dependent adult child

If the covered *employee* has an adult child who meets the following requirements, coverage may be available for that adult child until the end of the calendar year in which they reach age 30.

To be eligible for coverage, an adult child must satisfy the following requirements:

- The adult child is unmarried and does not have *dependents* of his or her own;
- The adult child is a resident of Florida, or a full-time or part-time student; and
- The adult child does not have coverage as a *covered person* under any other *health insurance coverage* or individual health benefits plan, or *Medicare*.

If an adult child is covered under this provision after the end of the year in which the adult child reaches age 25 and that coverage terminates, the adult child is not eligible to again be covered under the *policy* unless the adult child has *creditable coverage* without a gap of more than 63 days.

An adult child, as defined in the bulleted items above, ceases to be eligible for coverage under this provision:

- on the last day of the calendar year following the adult child's attainment of the limiting age; or
- when the adult child no longer meets the requirements listed above.

1200200FL 10/08

- By deleting the definition of *family member* in the "Glossary" section of the *certificate* and replacing it with the following:

Family member means *you, your* legally recognized spouse or *domestic partner*. It also means *your* or *your* legally recognized spouse's or *domestic partner's* child, brother, sister or parent.

1200300 12/03

Humana Health Insurance Company of Florida, Inc.



Michael B. McCallister
President

1200400FL 08/08

PRESCRIPTION DRUG BENEFIT RIDER

This rider is made part of the *policy* to which it is attached. The effective date of this change is the latter of the effective date of the *certificate* or the date this benefit is added to the *policy*.

Notwithstanding any other provisions of the *policy*, expenses covered under this Prescription Drug Benefit Rider are not covered under any other provision of the *policy*. Any amount in excess of the maximum amount provided under this benefit rider, if any, is not covered under any other provision in the *policy*.

Any expenses incurred by *you* under provisions of this rider do not apply toward *your out-of-pocket limit*, if any.

For the purposes of coordination of benefits, prescription drug coverage under this benefit rider will be considered a separate plan and will therefore only be coordinated with other prescription drug coverage.

All terms used in this benefit rider have the same meaning given to them in the *certificate* unless otherwise specifically defined in this benefit rider.

1800000 4/04

Prescription drug cost sharing

You are responsible for any and all payments of the following, when applicable, according to the "Schedule of Benefits-Prescription Drugs" section of this benefit rider:

- The *drug deductible*, if any; and
- The *copayment**.

* If the dispensing *pharmacy's* charge is less than the *copayment*, *you* will be responsible for the lesser amount. The amount paid by *us* to the dispensing *pharmacy* may not reflect the ultimate cost to *us* for the drug. *Your copayments* are made on a per *prescription* or refill basis and will not be adjusted if Humana receives any retrospective volume discounts or *prescription* drug rebates.

1800100 4/04

Definitions

The following terms are used in this benefit rider:

1800200 4/04

Brand-name medication means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designated as brand-name by an industry-recognized source used by *us*.

1800400 06/06

Copayment means the amount to be paid by *you* toward the cost of each separate *prescription* or refill of a covered *prescription* drug when dispensed by a *pharmacy*.

1800600

PRESCRIPTION DRUG BENEFIT RIDER (continued)

Dispensing limit means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition, as determined by *us*.

1800800 06/06

Generic medication means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by the chemical name, or any drug product that has been designated as generic by an industry-recognized source used by *us*.

1801000 06/06

Legend drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription".

1801100

Mail order pharmacy means a *pharmacy* that provides covered *mail order pharmacy* services, as defined by *us*, and delivers covered *prescriptions* or refills through the mail to *covered persons*.

1801700 06/06

Network pharmacy means a *pharmacy* that has signed a direct agreement with *us* or has been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered through the mail.

1801800 06/06

Non-network pharmacy means a *pharmacy* that has not signed a direct agreement with *us* or has not been designated by *us* to provide:

- Covered *pharmacy* services;
- Covered *specialty pharmacy* services; or
- Covered *mail order pharmacy* services,

as defined by *us*, to *covered persons*, including covered *prescriptions* or refills delivered through the mail.

1801900 06/06

PRESCRIPTION DRUG BENEFIT RIDER (continued)

Orphan drug means a drug or biological used for the diagnosis, treatment, or prevention of rare diseases or conditions, which:

- Affects less than 200,000 persons in the United States; or
- Affects more than 200,000 persons in the United States, however, there is no reasonable expectation that the cost of developing the drug and making it available in the United States will be recovered from the sales of that drug in the United States.

1802000

Pharmacist means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

1802200

Pharmacy means a licensed establishment where *prescription* medications are dispensed by a *pharmacist*.

1802300

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The *prescription* must be given by a *health care practitioner* to a *pharmacist* for *your* benefit and used for the treatment of a *sickness* or *bodily injury* which is covered under this plan. The drug, medicine or medication must be obtainable only by *prescription*. The *prescription* may be given to the *pharmacist* verbally, *electronically* or in writing by the *health care practitioner*. The *prescription* must include at least:

- *Your* name;
- The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
- The date the *prescription* was prescribed; and
- The name and address of the prescribing *health care practitioner*.

1802400 06/06

Prior authorization means the required prior approval from *us* for the coverage of *prescription* drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for *your* diagnosis, age and sex. Certain *prescription* drugs, medicines or medications may require *prior authorization*.

1802500

Self-administered injectable drugs means an FDA-approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin and is intended for use by *you*.

1802600

Specialty drug means a drug, medicine or medication used as a specialized therapy developed for chronic, complex *sicknesses* or *bodily injuries*. *Specialty drugs* may:

- Require nursing services or special programs to support patient compliance;
- Require disease-specific treatment programs;

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Have limited distribution requirements; or
- Have special handling, storage or shipping requirements.

Additional information can be obtained through your Human Resources Department or by calling the toll free customer service phone number on the back of your ID card.

FL234896.16 07/09

1802625

Specialty pharmacy means a *pharmacy* that provides covered *specialty pharmacy* services, as defined by us, to *covered persons*.

1802650

Year means the period of time which begins on any January 1st and ends on the following December 31st. When *you* first become covered by the *policy*, the first *year* begins for *you* on the effective date of *your* insurance and ends on the following December 31st.

1802690

Coverage description

We will cover *prescription* drugs that are received by *you* from a *network pharmacy* while *you* are covered under this Prescription Drug Benefit Rider. Benefits may be subject to *dispensing limits* and *prior authorization* requirements, if any.

Covered *prescription* drugs are:

- Drugs, medicines or medications that under federal or state law, may be dispensed only by *prescription* from a *health care practitioner*;
- Drugs, medicines or medications that are included on the *drug list*.
- Insulin and *diabetes supplies*;
- Growth hormones approved by us;
- Hypodermic needles or syringes when prescribed by a *health care practitioner* for use with insulin or *self-administered injectable drugs*. (Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to *you*);
- *Specialty drugs* and *self-administered injectable drugs* approved by us;
- Formulas necessary for the treatment of phenylketonuria or other inherited diseases; and
- Spacers and/or peak flow meters for the treatment of asthma.

PRESCRIPTION DRUG BENEFIT RIDER (continued)

Notwithstanding any other provisions of the *policy*, we may decline coverage or, if applicable, exclude from the *drug list* any and all *prescriptions* until the conclusion of a review period not to exceed six months following FDA approval for the use and release of the *prescriptions* into the market.

1802700FL 10/06

Schedule of benefits - prescription drugs

You are responsible for the following:

Retail pharmacy / specialty pharmacy

<i>Generic Medication</i>	\$20* <i>copayment</i> per <i>prescription</i> or refill per 30-day supply
<i>Brand Medication</i>	\$40* <i>copayment</i> per <i>prescription</i> or refill per 30-day supply

Some retail *pharmacies* participate in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill. *Your* cost is 1 times the applicable *copayment* as outlined above. *Self-administered injectable drugs* and *specialty drugs* are limited to a 30-day supply from a retail *pharmacy* or *specialty pharmacy*, unless otherwise determined by *us*.

Mail order pharmacy

For up to a 90-day supply of a <i>prescription</i> or refill	1 times the applicable <i>copayment</i> , as outlined above under Retail pharmacy / specialty pharmacy
--	---

1802800FL 08/08

Specialty drugs and injectable drugs per prescription

For up to a 30-day supply of a <i>prescription</i> or refill	\$0 <i>copayment</i> Specialty drugs and injectable drugs do not include self-administered injectable drugs.
--	---

*Prescription drug copayment does not apply to the out-of-pocket limits.

When a network pharmacy is used and you do not present your ID card to the network pharmacy at the time of purchase, you must pay the pharmacy the full retail price and submit the pharmacy receipt to Humana at the address listed below. You will be reimbursed at 100% of billed charges after the charge has been reduced by the applicable copayment.

PRESCRIPTION DRUG BENEFIT RIDER (continued)

When a *non-network pharmacy* is used you must pay the pharmacy the full retail price and submit the pharmacy receipt to Humana at the address listed below. *You* will be responsible for 30% of the actual charge made by the dispensing *pharmacy*, after this charge has been reduced by the applicable *copayment*.

FL234896.17 07/09

1803400 06/06

Mail pharmacy receipts to:

Humana Claims Office
Attention: Pharmacy Department
P.O. Box 14601
Lexington, KY 40512-4601

Mac C- If the member or physician request a brand name drug (and a generic is available), the member pays only the retail brand copay (no differential).

FL234896.18 07/09

1803100 04/04

Limitations and exclusions

No benefit is provided for:

1803600

- *Legend drugs* which are not deemed *medically necessary* by us;

1803700 06/06

- Any drug prescribed for intended use other than for:

- Indications approved by the FDA; or
- Off-label indications recognized through peer-reviewed medical literature or standard reference compendium;

1804000FL

- Any drug prescribed for a *sickness* or *bodily injury* not covered under the *policy*;

1804100

- Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any *experimental* or *investigational* drug, medicine or medication, even though a charge is made to *you*;

1804200 06/06

- Allergen extracts;

1804300

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Therapeutic devices or appliances including, but not limited to:
 - Hypodermic needles and syringes (except needles and syringes for use with insulin, and *self-administered injectable drugs* whose coverage is approved by us);
 - Support garments;
 - Test reagents;
 - Mechanical pumps for delivery of medications; and
 - Other non-medical substances;

1804400 06/06

- Dietary supplements; (except for formulas or low protein modified foods necessary for the treatment of phenylketonuria or certain other heritable diseases of amino and organic acids);

1804500

- Nutritional products, except legend multi-vitamins;

1804600

- Fluoride supplements;

1804700

- Minerals, except Calcium Acetate 667 mg tablets (Phoslo);

FL234896.19 07/09 1804800

- Growth hormones (medications, drugs or hormones to stimulate growth);

1804900

- Growth hormones (medications, drugs or hormones to stimulate growth) for idiopathic short stature;

1804950

- Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;

1805000

- Anabolic steroids;

1805100

- Anorectic or any drug used for the purpose of weight control;

1805200

- Any drug used for cosmetic purposes, including but not limited to:
 - Tretinoin, e.g. Retin A, except if *you* are under the age of 25 or are diagnosed as having adult acne;
 - Dermatologicals or hair growth stimulants; or
 - Pigmenting or de-pigmenting agents, e.g. Solaquin;

1805300

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Any drug or medicine that is:
 - Lawfully obtainable without a *prescription* (over the counter drugs), except insulin; or
 - Available in prescription strength without a *prescription*;

1805400

- Compounded drugs in any dosage form;
1805500

- Progesterone crystals or powder in any compounded dosage form;
1805600

- Abortifacients (drugs used to induce abortions);
1805800

- *Infertility services* including medications;
1805900

- Any drug prescribed for impotence and/or sexual dysfunction, except Viagra; limited to 12 doses per month or 36 doses per 90 days for mail order;
FL234896.20 07/09 1806000

- Any drug, medicine or medication that is consumed or injected at the place where the *prescription* is given, or dispensed by the *health care practitioner*;
1806100

- The administration of covered medication(s);
1806200

- *Prescriptions* that are to be taken by or administered to *you*, in whole or in part, while *you* are a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. *Inpatient* facilities include, but are not limited to:
 - *Hospital*;
 - *Rest home*;
 - *Skilled nursing facility*; or
 - *Hospice facility*;
 - *Sanitarium*
 - *Convalescent Hospital*

FL234896.21 07/09 1806300

- Injectable drugs, including but not limited to:
 - Immunizing agents;
 - Biological sera;

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Blood;
- Blood plasma; or
- *Self-administered injectable drugs* or *specialty drugs* for which coverage is not approved by us;
1806400 06/06

- *Prescription* refills:
 - In excess of the number specified by the *health care practitioner*; or
 - Dispensed more than one year from the date of the original order;
1806500

- Any portion of a *prescription* or refill that exceeds a 90-day supply, received from a *mail order pharmacy* or a retail *pharmacy* that participates in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill;
1806600 06/06

- Any portion of a *prescription* or refill that exceeds a 30-day supply, received from a retail *pharmacy* that does not participate in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill;
1806640

- Any portion of a *specialty drug* or *self-administered injectable drug* received from a retail *pharmacy* or a *specialty pharmacy* that exceeds a 30-day supply, unless otherwise determined by us;
1806650

- Any portion of a *prescription* or refill that:
 - Exceeds *our* drug specific *dispensing limit*, e.g. IMITREX; or
 - Is dispensed to a *covered person* whose age is outside the drug specific age limits defined by us;
 - Exceeds the duration-specific *dispensing limit*;
1806700

- Any drug for which *prior authorization* is required, as determined by us, and not obtained;
1806800

- Any drug for which a charge is customarily not made;
1806900

- Any drug, medicine or medication received by *you*:
 - Before becoming covered under this rider; or
 - After the date *your* coverage under this rider has ended;
1807000 07/06

- Any costs related to the mailing, sending or delivery of *prescription* drugs;
1807100

PRESCRIPTION DRUG BENEFIT RIDER (continued)

- Any intentional misuse of this benefit, including *prescriptions* purchased for consumption by someone other than *you*;
1807200
- Any *prescription* or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
1807300
- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications;
1807400
- Treatment for onychomycosis (nail fungus);
1807600
- More than one *prescription* or refill for the same drug or therapeutic equivalent medication prescribed by one or more *health care practitioners* and dispensed by one or more *pharmacies* until *you* have used, or should have used, at least 75% of the previous *prescription* or refill, unless the drug or therapeutic equivalent medication is purchased through a *mail order pharmacy*, or a retail *pharmacy* that participates in *our* program which allows *you* to receive a 90-day supply of a *prescription* or refill, in which case *you* have used, or should have used 66% of the previous *prescription*. (Based on the dosage schedule prescribed by the *health care practitioner*);
1807700 06/06
- Any drug or biological that has received designation as an *orphan drug*, unless approved by *us*;
1807800 4/04
- Any *copayment* *you* paid for a *prescription* that has been filled, regardless of whether the *prescription* is revoked or changed due to adverse reaction or change in dosage or *prescription*;
1807900 07/06
- Antacids;
- Ostomy supplies;
- Ribavirin powder.

These limitations and exclusions apply even if a *health care practitioner* has performed or prescribed a medically appropriate procedure, service, treatment, supply, or *prescription*. This does not prevent *your health care practitioner* or *pharmacist* from providing or performing the procedure, service, treatment, supply, or *prescription*; however, the procedure, service, treatment, supply or *prescription* will not be a *covered expense*.

FL234896.7 07/09

1807955

PRESCRIPTION DRUG BENEFIT RIDER (continued)

Humana Health Insurance Company of Florida, Inc.



Michael B. McCallister
President

1808000FL 10/07

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Guidance when you need it most

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HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

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NOTICES

The following pages contain important information about Humana’s claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

Women’s Health and Cancer Rights Act

Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act

Medical Child Support Orders

General Notice of COBRA Continuation of Coverage Rights

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Family And Medical Leave Act (FMLA)

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Your Rights Under ERISA

Certificate of Creditable Coverage

Privacy and Confidentiality Statement

NOTICES (continued)

Claims and appeals procedures

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures, Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA, should consult their benefit plan documents for the applicable claims and appeals procedures.

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Definitions

Adverse determination means a decision to deny benefits for a *pre-service claim* or a *post-service claim* under a *group health plan*.

Claimant means a covered person (or authorized representative) who files a claim.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana".

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim*.

NOTICES (continued)

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim (expedited review) means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care".

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

NOTICES (continued)

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

NOTICES (continued)

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims (expedited review)*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the *urgent-care claim*.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information but not less than 48 hours.

Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

NOTICES (continued)

- **Post-service claims** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

NOTICES (continued)

Appeals of adverse determinations

A claimant must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A claimant, on appeal, may request an expedited appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the claimant by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim.

On appeal, a claimant may review relevant documents and may submit issues and comments in writing. A claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;
- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

NOTICES (continued)

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the claimant, free of charge, upon request;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the claimant's right to bring an action under §502(a) of ERISA;
- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the claimant will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the determination;
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

NOTICES (continued)

Exhaustion of remedies

Upon completion of the appeals process under this section, a claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the claimant may proceed to the next level in the review process.

After exhaustion of remedies, a claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Federal legislation

Women's health and cancer rights act of 1998

Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

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

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

NOTICES (continued)

Statement of rights under the newborns' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

NOTICES (continued)

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

NOTICES (continued)

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer,^{^^} the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the

NOTICES (continued)

end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;
- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at <http://www.dol.gov/ebsa/>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

NOTICES (continued)

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- **Option 1** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- **Option 2** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- **Category 1** Medicare eligibles are:
 - Covered employees in active service who are age 65 or older who choose Option 1;
 - Age 65 or older covered spouses; and
 - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- **Category 2** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
 - Retired employees and their spouses; or
 - Covered dependents of a covered employee, other than his or her spouse.

NOTICES (continued)

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

NOTICES (continued)

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;
- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;
- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

NOTICES (continued)

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan. The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

NOTICES (continued)

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;
- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;
- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;
- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Certificate of Creditable Coverage

Upon termination of this group health plan, you will receive a certificate of creditable coverage. You may also call the Customer Service number on the back of your Humana identification card to request a copy.

Privacy and confidentiality statement

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

NOTICES (continued)

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose you PHI, without your consent/authorization, in the following ways:

- **Treatment:** We may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.
- **Payment:** We may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.