UnitedHealthcare Choice

Plan S62

Certificate of Coverage, Riders, Amendments and Notices
for
State of Florida

Group Number: 708585
Effective Date: January 1, 2008

Offered and Underwritten by
United HealthCare of Florida, Inc.
495 N. Keller Road
Suite 200
Maitland, FL 32751

Riders, Amendments, and Notices
begin immediately following the last page of the Certificate of Coverage

United HealthCare of Florida, Inc.

UnitedHealthcare Choice

Certificate of Coverage

Contact Customer Service at 1-866-527-9604 for benefit inquiries or to file a complaint. Coverage under the Contract is not subject to any preexisting condition limitation or exclusion.

UNITED HEALTHCARE OF FLORIDA, INC.

Daniel Rosenthal, Chief Executive Officer

Certificate of Coverage Table of Contents

Certificate of Coverage 1

Certificate is Part of Group Contract 1
Changes to the Document...1
Other Information You Should Have 1

Introduction to Your Certificate....................... 2

How to Use this Document 2
Information about Defined Terms 2
Your Contribution to the Required Premiums 2
Don't Hesitate to Contact Us 2

Section 1: What's Covered--Benefits Error! Bookmark not defined.

Accessing Benefits ....**Error! Bookmark not defined.**
Copayment...**Error! Bookmark not defined.**
Eligible Expenses................................**Error! Bookmark not defined.**
Notification Requirements ....**Error! Bookmark not defined.**
Payment Information 17
Annual Deductible.. 17
Out-of-Pocket Maximum 17
Maximum Contract Benefit... 17

To continue reading, go to right column on this page.

Benefit Information 18
1. Ambulance Services - Emergency only 18
2. Bones or Joints of the Jaw and Facial Region 18
3. Child Health Supervision Services 18
4. Cleft Lip/Cleft Palate Treatment 19
5. Dental Procedures - Anesthesia and Hospitalization 19
6. Dental Services - Accident only.. 20
7. Diabetes Treatment 21
8. Durable Medical Equipment... 21
9. Emergency Health Services.. 23
10. Eye Examinations 23
11. Home Health Care 23
12. Hospice Care 25
13. Hospital - Inpatient Stay.. 25
14. Injections received in a Physician's Office....................................... 25
15. Mammography 26
16. Mastectomy... 27
17. Maternity Services.. 27
18. Mental Health and Substance Abuse Services - Outpatient......... 28
19. Mental Health and Substance Abuse Services - Inpatient and Intermediate 30
20. Osteoporosis Treatment.. 31
21. Outpatient Surgery, Diagnostic and Therapeutic Services 31
22. Physician's Office Services 33
23. Prescription and Non-prescription Enteral Formulas 34
24. Professional Fees for Surgical and Medical Services 34
25. Prosthetic Devices 34
26. Reconstructive Procedures.. 35

To continue reading, go to left column on next page.

27. Rehabilitation Services - Outpatient Therapy ... 37
28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services ... 38
29. Spinal Treatment ... 38
30. Transplantation Services ... 38
31. Urgent Care Center Services ... 40

Section 2: What's Not Covered--Exclusions ... 41
How We Use Headings in this Section ... 41
We Do Not Pay Benefits for Exclusions ... 41
A. Alternative Treatments ... 41
B. Comfort or Convenience ... 41
C. Dental ... 42
D. Drugs ... 42
E. Experimental, Investigational or Unproven Services ... 42
F. Foot Care ... 42
G. Medical Supplies and Appliances ... 43
H. Mental Health/Substance Abuse ... 43
I. Nutrition ... 44
J. Physical Appearance ... 44
K. Providers ... 44
L. Reproduction ... 44
M. Services Provided under Another Plan ... 44
N. Transplants ... 45
O. Travel ... 45
P. Vision and Hearing ... 45
Q. All Other Exclusions ... 45

To continue reading, go to right column on this page.

Section 3: Obtaining Benefits ... 47
Benefits ... 47
Emergency Health Services ... 49

Section 4: When Coverage Begins ... 50
How to Enroll ... 50
If You Are Hospitalized When Your Coverage Begins ... 50
Who is Eligible for Coverage ... 51
Eligible Person ... 51
Dependent ... 51
When to Enroll and When Coverage Begins ... 52
Initial Enrollment Period ... 52
Open Enrollment Period ... 52
New Eligible Persons ... 52
Adding New Dependents ... 52
Special Enrollment Period ... 53

Section 5: How to File a Claim ... 55
If You Receive Covered Health Services from a Network Provider ... 55
If You Receive Covered Health Services from a Non-Network Provider ... 55
Reimbursement of Excess Copayments ... 56

Section 6: Questions, Complaints, Grievances ... 57
What to Do First ... 57
What to Do Next ... 57

To continue reading, go to left column on next page.

What to Do if You Disagree with Our Decision About Pre-Service Claims ... 58
What to Do if You Disagree with Our Decision About Post-Service Claims ... 58
What to Do if Your Complaint or Grievance Concerns Urgent Claims that Require Immediate Attention ... 59
What to Do if Your Complaint or Grievance Concerns Concurrent Care Claims ... 60
How to Appeal a Claim Decision ... 60
Appeal Process ... 60
Appeals Determinations ... 60
Urgent Claim Appeals that Require Immediate Action ... 61

Section 7: Coordination of Benefits ... 62
Benefits When You Have Coverage under More than One Plan ... 62
When Coordination of Benefits Applies ... 62
Definitions ... 62
Order of Benefit Determination Rules ... 64
Effect on the Benefits of this Plan ... 65
Right to Receive and Release Needed Information ... 65
Payments Made ... 66
Right of Recovery ... 66

Section 8: When Coverage Ends ... 67
General Information about When Coverage Ends ... 67
Events Ending Your Coverage ... 68
The Entire Group Contract Ends ... 68
You No Longer Reside or Work in Service Area ... 68

To continue reading, go to right column on this page.

You Are No Longer Eligible ... 68
We Receive Notice to End Coverage ... 68
Subscriber Retires or Is Pensioned ... 68
Other Events Ending Your Coverage ... 70
Fraud, Intentional Misrepresentation or False Information ... 70
Improper Use of ID Card ... 70
Threatening Behavior ... 70
Coverage for a Handicapped Child ... 71
Extended Coverage for Total Disability ... 71
Extended Coverage for Pregnancy ... 71
Continuation of Coverage and Conversion ... 71
Continuation Coverage under Federal Law (COBRA) ... 72
Qualifying Events for Continuation Coverage under Federal Law (COBRA) ... 72
Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA) ... 72
Terminating Events for Continuation Coverage under Federal Law (COBRA) ... 73
Conversion ... 74

Section 9: General Legal Provisions ... 76
Your Relationship with Us ... 76
Our Relationship with Providers and Enrolling Groups ... 76
Your Relationship with Providers and Enrolling Groups ... 77
Notice ... 77
Statements by Enrolling Group or Subscriber ... 77
Incentives to Providers ... 77
Incentives to You ... 78

To continue reading, go to left column on next page.

Interpretation of Benefits 78
Administrative Services 78
Amendments to the Contract 78
Clerical Error 79
Information and Records 79
Examination of Covered Persons 79
Workers' Compensation not Affected 80
Subrogation and Reimbursement 80
Refund of Overpayments 81
Limitation of Action 81
Entire Contract 82

Section 10: Glossary of Defined Terms 83

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Certificate of Coverage

United HealthCare of Florida, Inc.

UnitedHealthcare Choice

Certificate is Part of Group Contract

This Certificate of Coverage is part of the group Contract that is a legal document between United HealthCare of Florida, Inc. and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Contract. We issue the Contract based on the Enrolling Group's application and payment of the required Contract Charges.

In addition to this Certificate the Contract includes:

- The Enrolling Group's application.
- Any Amendments and Riders.

Coverage under the Contract is not subject to any preexisting condition limitation or exclusion.

You can review the Contract at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this Certificate by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Certificate. When that happens we will send you a new Certificate, Rider or Amendment pages.

To continue reading, go to right column on this page.

No one can make any changes to the Contract unless those changes are in writing.

Other Information You Should Have

Only we have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Contract, as permitted by law, without your approval.

This Certificate describes Benefits in effect as of January 1, 2008 for State of Florida.

On its effective date this Certificate replaces and overrules any Certificate that we may have previously issued to you. This Certificate will in turn be overruled by any Certificate we issue to you in the future.

The Contract will take effect on the date specified in the group Contract. Coverage under the Contract will begin at 12:01 a.m. and end at 12:00 midnight Eastern time. The Contract will remain in effect as long as the Contract Charges are paid when they are due, subject to termination of the Contract.

We are delivering the Contract in the State of Florida. The Contract is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Florida are the laws that govern the Contract.

To continue reading, go to left column on next page.

Introduction to Your Certificate

We are pleased to provide you with this Certificate of Coverage. This Certificate and the other Contract documents describe your Benefits, as well as your rights and responsibilities, under the Contract.

How to Use this Document

We encourage you to read your Certificate and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Certificate by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this Certificate and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the Certificate are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Certificate and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your Certificate of Coverage, and is not responsible for knowing or communicating your Benefits.

To continue reading, go to right column on this page.

Information about Defined Terms

Because this Certificate is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your Certificate.

When we use the words "we," "us," and "our" in this document, we are referring to United HealthCare of Florida, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Required Premiums

The Contract may require the Subscriber to contribute to the required Premiums. You can contact your Enrolling Group for information about any part of the Premium cost you are responsible for paying.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for Customer Service listed on your ID card. It will be our pleasure to assist you.

To continue reading, go to left column on next page.

SECTION 1:

SUMMARY OF HMO PLAN BENEFITS

Covered Services –

This chart provides a description of services and supplies covered by the HMO plan. However services and supplies not described here but mandated by state or federal law will be covered by the HMO plan.

The Health Plan pays the cost of covered care and medical supplies, less the copayment, as long as the care or supplies are: ordered by a covered provider; considered medically necessary for the covered person's treatment as a result of a covered accident, illness, condition or mental or nervous disorder; not specifically limited or excluded under this Health Plan; and rendered while this Health Plan is in force.

Types of Care	Special Limits/Circumstances
Ambulance • Ambulance service to the nearest hospital • Ambulance service to a covered person's home or skilled nursing facility • Ambulance service from a hospital which is unable to provide proper care to the nearest hospital that can provide proper care	*For services by boat, airplane or helicopter* • When the pick-up point is inaccessible by ground transportation • When the travel distance involved in getting the covered person to the nearest hospital that can provide proper care is too far for medical safety • When speed in excess of ground vehicle speed is critical
Anesthesia services	• Both inpatient and outpatient
Cancer Services • Diagnosis and Treatment	• Includes both inpatient and outpatient diagnostic tests and treatment except for experimental or investigational treatments
Cleft Lip and Cleft Palate	

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

• Treatment and services for children under 18 years, including medical, dental, speech therapy, audiology and nutrition services only as specified by statute.	
Contraceptive Supplies • Insertion and removal of IUD • Diaphragm • Insertion and removal of contraceptive implants • Contraceptive injections	
Cosmetic Surgery • Plastic & reconstructive • Reduction mammoplasty	• Repair or alleviation of damage if such treatment or surgery is the result of an accident. • For correction of a congenital anomaly for an eligible dependent. • Correction of an abnormal bodily function. • For an area of the body which was altered by the treatment of a disease. • All stages of reconstruction of a breast on which a mastectomy was performed in accordance with federal law. However, if there is no evidence of malignancy, such reconstruction and initial prosthetic device shall only be covered if received within two years after the date of the mastectomy.
Doctor's Care • Office visits • Medical treatment in hospital or outpatient facility or surgery (other than office visit) includes anesthesia services; concurrent physician care (surgical assistance provided by another physician) and consultations • Child health supervision services • Adult preventive medical services • Allergy treatment – including testing, desensitization therapy and allergy immunotherapy, which includes hyposensitization serum when administered by a health care	*For Concurrent Physician Care and Consultations:* *For surgical assistance:* • The additional physician must actively participate in the treatment and: the condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted; the physicians have different specialties or have the same specialty with different sub-specialties and; must be authorized by the covered person's PCP or the Health Plan.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

provider.

- Diagnostic procedures, lab tests or x-rays, including their interpretation, for the treatment of a covered condition.

For Consultations:

- PCP must request the consultation
- Consulting physician shall prepare a written report.

For child health supervision services:

Medical services and supplies include:

- newborn's first examination in the hospital
- periodic examinations which shall include a history and physical examination, developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child
- oral and/or injectable immunizations
- laboratory tests normally performed for a well child
- evaluation and management counseling and/or risk factor reduction intervention for covered dependents without symptoms or established illnesses
- hearing screenings
- vision screenings

These services shall conform with prevailing medical standards and shall not be less than 18 visits at approximately the following age intervals:

- birth
- 2,4,6,9,12,15 and 18 months
- 2,3,4,5,6,8,10,12,14 and 16 years

Adult preventive medical services include:

- Health history
- laboratory tests (e.g., urinalysis, hemoglobin, and hematocrit, stool for occult blood, sexually transmitted diseases, etc.)
- physical examination
- vision – routine (eye chart), or refractive eye exams and
- hearing screenings
- tuberculin skin test
- routine male and female screening exams and tests (e.g., pap

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

	smear, pelvic exam, prostate gland screening) – limited to one exam per calendar year
Durable Medical Equipment • At the Health Plan's option, the rental or purchase of medical equipment and medical supplies for the care and treatment of a condition covered under this Health Plan, which includes: - Trusses, braces, walkers, canes, crutches, casts and splits - Occlusal guards, bite or dental splints, repositioning devices, and TMJ study models for the treatment of temporomandibular joint (TMJ) syndrome - Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products - Oxygen and rental of equipment for the administration of oxygen, iron lung or other mechanical equipment for the treatment of respiratory paralysis - Ambulatory home uterine activity monitoring devices (AHUM) - Wheelchairs, hospital beds, lumbar-sacral-orthosis (LSO) and thoracic-lumbar-sacral-orthosis (TLSO) braces, and traction equipment - Other medical equipment and supplies as determined to be medically necessary	*Durable Medical Equipment:* • Shall not serve as a comfort, hygiene or convenience item. • Shall not be used for the sole purpose of exercise. • Shall not be used by any other party. • Shall have been manufactured specifically for medical use. • Shall not include shoe buildups, shoe orthotics, shoe braces or shoe supports unless the shoe is attached to a brace. • Shall not include water therapy devices, modifications to motor vehicles and/or homes or similar items.
Eye Care • Routine or refractive eye examinations as part of the adult preventive medical care or child health supervision services benefit	*For eyeglasses or contact lenses* • Limited to the first pair following an accident to the eye or cataract surgery. • Includes the examination for the prescribing or fitting thereof *For treatment of a covered condition:* • Aphakic patients and soft lenses or sclera shells

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

	• Following an injury, disease or accident.
Family Planning Services	Includes counseling and information on birth control, sex education and the prevention of sexually transmitted diseases.
Hemodialysis for Renal Disease	Includes equipment, training and medical supplies for home dialysis and dialysis centers.
Home Health Care • Services by a home healthcare agency for a covered person confined and convalescing at home for a covered condition. • *Home health care services include:* • Part-time, intermittent or continuous nursing care by registered nurses, or licensed practical nurses, nurse registries or home health agencies; • Physical, speech, occupational and respiratory therapy; and infusion therapy • Medical applicances, equipment, laboratory services, supplies, drugs, and medicines prescribed by the treating physician and other covered services provided by or for a home health care agency, through a licensed nurse registry, or by an independent nurse licensed under Chapter 464, Florida Statutes, to the extent that they would have been covered if the covered person had been confined in a hospital.	*For approval of home health care services by your PCP or the Health Plan:* • The treating physician must submit a home health care plan of treatment to your PCP. • The plan of treatment must document that home health care is medically necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and • Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility. *Services which shall not be covered under this benefit include:* • Any service that would not have been covered had the covered person been confined in a hospital. • Services which are solely for the convenience of the covered person. • Physical therapy is subject to outpatient limitations described under rehabilitative services.
Hospice Care • In-home care - Physician services - Physical, respiratory, massage, speech and occupational therapy if approved by the Health Plan - Medical supplies, drugs and appliances - Home health aide services - Part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) or private duty nursing service - Oxygen	*Hospice treatment program shall* • Meet the standards outlined by the National Hospice Association; • Be recognized as an approved hospice program by the Health Plan; • Be licensed, certified, and registered as required by Florida law; and • Be directed by the covered person's PCP or the Health Plan and coordinated by a registered nurse with a treatment plan that provides an organized system of hospice facility care, uses a hospice team, and has around-the-clock care available.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

- Infusion therapy • Hospice inpatient care - Room and board and general nursing care - Inpatient care services same as inpatient hospital care - Same covered services as in-home and outpatient hospice care - Includes care for pain control or acute chronic symptom management • Hospice outpatient care - Physician services - Laboratory, x-ray, and diagnostic testing - Ambulance service - Same covered services as in-home hospice care	*For hospice care:* • Treatment for and counseling of terminally ill patients whose doctor has certified that they have less than one year to live • Primary care physician (PCP) must submit a written hospice care plan or program; and • PCP must submit a life expectancy certification. • All hospice care expenses shall be approved in writing by the Health Plan • While in the hospice program, regular plan benefits are not payable for expenses related to the terminal illness. *These following services are not covered under this Health Plan:* • Social work services • Bereavement and pastoral • Financial • Legal • Dietary counseling • Day care • Homemaker and chore services • Funeral services
Hospital Inpatient Care • Hospital room, board and general nursing care for a semi-private room unless the Health Plan determines that a private room is medically necessary • Room, board and treatment in an intensive, progressive, cardiac or neonatal care unit	• Services and supplies must be furnished at a network hospital and must be authorized by the primary care physician or Health Plan in order to be covered. Exceptions to this include emergency services and other special circumstances, as approved by the Health Plan.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

• Other necessary services and supplies, for example: - use of operating room, labor room, delivery room and recovery room - Use of covered drugs and medicines used by patient - Intravenous solutions, including glucose - Dressings, ordinary casts, splints and trusses - Anesthesia and related supplies - Transfusion supplies and services including blood, blood plasma and serum albumin, if not replaced - respiratory therapy, including oxygen - diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms - basal metabolism examinations - x-ray, including therapy - diathermy - all covered rehabilitative services	• Excludes services and supplies provided when the covered person is admitted to a hospital or other facility primarily to provide rehabilitative services.
Immunizations	• Includes flu shots
Mammograms • Breast cancer screening • Diagnosis	*For mammograms:* • One baseline mammogram for women age 35 through 39 • One mammogram every two years – ages 40 through 49 • One mammogram every year – age 50 and over • At any age if deemed medically necessary
Maternity Care • Pre-natal and post-natal care and monitoring of the mother • Delivery in a hospital or birth center • Postpartum care • Newborn care and assessment, including initial exam from	*For maternity care:* • Maternity care is not covered for dependent children who become pregnant, except for certain pregnancy complications and care of the newborn. (See *Pregnancy Complications and Care of the Newborn)*

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

pediatrician • Medically necessary clinical tests and immunizations • Routine well-baby nursery services • Midwife services	• Covered hospital stays for the mother and newborn child will be no less than - 48 hours for a normal delivery - 96 hours for a Cesarean-section delivery unless agreed to by the provider and the patient
Mental Health, Alcoholism and Substance Abuse Care • Inpatient – hospital, specialty institution, or residential facility • Outpatient – alcoholism & substance abuse • Treatment program must be accredited by the Joint Commission on Accreditation of Hospitals or approved by the state. • Providers must be licensed in accordance with applicable law	*For inpatient care:* • Alcoholism and substance abuse care is limited to a maximum of 31 days per calendar year total including detox. • Mental health and nervous disorders treatment is limited to a maximum of 31 days per calendar year total. *For outpatient care:* • Mental health and nervous disorders treatment is limited to a maximum of 26 visits per calendar year total and includes diagnostic evaluation and psychiatric treatment, and individual and group therapy. • For learning and behavioral disabilities or mental retardation, coverage is limited to evaluation and diagnosis. • No coverage is provided for marriage counseling, court ordered care or testing or required as a condition of parole or probation, testing for aptitude, ability, intelligence or interest.
Nutrition Counseling	
Nursing Services • Nursing care by a registered nurse (RN) or licensed practical nurse (LPN)	*For nursing care:* • Includes inpatient private duty nursing when authorized by the Health Plan • Includes home health care services and hospice services
Oral Surgery • Surgical treatment of non-dental injury to teeth, fractured or	

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

dislocated jaw, excision of tumors, cysts, abscesses and lesions of the mouth and surgical treatment of temporomandibular joint (TMJ) syndrome

- Services related to an accident or injury occurring while, and as a result of, biting or chewing.

Organ Transplants

Services, care and treatment received for or in connection with the approved transplantation of the following human tissue and organs:

- Heart
- Heart/lung
- Lung
- Liver
- Kidney
- Kidney/pancreas
- Bone marrow
- Cornea

Covered Services include:

- Hospital and medical expenses in accordance with the same terms and conditions as the Health Plan shall pay benefits for care and treatment of any other covered condition; and
- Organ acquisition and donor costs.
  However, donor costs shall not be payable under this Health Plan if they are payable in whole or in part by any other insurance health plan, organization or person other than the donor's family or estate.

To continue reading, go to right column on this page.

For organ transplants:

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation.

To have a transplant covered:

- Prior approval for the transplant must be obtained by the covered person's PCP from the Health Plan in advance of the covered person's initial evaluation for the procedure.
- The Health Plan shall be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval shall be based on written criteria and procedures established by the Health Plan.
- The facility in which the pre-transplant services, transplant services, transplant procedure and post-discharge services will be performed must be licensed as a transplant facility and authorized by the Health Plan.

For bone marrow transplants:

- Includes the harvesting, transplantation and chemotherapy components.
- Donor costs are covered in the same way as costs for the covered person, including limitations and non-covered services.

Transplant services shall not be covered when:

- Expenses are eligible to paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received;

To continue reading, go to left column on next page.

	• The expense relates to the transplantation of any non-human organ or tissue; • The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ; • The organ is sold rather than donated to the covered person; • The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan except in the case of the donor costs for bone marrow transplants; or • A denied transplant is performed; this includes follow-up care, immunosuppressive drugs, and complications of such transplant. *The following services and supplies shall not be covered:* • Artificial heart devices used as a bridge to transplant; • Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use; and • Any service or supply in connection with identification of a donor from a local, state, or national listing.
Outpatient Care • Treatment as an outpatient in a hospital, a health care provider's office, an ambulatory surgical center or other licensed outpatient healthcare facility • Clinical laboratory services • Services for outpatient surgery and outpatient treatment of an injury	• Includes medically necessary supplies provided or used by the facility during the surgery or treatment, such as: - use of operating room, and recovery room - use of covered drugs and medicines used by the patient - intravenous solutions, including glucose - dressings, ordinary casts, splints and trusses - anesthesia, related supplies and their administration - transfusion supplies and services including blood, Blood plasma and serum albumin, if not replaced

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

	- respiratory therapy, including oxygen - diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms - basal metabolism examinations - x-ray, including therapy - diathermy - services provided by a birthing center licensed pursuant to section 383.30-383.335, Florida Statutes - other covered necessary services and supplies
Pathologist services	Both inpatient and outpatient
Pre-admission tests	• Tests shall be ordered or authorized by the covered person's PCP; and • Tests shall be performed in a facility accepted by the hospital and the Health Plan in lieu of the same tests which would normally be done while hospital confined.
Prostheses and Orthotic Devices • Initial placement of the most cost effective prosthetic or orthotic device, fitting, adjustments and repair.	*For prostheses and orthotic devices:* • Replacements covered if due to growth or change and approved by the Health Plan as medically necessary. • Shoe orthotics shall be covered only when attached to a brace.
Radiologist Services	• Both inpatient and outpatient
Rehabilitative Services • Spine and back disorder treatment • Manipulative services • Physical therapy • Speech therapy	*For Rehabilitative Services* • Requires Health Plan approval of a written plan of treatment • Agreement that the covered person's condition should improve significantly within 60 days of the date therapy begins • Outpatient rehabilitative services limited to 60 visits per

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

All services shall be provided by licensed therapists, chiropractors and physicians for the purpose of aiding in the restoration of normal physical function.	injury; inpatient rehabilitative services limited to the duration of hospital confinement. Rehabilitative services shall not be covered when: • The covered person was admitted to a hospital or other facility primarily for the purpose of providing rehabilitative services; or • The services or supplies maintain rather than improve a level of physical function, or where it has been determined that the services shall not result in significant improvement in the covered person's condition within a 60 day period.
Respiratory Therapy • Services of respiratory or inhalation therapists • Oxygen	• Inpatient or outpatient basis
Second Medical Opinions May be requested by the covered person or the Health Plan for: • Elective surgery • When the appropriateness or necessity of a covered surgical procedure is questioned • Serious injury or illness	The covered person: • Must provide prior notice to the Health Plan. • May obtain the opinion from <u>any</u> licensed physician within the Health Plan's service area. The use of second medical opinions in connection with a particular diagnosis or treatment may be restricted to a maximum of three per calendar year. • All necessary tests for the second medical opinion may be conducted by participating providers. • The Health Plan shall review the second medical opinion, once rendered, and determine the treatment obligations of the Health Plan. That judgment shall be controlling. Any treatment obtained that is not authorized by the Health Plan shall be at the covered person's expense. Covered expenses for the second opinion: • If a participating physician is selected, the only costs to the covered person will be the applicable copayment. • If a non-participating physician is selected, the Health Plan

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

	shall pay 60 percent of the usual and customary charges for those services in the community in which they were rendered as determined by the Health Plan and the covered person shall be responsible for the remainder of the fee.
Skilled Nursing Facility Care • Room, board and general nursing care • Services and supplies for necessary treatment	*For skilled nursing facility care:* • PCP or Health Plan approval of a written plan of treatment. • Patient must require skilled care for a condition (or related condition) which was treated in the hospital and such are can be provided at a skilled nursing facility in lieu of hospitalization or continued hospitalization. • Patient shall be admitted to the facility immediately following discharge from the hospital. • Skilled nursing care or services are provided on a daily basis • Limited to 60 days of confinement per calendar year. • Services shall be ordered by and provided under the direction of a physician.
Surgical Procedures	• Inpatient or outpatient basis
Surgical Procedures	• Limited to tubiligations and vasectomies.

Pregnancy Complications and Care of the Newborn

Maternity care in connection with the pregnancy of eligible children due to the following complications of pregnancy are covered by the Health Plan:

- Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy;
- Conditions that are caused by pregnancy, such as acute nethritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
- A non-elective cesarean section;
- An ectopic pregnancy which is terminated; and
- A spontaneous termination of pregnancy, which occurs before the twenty-second (22nd) week of gestation.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

NOTE: Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy which do not constitute a nosologically distinct complication of pregnancy.

Newborn Care

Coverage for the newborn child of an eligible dependent will be terminated 18 months after the birth of the newborn.

This coverage shall include:

- Coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity
- the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. Such transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.

Coverage for the newborn child of a mother who does not convert to family coverage within the prescribed time period is limited to well-baby hospital nursery services.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	$1,250 per Covered Person per calendar year, not to exceed $2,500 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	$3,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family.
Maximum Contract Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Contract.	No Maximum Contract Benefit.

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed including transportation costs of a newborn to and from the nearest appropriate facility to treat the newborn's condition up to a maximum of $1,000 per transport. The transportation must be certified by the attending Physician to protect the health and safety of the newborn.	*Ground Transportation:* 20% *Air Transportation:* 20%	Yes	Yes
2. Bones or Joints of the Jaw and Facial Region Health Services for diagnostic and surgical procedures involving bones or joints of the jaw and facial region to treat conditions caused by congenital or developmental deformity, Sickness or Injury. **Note:** Covered Health Services do not include care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services.		
3. Child Health Supervision Services Benefits from the moment of birth to age 16 for periodic visits including medical history, physical examinations, developmental assessments and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards	Same as Physician's Office Services, Professional Fees, and Outpatient Surgery, Diagnostic and Therapeutic Services.		No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Benefits are limited to one visit payable to one provider for all of the services provided at each visit.			

4. Cleft Lip/Cleft Palate Treatment

Benefits for the treatment of cleft lip and cleft palate for any Covered Person under the age of 18. This includes medical, dental, speech therapy, audiology and nutritional Covered Health Services under the direction of a Physician.

Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services and Rehabilitation Services - Outpatient Therapy.

5. Dental Procedures - Anesthesia and Hospitalization

Covered Health Services including hospitalization expenses and anesthesia in a Hospital or Alternate Facility for dental conditions likely to result in a medical condition if left untreated. Treatment is limited to a Covered Person who:

- Is under 8 years of age and is determined by a dentist and a Network Physician to require dental treatment in a Hospital or Alternate Facility due to a complex dental condition or a developmental disability that prevents effective treatment in a dental office; or
- Has one or more medical conditions that would create undue medical risk if dental treatment were rendered in a dental office.

Coverage does not include expenses for the diagnosis and treatment

Same as Professional Fees, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
of dental disease.			
6. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not	20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. Please remember that you must notify us as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.)			
7. Diabetes Treatment Diabetes equipment, supplies and diabetes self-management training and educational programs when provided by or under the direction of a Physician. Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies.	Same as Physician's Office Services, Professional Fees, Outpatient Surgery, Diagnostic and Therapeutic Services, Durable Medical Equipment.		
8. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet	20%	Yes	Yes

your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every 3 calendar years. We will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Equipment from the vendor we identify. The calendar year limit shown above does **not** apply to Durable Medical Equipment classified as diabetic supplies and covered under Diabetes Treatment.			
9. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).	20%	Yes	No
10. Eye Examinations Eye examinations received from a health care provider in the provider's office. Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider each calendar year. Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.	20%	Yes	Yes
11. Home Health Care Services received from a Home Health Agency that are both of the following:	20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

No Visit Limitations

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card. Benefits are limited to 360 days during the entire period of time you are covered under the Contract.	20%	Yes	Yes
13. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services.*	20%	Yes	Yes
14. Injections received in a Physician's	20% per injection	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Office

Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

---

15. Mammography

	Your Copayment Amount	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Mammography	No Copayment	No	No

Benefits under this section include:

- One baseline screening mammogram for women age 35-39;
- One baseline screening mammogram every two years (or more frequently, based on the recommendation of the treating Physician), for women age 40-49;
- An annual screening mammogram for women age 50 and older; and
- One or more mammograms per year, based on the Covered Person's Physician's recommendation, for any woman who is at risk for breast cancer due to:
  - — a personal or family history of breast cancer;
  - — a history of biopsy-proven benign breast disease;
  - — having a mother, sister or daughter who has had breast cancer; or
  - — a woman not having given birth before the age of thirty (30).

Except for mammograms done more frequently than every two years for women 40 years of age or older, but younger than 50 years of age, benefits are payable when, with or without a prescription

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
from a Physician, the Covered Person obtains a mammogram in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the Department of Health for breast cancer screening. Benefits are not subject to the Calendar Year Deductible and Coinsurance Percentage provisions, but are subject to all other terms and conditions applicable to other benefits.			
16. Mastectomy Mastectomy means the removal of all or part of the breast for medical reasons as determined by a Physician. Mastectomy coverage includes confinements for any period, determined by the treating Physician, in accordance with prevailing medical standards and after consultation with the Covered Person. Outpatient post surgical follow-up care is also covered in accordance with prevailing medical standards by a licensed healthcare professional qualified to provide postsurgical mastectomy care. The treating Physician, after consultation with the Covered Person, may choose that the outpatient care be provided at the most appropriate setting, which may include a Hospital, Physician's office, outpatient center or home of the Covered Person.	Same as Physician's Office Services, Professional Fees for Surgical and Medical Services, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.		
17. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications provided by certified nurse-midwives, midwives licensed according to state law and licensed birthing	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

centers.

Post delivery care includes a postpartum assessment and a newborn assessment. Post delivery care may be provided at a Hospital, an outpatient maternity center or in the home by a qualified licensed health care professional.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Maternity Services will not be limited for those services that have been determined to be medically appropriate.

Description of Covered Health Service	Your Copayment Amount	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Mental Health and Substance Abuse Services - Outpatient	20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health and Substance Abuse Services. Benefits for Mental Health Services and/or Substance Abuse Services are limited to 30 visits per calendar year. **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.			
19. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will arrange for the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services.	20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Benefits for Mental Health Services and/or Substance Abuse Services are limited to 31 days per calendar year.

Authorization Required

Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card.

Without authorization, you will be responsible for paying all charges and no Benefits will be paid.

20. Osteoporosis Treatment

Coverage is provided for services related to diagnosis, treatment, and appropriate management of osteoporosis for high-risk individuals. Services include, but are not limited to, all Food and Drug Administration-approved technologies, including bone mass measurement as recommended by the Physician.

Same as Physician's Office Services, Professional Fees, and Outpatient Surgery, Diagnostic and Therapeutic Services.

21. Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Your Copayment Amount	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20%	Yes	Yes

Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon's fees related to outpatient

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
surgery are described under *Professional Fees for Surgical and Medical Services*. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.			
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/Xray. Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.	***For lab and radiology/Xray:*** No Copayment	No	No
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Outpatient Therapeutic Treatments Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	20%	Yes	Yes
22. Physician's Office Services **Covered Health Services for preventive medical care. Preventive medical care includes:** • Voluntary family planning. • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.) • Immunizations.	No Copayment	No	No
Covered Health Services for the diagnosis and treatment of a	20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Sickness or Injury received in a Physician's office.			
23. Prescription and Non-prescription Enteral Formulas Including low protein food products for home use when prescribed or recommended by a Physician for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein for Covered Persons through the age of 24. Coverage of low protein food products is limited to $2,500 per calendar year.	20%	Yes	Yes
24. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	20%	Yes	Yes
25. Prosthetic Devices External prosthetic devices that replace a limb or an external body	20%	Yes	Yes

part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every 3 calendar years.

Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to $0 per calendar year. This limit applies to the total amount that we will pay for the prosthetics, and does not include any Copayment or Annual Deductible responsibility you may have.

Once this Benefit limit is reached, no additional Benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.

26. Reconstructive Procedures

Same as Physician's Office Services, Professional Fees,

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast cancer, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.	Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
27. Rehabilitation Services - Outpatient Therapy	20%	Yes	Yes

27. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Benefits are limited as follows:

- 60 visits of physical therapy per calendar year.
- 60 visits of occupational therapy per calendar year.
- 60 visits of speech therapy per calendar year.
- 60 visits of pulmonary rehabilitation therapy per calendar year.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• 60 visits of cardiac rehabilitation therapy per calendar year.			
28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits are limited to 60 days per calendar year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.	20%	Yes	Yes
29. Spinal Treatment Benefits for Spinal Treatment when provided by a Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Benefits for Spinal Treatment are limited to 60 visits per calendar year.	20%	Yes	Yes
30. Transplantation Services	20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The reasonable costs of searching for the donor may be limited to immediate family members and the National Bone Marrow Donor Program.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.

Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.			
31. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section. To ensure prompt and accurate payment of your claim, notify us within two business days after you receive care at an Urgent Care Center outside the Service Area.	20%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:
- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Contract.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

To continue reading, go to right column on this page.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: What's Covered--Benefits) or through a Rider to the Contract. If this is the case, any Exclusion of such a service, treatment, item or supply shown in this section does not apply.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners.
   - Air purifiers and filters.
   - Batteries and battery chargers.
   - Dehumidifiers.
   - Humidifiers.
6. Devices and computers to assist in communication and speech.

To continue reading, go to left column on next page.

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident only* and *Cleft Lip/Cleft Palate Treatment*.
2. Preventive care, diagnosis, treatment of or related to the teeth or gums. Examples include all of the following:
   - Extraction, restoration and replacement of teeth.
   - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - Transplant preparation.
   - Initiation of immunosuppressives.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.
   - Dental care described in (Section 1: What's Covered--Benefits) under the heading *Dental Procedures - Anesthesia and Hospitalization*.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly except in connection with cleft lip or cleft palate.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications except as described in (Section 1: What's Covered--Benefits) under the heading *Diabetes Treatment*.

To continue reading, go to right column on this page.

3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded except (a) bone marrow transplants and (b) medically appropriate medications prescribed for the treatment of cancer, for a particular indication, if that drug is recognized for the treatment of that indication in a standard reference compendium or recommended in the medical literature. The fact that an Experimental, Investigational, or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses).
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.

To continue reading, go to left column on next page.

6. Shoe orthotics.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Syringes except as described in (Section 1: What's Covered--Benefits) under the heading *Diabetes Treatment*.
3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that

To continue reading, go to right column on this page.

will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/ Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/ Substance Abuse Designee.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

   The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

To continue reading, go to left column on next page.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups, except as described in (Section 1: What's Covered--Benefits) under the heading *Diabetes Treatment*.
3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk except as described in (Section 1: What's Covered--Benefits) under the heading *Prescription and Non-prescription Enteral Formulas*.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms). Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

To continue reading, go to right column on this page.

5. Wigs regardless of the reason for the hair loss.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

1. Health services for which other coverage is paid under arrangements required by federal, state or local law. This

To continue reading, go to left column on next page.

includes, but is not limited to, coverage paid by workers' compensation, no-fault automobile insurance or similar legislation.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Contract.)
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in (Section 1: What's Covered--Benefits).

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

To continue reading, go to right column on this page.

P. Vision and Hearing

1. Purchase cost of eye glasses, contact lenses, or hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Contract when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Contract ends, including health services for medical conditions arising before the date your coverage under the Contract ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Contract.

To continue reading, go to left column on next page.

6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature except as described in (Section 1: What's Covered--Benefits) under the heading *Bones or Joints of the Jaw and Facial Region*.
8. Surgical and non-surgical treatment of obesity, including morbid obesity, unless deemed medically necessary and approved by the Plan.
9. Growth hormone therapy.
10. Sex transformation operations.
11. Custodial Care.
12. Domiciliary care.
13. Private duty nursing.
14. Respite care.
15. Rest cures.
16. Psychosurgery.
17. Treatment of benign gynecomastia (abnormal breast enlargement in males).
18. Medical and surgical treatment of excessive sweating (hyperhidrosis).
19. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
20. Oral appliances for snoring.
21. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cleft lip/cleft palate or a Congenital Anomaly.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Section 3: Obtaining Benefits

This section includes information about:

- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the Service Area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse*.

To continue reading, go to right column on this page.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You will be given a directory of Network providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Customer Service.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

*Care Coordination*SM

Your Network Physician is required to notify us regarding certain proposed or scheduled health services. When your Network Physician notifies us, we will work together to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease

To continue reading, go to left column on next page.

management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify us. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify us, we will provide you the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or other provider chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by us.

You or your Network Physician must notify us of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Your right to a Second Opinion

You have the right to seek a second medical opinion whenever you disagree with either our or the Network Physician's opinion of the reasonableness or necessity of surgical procedures or with the prescribed treatment for a serious injury or illness.

To continue reading, go to right column on this page.

At any time you may seek a second opinion from another Network Physician. Covered Health Services in connection with a second opinion are subject to the applicable copayments and limitations in Section 1. You may also seek a second opinion from a non-Network Physician who is located within the Service Area. You may be subject for up to 40% of Eligible Expenses you incur for services received from a non-Network Physician. Any tests or diagnostic procedures related to a second opinion must be provided by Network providers or otherwise arranged by us.

After review of the second opinion, we have the sole responsibility of making a final decision regarding coverage of any services in question. If, in our judgement, you have over-utilized the second opinion privilege (such as requesting more than three second opinions in a calendar year), we may deny coverage for services resulting from a second opinion. If we deny coverage, you may appeal that decision as described in Section 6 of this Certificate.

Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, we will pay Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

To continue reading, go to left column on next page.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you. If you fail to use the selected Network Physician, Benefits for Covered Health Services will not be paid.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider. You are not required to notify us or get prior approval from us to use non-Network Emergency Health Services.

- If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be available.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the properly completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

You should notify us within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Benefits are available only if you receive Covered Health Services from Network providers.

To continue reading, go to right column on this page.

If you have prior coverage which has been required by state law to extend benefits for a particular condition or a disability as defined by state law, Benefits for the condition or disability will not be paid under the Contract until your prior coverage is exhausted.

To continue reading, go to left column on next page.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see (Section 10: Glossary of Defined Terms). Eligible Persons must reside or work within the Service Area, which is a specific geographic area that we serve. If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	We and the Enrolling Group determine who is eligible to enroll under the Contract.
Dependent	Dependent generally refers to the Subscriber's spouse and children but may also include the newborn child of any covered Dependent other than the Subscriber's spouse in accordance with state law. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Contract. If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent. Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll without our written permission.	We and the Enrolling Group determine who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period When the Enrolling Group purchases coverage under the Contract from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified in this Certificate if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	We and the Enrolling Group determine the Open Enrollment Period. Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date agreed to by the Enrolling Group and us if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.
Adding New Dependents	Subscribers may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption.	For Marriage, Placement for foster care, Legal guardianship or Court or administrative order, coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

When to Enroll	Who Can Enroll	Begin Date
	• Placement for foster care. • Marriage. • Legal guardianship. • Court or administrative order.	For Birth, coverage begins at the moment of birth. For Legal adoption or Placement for adoption, coverage begins on the date of placement. For newborns and adopted children, no premium will be charged for the first 31 days if written notice to enroll the new dependent is given within 31 days of the event. In the case of newborn and adopted dependents, if the Subscriber fails to enroll the new dependent within 31 days, but enrolls the new dependent within 63 days of the event, the Subscriber will be required to pay an additional premium from the date of birth or placement. If written notice is given within 63 days of the date of birth or placement, coverage will not be denied for failure to timely notify or to pre-enroll the dependent. If written notice is not given within 63 days of birth or placement, the newborn or adopted child may be enrolled during the next Open Enrollment Period. This provision also applies to the newborn child of any covered Dependent other than the Subscriber's spouse. Coverage for such a Dependent's newborn child ends 18 months after the date of birth.
Special Enrollment Period An Eligible Person and/or Dependent may also be able to enroll	A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:	**Event Takes Place** (for example, a birth or marriage). Coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days

When to Enroll	Who Can Enroll	Begin Date
during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.	• Birth. • Legal adoption. • Placement for adoption. • Marriage. A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true: • The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and • Coverage under the prior plan ended because of any of the following: — Loss of eligibility (including, without limitation, legal separation, divorce or death). — The employer stopped paying the contributions. — In the case of COBRA continuation coverage, the coverage ended.	of the event. **Missed Initial Enrollment Period or Open Enrollment Period.** Coverage begins on the day immediately following the day coverage under the prior plan ends if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting the Annual Deductible and for paying Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-

To continue reading, go to right column on this page.

Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require as described below.

You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

A. The Subscriber's name and address.

B. The patient's name and age.

C. The number stated on your ID card.

D. The name and address of the provider of the service(s).

E. A diagnosis from the Physician.

F. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.

G. The date the Injury or Sickness began.

H. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

After receiving the required information above, we will reimburse all claims or any portion of any claim from a Subscriber or a

To continue reading, go to left column on next page.

Subscriber's assignees, for payment under the Contract, within 20 days after we receive an electronic claim or 40 days after we receive a non-electronic claim. If we contest a claim or a portion of a claim, the Subscriber or the Subscriber's assignees will be notified, in writing, that the claim is contested or denied, within 20 days after we receive the claim. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested from the Subscriber or the Subscriber's assignees, we will pay or deny the contested claim or portion of the contested claim, within 60 days.

We will pay or deny any claim no later than 120 days after receiving electronic claims or 140 days after receiving non-electronic claims.

Payment will be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

All overdue payments will bear simple interest at the rate of 12 percent per year.

Upon written notification by a Subscriber, we will investigate any claim of improper billing by a physician, hospital, or other health care provider. The Subscriber will determine if the billing was only for those procedures and services that were actually received. If we determine that the Subscriber has been improperly billed, we will notify the Subscriber and the provider of its findings and will reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the Subscriber, we will pay to the Subscriber 20 percent of the amount of the reduction, up to $500.

To continue reading, go to right column on this page.

Reimbursement of Excess Copayments

The amount you are required to pay in Copayments is limited as stated in the Out-of-Pocket Maximum explanation in (Section 1: What's Covered--Benefits). Because Copayments are paid directly to the Network provider, we may not know that you have exceeded the Out-of-Pocket Maximum. We will reimburse the Subscriber for Copayments for Benefits paid that exceed the Out-of-Pocket Maximum stated in (Section 1: What's Covered--Benefits).

To be reimbursed for excess Copayments, the Subscriber must notify us in writing that excess Copayments have been paid. We must receive this notice no later than 90 days after the end of the calendar year. The notification must include proof of the payment of all Copayments, such as a cancelled check or a receipt from the provider.

To continue reading, go to left column on next page.

Section 6: Questions, Complaints, Grievances

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a Complaint.
- We notify you that we will not be paying a claim because we have determined that a service or supply is excluded under the Contract.

To resolve a question, complaint, or Grievance involving **Network** Benefits, just follow these steps:

What to Do First

Contact Our Customer Service Department

The telephone number is shown on your ID card.

Customer Service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A Customer Service representative will return your call. If you would rather send your

To continue reading, go to right column on this page.

complaint to us in writing at this point, the Customer Service representative can provide you with the appropriate address.

What to Do Next

Our authorized representative will attempt to address the concern through informal discussions. If the issue is not resolved through informal discussions, you may file a Grievance and/or request an appeal according to the instructions shown below.

You will receive a written acknowledgment of your Grievance within five business days after receipt.

If your Grievance does NOT concern an Adverse Determination about Benefits:

- You have up to one year after the date of occurrence of the action that is the focus of the Complaint to submit a Grievance.
- Your Grievance should be sent to us at the following address:

  National Appeals Service Center
  Florida Team
  P.O. Box 659773
  San Antonio, TX 78265

Your Grievance will be resolved:

a. within 60 days after the date the Grievance is received, unless you agree to extend the time frame, or

b. within 90 days in the event the Grievance involves the collection of information outside the Service Area.

To continue reading, go to left column on next page.

The time limitations prescribed in this paragraph are deferred when we notify you in writing that additional information is required from outside the Service Area, for proper review of the Grievance, and that such time limitations are deferred until such information is received. After we receive the requested information, the time allowed for completion of the grievance process resumes.

You have the right to contact the Agency for Health Care Administration in writing at, 2727 Mahan Dr., Tallahassee, FL 32308, at any time during the process or by calling 1-888-419-3456.

If your Grievance concerns an Adverse Determination about Benefits, determine which of the categories below applies to your situation.

What to Do if You Disagree with Our Decision About Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care.

- If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from us within 15 days of receipt of the claim.
- If you filed a pre-service claim improperly, we will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received.
- If additional information is needed to process the pre-service claim, we will notify you of the information needed within 15 days after the claim was received.
- **Extension:** we may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received.
- If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

To continue reading, go to right column on this page.

Note: If you have prescription drug benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health claim in accordance with the applicable claim filing procedure. When you have filed a claim, your claim will be treated under the same procedures for pre-service group health plan claims as described in this section.

What to Do if You Disagree with Our Decision About Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received.

- If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim.
- We will notify you within this 30-day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information.
- If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received.

To continue reading, go to left column on next page.

- If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Note: If you have prescription drug benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Contract, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

What to Do if Your Complaint or Grievance Concerns Urgent Claims that Require Immediate Attention

Your Complaint requires immediate action when your Physician judges that a delay in treatment would significantly increase the risk to your health or your ability to regain maximum function, or could cause you severe pain, In these urgent situations:

- A Grievance or Complaint adverse decision may be submitted orally or in writing. You or your Physician should call us as soon as possible. Please note that unless it is submitted in writing, the request for review will be considered an appeal of a utilization decision and not a Grievance.
- We will notify you of the decision within 72 hours after your Grievance or Complaint is received. A written or electronic confirmation of the decision will be mailed within three days

To continue reading, go to right column on this page.

from the date of the decision. The written or electronic confirmation will advise you or the Provider acting on your behalf of the right to submit the Grievance to the Statewide Provider and Provider Assistance Program if the final decision is to uphold the original determination.

Additional Information: If additional information is needed to process the claim, we will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

The Grievance process for urgent situations does not apply to prescheduled treatments, therapies, surgeries or other procedures that we do not consider urgent situations.

If you are not satisfied with our decision, you have the right to take your Grievance to the Statewide Provider and Subscriber Assistance Program.

To continue reading, go to left column on next page.

What to Do if Your Complaint or Grievance Concerns Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent claim as defined above, your request will be decided upon within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

- We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.
- If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described above.
- If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Claim Decision

If you disagree with our decision after following the above steps, you can ask us in writing to formally reconsider your Grievance.

If the Grievance relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).

To continue reading, go to right column on this page.

- The provider's name.
- The reason you believe the claim should be paid.
- Any new information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. There are no fees for appeals.

Appeals Determinations

Pre-service and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of **pre-service claims** as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

To continue reading, go to left column on next page.

- For appeals of **post-service claims** as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see *Urgent Claim Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not benefits are available under the Contract for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your physician.

We will appoint a committee to resolve or recommend the resolution of the Grievance. If your Grievance is related to clinical matters, the committee will include health care professionals who did not make the first determination. We may consult with, or seek the participation of, medical experts as part of the Grievance resolution process.

The committee will meet to resolve your Grievance within 30 days of receiving your request. The committee will review testimony, explanations or other information that it decides is necessary for a fair review of the Grievance.

We will send you written notification of the committee's decision within 5 business days of the review. If you are still not satisfied with our decision, you have the right to take your Grievance to the

To continue reading, go to right column on this page.

Statewide Provider and Subscriber Assistance Program in writing at 2727 Mahan Dr., Tallahassee, FL 32308, or by calling (850) 921-5458, after receiving our final disposition.

Please note that our decision is based only on whether or not Benefits are available under the Contract for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

To continue reading, go to left column on next page.

Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Contract will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some

To continue reading, go to right column on this page.

expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

1. "Coverage Plan" is any of the following that provides 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 parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

To continue reading, go to left column on next page.

2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

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

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example 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 Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Contract. The following are additional examples of expenses or services that are not Allowable Expenses:

   a. 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 Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "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 Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage 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 Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "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.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Order of Benefit Determination Rules

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

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision 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 Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

   1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage 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 Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of

To continue reading, go to right column on this page.

benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

   2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

      a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

         1) The parents are married;

         2) The parents are not separated (whether or not they ever have been married); or

         3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

      b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

      c. 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:

         1) The Coverage Plan of the custodial parent;

         2) The Coverage Plan of the spouse of the custodial parent;

         3) The Coverage Plan of the noncustodial parent; and then

To continue reading, go to left column on next page.

4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage 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 Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).
4. 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 Coverage Plan, the Coverage 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 Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Subscriber's benefit will pay first.

Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans

To continue reading, go to right column on this page.

during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage 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 Coverage Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the Covered Person; and
3. Determine whether there are any unpaid Allowable Expenses during that claims determination period.

If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

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 Coverage Plan and other Coverage Plans. We may get the facts we

To continue reading, go to left column on next page.

need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage 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 Coverage Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage 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 Coverage 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 reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made 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 you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Extended coverage.
- Continuation of coverage under federal law (COBRA).
- Conversion.

To continue reading, go to right column on this page.

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Contract, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends but if you are hospitalized or are otherwise receiving medical treatment on that date, coverage will be continued as described below under Extended Coverage for Total Disability.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended unless required by state or federal law.

An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

To continue reading, go to left column on next page.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Group Contract Ends	Your coverage ends on the date the group Contract ends. The Enrolling Group is responsible for notifying you that your coverage has ended. If we end this coverage because of a decision to no longer issue this particular type of health benefit plan, we will provide written notice to you at least 90 days prior to the renewal date of the group Contract. If we end this coverage because of a decision to no longer issue any type of health benefit plan, we will provide written notice to you and the applicable state authority at least 180 days prior to the renewal date of the group Contract.
You No Longer Reside or Work in Service Area	Your coverage ends on the last day of the calendar month in which you no longer reside or work in the Service Area. Coverage will end on the date of that move, even if you do not notify us. (This does not apply to an Enrolled Dependent child for whom the Subscriber is required to provide health insurance coverage through a Qualified Medical Child Support Order or other court or administrative order.) The Subscriber or the Enrolling Group must notify us if you move from the Service Area.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. If a Dependent's eligibility ends due to reaching the Dependent's limiting age, the Dependent's eligibility continues until the end of the calendar year in which the Dependent reaches the limiting age. Please refer to (Section 10: Glossary of Defined Terms) for a more completed definition of the terms "Eligible Person", "Subscriber", "Dependent" and "Enrolled Dependent."
We Receive Notice to End Coverage	Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.
Subscriber Retires or Is Pensioned	Your coverage ends on the last day of the calendar month in which the Subscriber is retired or pensioned under the Enrolling Group's plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

Ending Event	What Happens
	This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

Ending Event	What Happens
Fraud, Intentional Misrepresentation or False Information	Fraud or intentional misrepresentation, or because the Subscriber knowingly gave us false material information. Examples include false information relating to residence and/or employment within the Service Area, or false information relating to another person's eligibility or status as a Dependent. During the first two years the Contract is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Contract. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Contract.

Once a claim is denied because the child reached a certain age and before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Contract is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earliest of the following events:

To continue reading, go to right column on this page.

- The expiration of 12 months.
- Such time as the Subscriber is no longer Totally Disabled.
- A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.
- The maximum benefits payable under the Contract have been paid.

Extended Coverage for Pregnancy

If a Covered Person is pregnant on the date the entire Contract is terminated, Benefits for the Pregnancy will be extended to cover Eligible Expenses related directly to the Pregnancy. Such Benefits will be extended until the Pregnancy ends, unless Pregnancy Benefits are covered by the succeeding carrier.

Continuation of Coverage and Conversion

If your coverage ends under the Contract, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Contract, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

To continue reading, go to left column on next page.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Contract on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.
- A Subscriber's former spouse.

To continue reading, go to right column on this page.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct, or reduction of hours; or

B. Death of the Subscriber; or

C. Divorce or legal separation of the Subscriber; or

D. Loss of eligibility by an Enrolled Dependent who is a child; or

E. Entitlement of the Subscriber to Medicare benefits; or

F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan

To continue reading, go to left column on next page.

administrator of these events within the 60 day period, the Enrolling Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Enrolling Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Enrolling Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Contract will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the

To continue reading, go to right column on this page.

   disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.

D. The date coverage terminates under the Contract for failure to make timely payment of the Premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.

To continue reading, go to left column on next page.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Contract ends.

H. The date coverage would otherwise terminate under the Contract as described in this section under the heading *Events Ending Your Coverage.*

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. qualifying event F) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

To continue reading, go to right column on this page.

Conversion

If your coverage terminates for one of the reasons described below, and you continue to reside in the Service Area, you may apply for conversion coverage without furnishing evidence of insurability.

You must apply in writing and pay the first premiums on the conversion plan within 63 days after your coverage under this Contract terminates. We will mail an application, premium notice form and the outline of coverage to an individual interested in applying for coverage within 14 days.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Contract ends and is not replaced.

Application and payment of the initial Premium must be made within 63 days after coverage ends under this Contract or after notice of termination of coverage due to non-payment of the Premium by the Enrolling Group is mailed to the Subscriber.

A Covered Employee's dependents who are covered as dependents under this Group Plan may also convert, but only as dependents of the Covered Employee, not on their own.

However, when a Covered Employee's dependents have been covered for three (3) consecutive months before coverage ends, they may, on their own, convert to a conversion plan under one of these following conditions:

To continue reading, go to left column on next page.

- If the Covered Employee's conversion coverage terminates, Covered Dependents may convert as dependents under a new conversion plan.
- If the Covered Employee dies, the covered spouse may convert.
- If the Covered Employee and the covered spouse die simultaneously or upon the death of the last surviving parent, the covered children may convert if they are of contracting age.
- If the covered spouse is no longer a qualified family Covered Person, the spouse may convert.
- If a Covered Dependent child is no longer an Eligible Dependent as defined in this Group Plan, such dependent may convert.

Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this Contract.

We may designate a carrier to provide conversion coverage if you no longer reside within the Service Area and if you cease to be eligible for coverage under the Contract because:

- For the Subscriber, both your residence and employment are no longer in the Service Area.
- For an Enrolled Dependent, your residence is no longer in the Service Area.
- You cease to be eligible as a Subscriber or Enrolled Dependent.

Application to convert coverage effective on the date of termination, without furnishing evidence of insurability, must be made to our designated carrier within 63 days after end of coverage under the Contract. A conversion contract may be issued in accordance with the terms and conditions that the designated carrier has in effect at

To continue reading, go to right column on this page.

the time of application. Conversion coverage may be substantially different from Benefits available under the Contract.

In accordance with Florida law, you are entitled to select from a minimum of two conversion plans. Please contact us for plan details and enrollment information.

To continue reading, go to left column on next page.

Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning your Contract.

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's benefit plan and how it may affect you. We help finance or administer the Enrolling Group's benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's benefit plan will cover or pay for the health care that you may receive. The plan pays for certain medical costs, which are more fully described in this Certificate. The plan may **not** pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.
- We do not decide what care you need or will receive. You and your Physician make those decisions.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable

To continue reading, go to right column on this page.

information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).

To continue reading, go to left column on next page.

- The timely payment of the Contract Charge to us.
- Notifying you of the termination of the Contract.

When the Enrolling Group purchases the Contract to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the Pension and Welfare Benefits Administration, U. S. Department of Labor.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Contract.

To continue reading, go to right column on this page.

Notice

When we provide written notice regarding administration of the Contract to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Contract or deny any claim after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or

To continue reading, go to left column on next page.

arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Interpretation of Benefits

We have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Contract.
- Interpret the other terms, conditions, limitations and exclusions set out in the Contract, including this Certificate of Coverage and any Riders and Amendments.
- Make factual determinations related to the Contract and its Benefits.

To continue reading, go to right column on this page.

We may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Contract.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Contract, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Contract

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Contract.

Any provision of the Contract which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Contract is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

To continue reading, go to left column on next page.

No other change may be made to the Contract unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Contract are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Contract or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Contract.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Benefits under the Contract, nor will it create a right to Benefits. If the Enrolling Group makes a clerical error (including, but not limited to, sending us inaccurate information regarding your enrollment for coverage or the termination of your coverage under the Contract) we will not make retroactive adjustments beyond a 60-day time period.

Information and Records

At times we may need additional information from you. You agree to furnish us with all information and proofs that we may reasonably require regarding any matters pertaining to the Contract. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

By accepting Benefits under the Contract, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any

To continue reading, go to right column on this page.

reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Contract, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Contract, we and our related entities may use and transfer the information gathered under the Contract in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

To continue reading, go to left column on next page.

Workers' Compensation not Affected

Benefits provided under the Contract do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Certificate of Coverage, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

To continue reading, go to right column on this page.

These third parties and persons or entities are collectively referred to as "Third Parties".

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - — providing any relevant information requested by us,
  - — signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - — responding to requests for information about any accident or injuries,
  - — making court appearances, and
  - — obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

To continue reading, go to left column on next page.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are

To continue reading, go to right column on this page.

seeking recovery, to be paid before any other of your claims are paid.

- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Contract.

The refund equals the amount we paid in excess of the amount we should have paid under the Contract. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim). If you want to bring a legal action against us you must do so within three years from the expiration of the time period in which a

To continue reading, go to left column on next page.

request for reimbursement must be submitted or you lose any rights to bring such an action against us.

You cannot bring any legal action against us for any other reason unless you first complete all the steps in the complaint process described in (Section 6: Questions, Complaints, Grievances). After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your complaint or you lose any rights to bring such an action against us.

Entire Contract

The Contract issued to the Enrolling Group, including this Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitutes the entire Contract.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Certificate.
- Is not intended to describe Benefits.

Adverse Determination - a coverage determination by us that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

To continue reading, go to right column on this page.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Contract. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Contract, except for those that are specifically amended.

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

Benefits - your right to payment for Covered Health Services that are available under the Contract. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Contract, including this Certificate of Coverage and any attached Riders and Amendments.

Child Health Supervision Services - state required Covered Health Services for children from birth to age 16 delivered or supervised by a Physician, including the following periodic visits:

- A history.
- A physical examination.
- A developmental assessment and anticipatory guidance.
- Appropriate immunizations.
- Laboratory tests.

The Covered Health Services will be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics.

To continue reading, go to left column on next page.

Complaint - means any dissatisfaction expressed by a Subscriber concerning an insurer or its network providers.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Contract - the entire agreement issued to the Enrolling Group, that includes all of the following:

- The group Contract.
- This Certificate of Coverage.
- The Enrolling Group's application.
- Amendments.
- Riders.

These documents make up the entire agreement that is issued to the Enrolling Group.

Contract Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Contract.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment is stated as a set dollar amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

To continue reading, go to right column on this page.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Contract. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or a dependent child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A newborn child of any covered Dependent other than the Subscriber's spouse. Benefits for the newborn child will terminate 18 months after their birth.

To continue reading, go to left column on next page.

To be eligible for coverage under the Contract, a Dependent must reside within the Service Area or reside with the Subscriber who works within the Service Area.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any dependent child under 19 years of age.
- A Dependent includes a dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must be a full-time or part-time student; or
  - The child must reside in the Subscriber's household.
  - The child must be primarily dependent upon the Subscriber for support and maintenance and qualify at all times for the dependent exemption, as defined in the Internal Revenue Code and the Federal Tax Regulation. We have the right to request proof of the child's dependency status at any time.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order, even if the child does not reside within the Service Area. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

To continue reading, go to right column on this page.

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with us or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - the amount we will pay for Covered Health Services, incurred while the Contract is in effect, are determined as stated below:

Eligible Expenses are based on one of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by state law.

To continue reading, go to left column on next page.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Contract. An Eligible Person must reside and/or work within the Service Area.

Note: If you currently reside in a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, this notice applies to you. You may request to be referred to that facility's skilled nursing unit or assisted living facility. If the request for referral is denied, you may use the appeal process described in *Section 6: Questions, Complaints and Appeals*.

Emergency -

1. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

2. With respect to a pregnant woman:

- That there is inadequate time to effect safe transfer to another hospital prior to delivery;
- That a transfer may pose a threat to the health and safety of the patient or fetus; or
- That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

To continue reading, go to right column on this page.

Emergency Health Services - a medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Enrolled Dependent - a Dependent who is properly enrolled under the Contract.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Contract is issued.

Enrollment Date - with respect to an individual covered under a group health contract, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period of such enrollment.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations,

To continue reading, go to left column on next page.

regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

This definition does not apply to bone marrow transplant procedures that are deemed by the Agency for Health Care Administration to be accepted within the appropriate oncological specialty and not experimental.

Grievance - a written Complaint submitted by you or on behalf of you to us or to a state agency regarding:

- Availability, coverage for the delivery or quality of health care services, including a Complaint regarding an Adverse Determination made pursuant to Care Coordination review; claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between you and us.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law, that is all of the following:

To continue reading, go to right column on this page.

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Benefits under the Contract. It only expands the setting where Covered Benefits may be performed.

Initial Enrollment Period - the initial period of time, as we agree with the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under the Contract.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy,

To continue reading, go to left column on next page.

occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Medicare - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Contract.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Contract.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case,

To continue reading, go to right column on this page.

the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Contract. We and the Enrolling Group will agree upon the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

To continue reading, go to left column on next page.

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, opthalmologist, registered nurse anesthetist, dermatologist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Contract.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Contract.

Rider - any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Contract except for those that are specifically amended in the Rider.

To continue reading, go to right column on this page.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area we serve and that has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Subscriber - an Eligible Person who is properly enrolled under the Contract. The Subscriber is the person (who is not a Dependent) on whose behalf the Contract is issued to the Enrolling Group.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric

To continue reading, go to left column on next page.

Association does not mean that treatment of the disorder is a Covered Health Service.

Total Disability or Totally Disabled - means a Subscriber's inability to engage in any employment or occupation for which the individual is or may become qualified by reason of education, training, or experience, and being under the regular care of a physician.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

To continue reading, go to right column on this page.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

- End of Certificate -

To continue reading, go to left column on next page.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Riders, Amendments, Notices

2004 Amendment to the Certificate of Coverage

Outpatient Prescription Drug Rider

Ostomy Supplies Rider

High Deductible Medical Plan Notice

Women's Health and Cancer Rights Act of 1998

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Claims and Appeal Notice

HIPAA Notice

COBRA Notice

Notice of Privacy Practices

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

Financial Information Privacy Notice

ERISA

2004 Amendment to the Certificate of Coverage

The Certificate of Coverage is modified as described in this Amendment.

Section 1: What's Covered--Benefits

The Annual Deductible provision in the Payment Information table in (Section 1: What's Covered--Benefits) is replaced with the following:

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms). The Annual Deductible applies to all Covered Health Services under the Contract, including Covered Health Services provided under the Outpatient Prescription Drug Rider.	For single coverage, the Annual Deductible is $1,250 per Covered Person per calendar year. If more than one person in a family is covered under the Contract, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $2,500 per calendar year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.

The Out-of-Pocket Maximum provision in the Payment Information table in (Section 1: What's Covered--Benefits) is replaced with the following:

Payment Information

Payment Term	Description	Amounts
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms). The Out-of-Pocket Maximum applies to all Covered Health Services under the Contract, including Covered Health Services provided under the Outpatient Prescription Drug Rider.	For single coverage, the Out-of-Pocket Maximum is $3,000 per Covered Person per calendar year. If more than one person in a family is covered under the Contract, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $6,000 per calendar year. The Out-of-Pocket Maximum does include the Annual Deductible.

Emergency Health Services described in (Section 1: What's Covered--Benefits) is replaced with the following:

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).	20%	Yes	Yes

Outpatient Surgery, Diagnostic and Therapeutic Services described in (Section 1: What's Covered--Benefits) is replaced with the following:

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Outpatient Surgery, Diagnostic and Therapeutic Services	20%	Yes	Yes

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeons fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray.	***For preventive diagnostic services:*** No Copayment	No	No
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.	***For Sickness and Injury-related diagnostic services:*** 20%	Yes	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	20%	Yes	Yes
Outpatient Therapeutic Treatments Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	20%	Yes	Yes

Physician's Office Services described in (Section 1: What's Covered--Benefits) is replaced with the following:

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Physician's Office Services **Covered Health Services for preventive medical care.** Preventive medical care includes: • Voluntary family planning. • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See *Eye Examinations* earlier in this section.) • Immunizations.	No Copayment	No	No
Covered Health Services for the diagnosis and treatment of a Sickness or Injury.	20%	Yes	Yes

Section 10: Glossary of Defined Terms

The definition of Annual Deductible is replaced with the following:

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year. The Annual Deductible applies to all Covered Health Services under the Contract, including Covered Health Services provided under the Outpatient Prescription Drug Rider.

The definition of Out-of-Pocket Maximum is replaced with the following:

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. The Out-of-Pocket Maximum applies to all Covered Health Services under the Contract, including Covered Health Services provided under the Outpatient Prescription Drug Rider. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

To continue reading, go to right column on this page.

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.

The definition of Specialist Physician is replaced with the following:

Specialist Physician - A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

To continue reading, go to left column on next page.

UNITED HEALTHCARE OF FLORIDA, INC.

Daniel Rosenthal, Chief Executive Officer

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

United HealthCare of Florida, Inc.

Outpatient Prescription Drug Rider

Table of Contents

Outpatient Prescription Drug Rider 1

Introduction 2

Benefits for Outpatient Prescription Drug Products 2
Coverage Policies and Guidelines 2
Identification Card (ID Card) - Network Pharmacy 2
Designated Pharmacies 3
Limitation on Selection of Pharmacies..3
Rebates and Other Payments to Us 3
Coupons, Incentives and Other Communications 3

Section 1: What's Covered--Prescription Drug Benefits 4

Benefits for Outpatient Prescription Drug Products 4
When a Brand-name Drug Becomes Available as a Generic 4
Supply Limits...4
Notification Requirements 4
What You Must Pay 5
Payment Information 6
Copayment...6
Benefit Information..7
Prescription Drugs from a Retail Network Pharmacy 7

To continue reading, go to right column on this page.

Prescription Drug Products from a Home Delivery Network Pharmacy 7

Section 2: What's Not Covered--Exclusions 9

Section 3: Glossary of Defined Terms 11

To continue reading, go to left column on next page.

Outpatient Prescription Drug Rider

This Rider to the Contract is issued to the Enrolling Group and provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms) of the Certificate of Coverage and in (Section 3: Glossary of Defined Terms) of this Rider.

To continue reading, go to right column on this page.

When we use the words "we," "us," and "our" in this document, we are referring to United HealthCare of Florida, Inc.. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Certificate of Coverage (Section 10: Glossary of Defined Terms).

NOTE: The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Certificate of Coverage does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

UNITED HEALTHCARE OF FLORIDA, INC.

Daniel Rosenthal, Chief Executive Officer

To continue reading, go to left column on next page.

Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on our Prescription Drug List at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the three tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

Coverage Policies and Guidelines

Our Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur

To continue reading, go to right column on this page.

quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Certificate of Coverage (Section 5: How to File a Claim). When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed.

To continue reading, go to left column on next page.

The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

Designated Pharmacies

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments to Us

We may receive rebates for certain drugs included on our Prescription Drug List. We do not consider these rebates in calculating any percentage Copayments. We are not required to pass on to you, and we do not pass on to you, amounts payable to us under rebate programs or other such discounts.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this

To continue reading, go to right column on this page.

Outpatient Prescription Drug Rider. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. We are not required to pass on to you, and we do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

To continue reading, go to left column on next page.

Section 1: What's Covered--Prescription Drug Benefits

We provide Benefits under the Contract for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Certificate of Coverage (Section 2: What's Not Covered--Exclusions) and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

To continue reading, go to right column on this page.

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify us or our designee. The reason for notifying us is to determine

To continue reading, go to left column on next page.

whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying us.

If we are not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

If we are not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Certificate of Coverage (Section 5: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that

To continue reading, go to right column on this page.

the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table when Prescription Drug Products are obtained from a retail or home delivery pharmacy.

The amount you pay for any of the following under this Rider will not be included in calculating **any Out-of-Pocket Maximum stated in your Certificate of Coverage**:

- Copayments for Prescription Drug Products.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost. Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products from a home delivery Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.***

Benefit Information

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.	**Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.** 30% of the Prescription Drug Cost per Prescription Order or Refill for a **Tier-1 Prescription Drug Product.** 30% of the Prescription Drug Cost per Prescription Order or Refill for a **Tier-2 Prescription Drug Product.** 50% of the Prescription Drug Cost per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**
Prescription Drug Products from a Home Delivery Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a home delivery Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a home	**Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.** **For up to a 90-day supply, your Copayment is:** 30% of the Prescription Drug Cost per Prescription Order

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
delivery Copayment for any Prescription Orders or Refills sent to the home delivery pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 90-day supply, not a 30-day supply with three refills.	or Refill for a **Tier-1 Prescription Drug Product.** 30% of the Prescription Drug Cost per Prescription Order or Refill for a **Tier-2 Prescription Drug Product.** 50% of the Prescription Drug Cost per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

Section 2: What's Not Covered--Exclusions

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
5. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided from the local, state or federal government (for example, Medicare).
7. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment

To continue reading, go to right column on this page.

for which benefits are paid under any workers' compensation law or other similar laws.

8. Any product dispensed for the purpose of appetite suppression and other weight loss products.
9. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Prescription Drug Products for smoking cessation.
18. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.

To continue reading, go to left column on next page.

19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
20. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in (Section 10: Glossary of Defined Terms) of your Certificate of Coverage.
- Is not intended to describe Benefits.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

To continue reading, go to right column on this page.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or our designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

A Network Pharmacy can be either a retail or a home delivery pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Prescription Drug List Management Committee.
- December 31st of the following calendar year.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

To continue reading, go to left column on next page.

Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

Prescription Drug List Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Contract, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;
  - glucose monitors.

To continue reading, go to right column on this page.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

- End of Outpatient Prescription Drug Rider -

To continue reading, go to left column on next page.

Ostomy Supplies Rider

We provide Benefits for ostomy supplies as described in this Rider to the Contract.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	20%	Yes	Yes

UNITED HEALTHCARE OF FLORIDA, INC.

Daniel Rosenthal, Chief Executive Officer

High Deductible Medical Plan Notice

Important Information about This High Deductible Medical Plan

Benefits available under this high deductible medical plan are described in your Certificate of Coverage.

Rebates and Other Payments to Us:

We may receive rebates for certain drugs included on our Prescription Drug List or for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that you purchase or that are administered to you before you meet your Annual Deductible. We do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copayments.

The Annual Deductible

Because the Annual Deductible under this high deductible medical plan is calculated on the basis of Eligible Expenses, it's possible that every dollar you pay may not apply toward meeting the Annual Deductible, even if it was paid from a Health Savings Account or other funding source.

To continue reading, go to right column on this page.

Covered Health Services from Network Providers

When you receive Covered Health Services from a Network provider before the Annual Deductible is met, the amount you pay is based on our contracted rates with that Network provider. The entire amount you pay will apply to the Annual Deductible if all services received were Covered Health Services.

Covered Health Services from Non-Network Providers

When you receive Covered Health Services from a non-Network provider before the Annual Deductible is met, the amount you pay is calculated on the basis of Eligible Expenses, as defined in the Certificate of Coverage. Any amount you pay a non-Network provider that exceeds Eligible Expenses will not apply to the Annual Deductible.

To continue reading, go to left column on next page.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Claims and Appeal Notice

This Notice is provided to you as a result of changes in federal law regarding our responsibilities for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you

To continue reading, go to right column on this page.

don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within 5 days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the

To continue reading, go to left column on next page.

information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is

To continue reading, go to right column on this page.

needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

To continue reading, go to left column on next page.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a customer service representative. If you first informally contact our customer service department and later wish to request a formal appeal in writing, you should again contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to the *Urgent Appeals that Require Immediate Action* section below and contact our customer service department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

To continue reading, go to right column on this page.

- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of **pre-service requests for Benefits** as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

To continue reading, go to left column on next page.

- For appeals of **post-service claims** as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals That Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of

To continue reading, go to right column on this page.

the determination, taking into account the seriousness of your condition.

To continue reading, go to left column on next page.

HIPAA Notice

Changes Required By Final HIPAA Regulations

Changes required by the final HIPAA Portability Regulations are effective July 1, 2005. Those changes include clarification of the requirements for a Special Enrollment Period and Continuous Creditable Coverage as described below.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.

To continue reading, go to right column on this page.

- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or any applicable Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or any applicable Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - — Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - — The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - — In the case of COBRA continuation coverage, the coverage ended.
  - — The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - — The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - — An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

Continuous Creditable Coverage

To continue reading, go to left column on next page.

Continuous Creditable Coverage is defined as health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the Indian Health Services Program or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- The State Children's Health Insurance Program (S-CHIP).
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Maximum Policy Benefit

The terms of your Certificate of Coverage may define and establish terms relating to a Maximum Policy Benefit. This maximum policy benefit may impose a preexisting condition limitation under the updated HIPAA Portability regulations.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

COBRA Notice

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.
- A Subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified

To continue reading, go to right column on this page.

Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct.
B. Reduction in the Subscriber's hours of employment.

With respect to a Subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than the Subscriber's gross misconduct.
B. Reduction in the Subscriber's hours of employment.
C. Death of the Subscriber.
D. Divorce or legal separation of the Subscriber.
E. Loss of eligibility by an Enrolled Dependent who is a child.
F. Entitlement of the Subscriber to Medicare benefits.
G. The Enrolling Group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

To continue reading, go to left column on next page.

Notification Requirements for Qualifying Event

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator within 60 days of the latest of the date of the following events:

- The Subscriber's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.
- The date the Qualified Beneficiary would lose coverage under the Policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Subscriber or other Qualified Beneficiary must also notify the Enrolling Group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Subscriber or other Qualified Beneficiary fails to notify the Enrolling Group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under federal law, the Subscriber must notify the Enrolling Group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the Enrolling Group's plan administrator at the address stated in

To continue reading, go to right column on this page.

the ERISA Statement. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Enrolling Group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

To continue reading, go to left column on next page.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Enrolling Group for additional information. You must contact the Enrolling Group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying events A and B).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   — Notice of such disability must be provided within the latest of 60 days after:
     - the determination of the disability; or
     - the date of the qualifying event; or
     - the date the Qualified Beneficiary would lose coverage under the Policy; and
     - in no event later than the end of the first eighteen months.

To continue reading, go to right column on this page.

   — The Qualified Beneficiary must agree to pay any increase in the required Premium for the additional eleven months.

   — If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).

C. With respect to Qualified Beneficiaries, and to the extent that the Subscriber was entitled to Medicare prior to the qualifying event:

   — Eighteen months from the date of the Subscriber's Medicare entitlement; or

   — Thirty-six months from the date of the Subscriber's Medicare entitlement, if a second qualifying event (that was due to either the Subscriber's termination of employment or the Subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Subscriber became entitled to Medicare subsequent to the qualifying event:

To continue reading, go to left column on next page.

— Thirty-six months from the date of the Subscriber's termination from employment or work hours being reduced (first qualifying event) if:
    - ♦ The Subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
    - ♦ if, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Policy for failure to make timely payment of the Premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. qualifying event G) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Subscriber's death.

H. The date the entire Policy ends.

I. The date coverage would otherwise terminate under the Policy as described in the Certificate of Coverage (Section 8: When Coverage Ends) under the heading *Events Ending Your Coverage.*

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We* are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our website, www.myuhc.com.

To continue reading, go to right column on this page.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

To continue reading, go to left column on next page.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- ***For Payment*** of premiums due us and to process claims for health care services you receive.
- ***For Treatment***. We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- ***For Health Care Operations***. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- ***To Provide Information on Health Related Programs or Products*** such as alternative medical treatments and programs or about health related products and services.
- ***To Plan Sponsors***. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- ***For Appointment Reminders***. We may use health information to contact you for appointment reminders with providers who provide medical care to you.

To continue reading, go to right column on this page.

We may use or disclose your health information for the following purposes under limited circumstances:

- ***To Persons Involved With Your Care.*** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- ***For Public Health Activities*** such as reporting disease outbreaks.
- ***For Reporting Victims of Abuse, Neglect or Domestic Violence*** to government authorities, including a social service or protective service agency.
- ***For Health Oversight Activities*** such as governmental audits and fraud and abuse investigations.
- ***For Judicial or Administrative Proceedings*** such as in response to a court order, search warrant or subpoena.
- ***For Law Enforcement Purposes*** such as providing limited information to locate a missing person.
- ***To Avoid a Serious Threat to Health or Safety*** by, for example, disclosing information to public health agencies.
- ***For Specialized Government Functions*** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- ***For Workers Compensation*** including disclosures required by state workers compensation laws of job-related injuries.

To continue reading, go to left column on next page.

- ***For Research Purposes*** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- ***To Provide Information Regarding Decedents***. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- ***For Organ Procurement Purposes***. We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as

To continue reading, go to right column on this page.

well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a Summary of State Laws on Use and Disclosure of Certain Types of Medical Information.

What Are Your Rights

The following are your rights with respect to your health information.

- ***You have the right to ask to restrict*** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. ***Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.***
- ***You have the right to ask to receive confidential communications*** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).

To continue reading, go to left column on next page.

- ***You have the right to see and obtain a copy*** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- ***You have the right to ask to amend*** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- ***You have the right to receive an accounting*** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- ***You have the right to a paper copy of this notice***. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.myuhc.com.

Exercising Your Rights

- ***Contacting your Health Plan***. If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.

To continue reading, go to right column on this page.

- ***Filing a Complaint***. If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

  United Healthcare
  Customer Service - Privacy Unit
  PO Box 740815
  Atlanta, GA 30374-0815

  You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any action against you for filing a complaint.**

To continue reading, go to left column on next page.

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule with respect to the use or disclosure of protected health information in the categories listed below.	
Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use and/or (2) retention of genetic information.	CO, GA, IL, NV, NJ, NM, VT
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV

HIV / AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, WV, WI
A specific written statement must accompany any HIV/AIDS information disclosures.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VT, WA, WV
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN
Child or Adult Abuse	
Abuse-related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, WI

Financial Information Privacy Notice

Effective: April 14, 2003

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering

To continue reading, go to right column on this page.

your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group of California, Inc.; ACN Group IPA of New York, Inc.; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG OnLine, LLC; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Dental Insurance Company of America; EverCare of New York, IPA, Inc.; Fidelity Benefit Administrators, Inc.; Lifemark Corporation; MAMSI Insurance Agency of the Carolinas, Inc.; MAMSI Insurance Resources, Inc.; Managed Physical Network, Inc.; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; Uniprise, Inc.; United Behavioral Health of New York, IPA, Inc.; United HealthCare Services, Inc.; United HealthCare Service LLC.

To continue reading, go to left column on next page.

ERISA

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

To continue reading, go to right column on this page.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

To continue reading, go to left column on next page.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you 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 you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

To continue reading, go to right column on this page.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

To continue reading, go to left column on next page.

ERISA Statement

If the Enrolling Group is subject to ERISA, the following information applies to you.

Summary Plan Description

Name of Plan: State of Florida Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

State of Florida
4050 Esplanade Way
Suite 260.4Z
Tallahassee, FL 32399-0950
(850) 921-4548

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Claims Fiduciary:

United HealthCare of Florida, Inc.

Employer Identification Number (EIN): 59-3458983

IRS Plan Number: 501

Effective Date of Plan: January 1, 2008

To continue reading, go to right column on this page.

Type of Plan: Health care coverage plan

Name, business address, and business telephone number of Plan Administrator:

State of Florida
4050 Esplanade Way
Suite 260.4Z
Tallahassee, FL 32399-0950
(850) 921-4548

Type of Administration of the Plan:
Benefits are paid pursuant to the terms of a group health policy issued and insured by:

United HealthCare of Florida, Inc.
495 N. Keller Road
Suite 200
Maitland, FL 32751

The Plan is administered on behalf of the Plan Administrator by United HealthCare of Florida, Inc. pursuant to the terms of the group Policy. United HealthCare of Florida, Inc. provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Person designated as agent for service of legal process:
Plan Administrator

Source of contributions and funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

To continue reading, go to left column on next page.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending January 1.

Determinations of Qualified Medical Child Support Orders. The plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.