TRUSTMARK INSURANCE COMPANY (MUTUAL)

400 Field Drive
Lake Forest, Illinois 60045-2581

Standard Conversion Insurance Policy

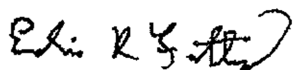
Trustmark Insurance Company (hereinafter referred to as We, Us or Our), agrees to provide the health care services described under the provisions of this Conversion Policy to the Insured and the Insured's eligible Dependents who have transferred enrollment from one of Our Group Contracts. The provision of services is subject to all of the terms on this page and those that follow, including any limitations, restrictions or exclusions, as well as any amendments made a part of this Policy.

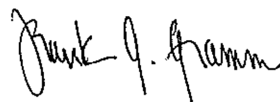
This Policy is issued in consideration of the submission of an application for conversion and payment of premium in advance at Our home office.

Any changes in this Policy must be approved by an officer of the company, and endorsed on the certificate or attached to it. Any verbal promise made by an officer or employee of the company, or any other person, including an agent, will not be binding on the company unless it is contained in writing in this certificate or an endorsement to it.

This Policy is effective on the Effective Date shown on the Policy Information Page. The first premium covers the period starting on the Effective Date.

Please call [1-800-366-6663] for assistance regarding claims and information about coverage.





Edwin R. Fattes
President & Chief Operating Officer

Frank G. Gramm
Corporate Secretary & General Counsel

POLICY INFORMATION PAGE

Insured's Name:

Policy Number:

Covered Dependents:

Effective Date of Coverage:

Policy Anniversary Date

Premium Amount:

Premium Payment Mode:

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ADMINISTRATIVE PROVISIONS

OUR RESPONSIBILITIES

In consideration of the payment of premium by the Insured, We shall provide coverage for the Insured and their Covered Dependents. We agree to provide coverage without discrimination because of race, color, sex, religion, national origin or any other basis prohibited by law.

TERMINATION OF THIS POLICY BY THE INSURED

The Insured may terminate this Policy as of any premium due date by giving at least 45 days prior written notice. In such event, no benefits will be provided on or after such termination date, except as specifically set forth in this Policy.

TERMINATION OF THIS POLICY BY US

We may terminate this Policy as of any premium due date if the Insured has not paid the required premium by the end of the grace period, as defined in the Grace Period provision. However, if the Insured has given Us prior written notice in advance of an earlier date of termination, this Policy will terminate as of that earlier date. The Insured is liable to Us for any unpaid premium for the time the Policy was in force.

TERMS OF RENEWAL

We guarantee the Insured the right to renew this Policy at the Insured's option. However, We may refuse to renew or discontinue this Policy, and all coverage provided under this Policy, if one of the following circumstances has occurred:

A. Failure to timely pay premiums in accordance with the terms of the Policy;

B. The carrier ceases offering the Policy to all Policyholders;

C. The Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy.

D. [The Covered Person no longer lives, or resides, or works in the Our service area or in the area in which We are authorized to do business.]

If, based on the occurrence of one or more of above circumstances (except for nonpayment of premium), We decide to non-renew or discontinue this Policy, We will give the Insured at least 90 days advance notice, in writing, of its intent to non-renew or discontinue this Policy.

TERMINATION OF INSURED'S COVERAGE

The coverage under this Policy for the Insured will end at 12:01 a.m., local standard time, on the earliest of the following dates:

A.The Policy between the Insured and Us ends.

B.The Insured fails to pay the premium due, or the Insured otherwise fails to continue to meet each of the eligibility requirements under this Policy.

TERMINATION OF DEPENDENT'S COVERAGE

The coverage under this Policy for any Covered Dependent will end automatically at 12:01 a.m., local standard time, on the earliest of the following dates:

A.The Policy between the Insured and Us ends.

B.The Insured's coverage ends for any reason.

C.The dependent fails to continue to meet each of the dependent eligibility requirements under this Policy, except in the case of a handicapped child.

D.A court order, including a qualified medical child support order, covering a dependent child is no longer in effect, or a change in marital status that makes a person ineligible under the terms of this Policy.

However, an Insured's dependents may if covered under this Policy, on their own, convert to a conversion Policy under one of these following conditions:

A.If the Insured's conversion coverage terminates, Covered Dependents may convert as dependents under a new conversion Policy.

B.If the Insured dies, the Covered spouse may convert.

C.If the Insured 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.

D.If the covered spouse is no longer a qualified family Covered Person, the spouse may convert.

E.If a Covered Dependent child is no longer an Eligible Dependent as defined in this Policy, such dependent may convert.

The new conversion policy will be a benefit policy in use by Us on the date the request is made. The new coverage will be issued at rates that apply to the person's class of risk and age at the nearest birthday on the date coverage

under this Policy stops.

PREMIUM PROVISIONS

PAYMENT OF PREMIUM

The first premium payment is due on the Effective Date shown on the Policy Information Page. Each following premium payment is due monthly unless the Insured and Us agree on some other method and/or frequency of payment. Premium payments should be sent to Our [home office] [or may be given to Our authorized agent.]

PREMIUM DUE DATE

After the Effective Date shown on the Policy Information Page, the premium due date will be [the day of the month with the same number as the anniversary date. If there is a month with no day having the same number as the anniversary date, premium are due on the last day of that month.]

THE GRACE PERIOD

This Policy has a 10 day grace period. A grace period means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period immediately following that premium due date. During the grace period, the Policy will stay in force. The grace period does not apply to the premium due on the Effective Date, or if the Insured has given Us written notice that the Policy is to be terminated prior to the premium due date. If the premium is not paid by the end of the grace period, the Policy may terminate as of the date the payment was due. Any late payment penalties are subject to Department of Insurance approval.

PREMIUM

The monthly premium rate for each Insured is shown on the Policy Information Page. The premium is determined in accordance with premium rates applicable to the age and class of risk of each person to be covered under this Policy and to the type and amount of coverage provided.

However, We may change premium at any time if Our liability is altered either because of a change in state or federal law or because of a revision in the coverage provided under this Policy. Any such change in premium will take

effect on the later of: the effective date of the change in law or change in coverage; or the date the premium change is approved by the Florida Department of Insurance, if such approval is required.

The Policy will give the Insured written notice of any changes in premium at least 45 days in advance.

If an increase in premium takes place on other than a premium due date, a pro rata premium increase will be applied from the date of the increase to the next premium due date. If a decrease in premium takes place on other than a premium due date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next premium due date.

INCORRECT PREMIUM PAYMENT

Any premium adjustment made due to the correction of an error in the premium payments will be made without interest on the next premium due date after the facts are made known to Us.

GENERAL POLICY PROVISIONS

ENTIRE POLICY

The entire agreement is made up of this Policy, the Insured's application for this coverage and any amendments or riders attached to this Policy. All statements made by the Insured are considered to be representations, not warranties. This means that the statements are considered to have been made in good faith. No such statement will void this Policy, reduce the benefits it provides, or be used in defense to a claim for coverage unless it is contained in a written application and a copy is furnished to the person making such statement.

TIME LIMIT FOR CERTAIN DEFENSES

After two years from the effective date of this Policy, no misstatement made by a Covered Persons, except a fraudulent misstatement made in a Covered Person's application, may be used to void the Policy. After two years from a Covered Person's effective date, no misstatement made by a Covered Person, except a fraudulent misstatement on his or her application, may be used to deny a claim for any benefit which begins after the end of the two-year period from the Covered Person's effective date.

FINANCIAL RESPONSIBILITIES OF THE INSURED

We reserve the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Recovery efforts will relate to benefit payments made for services or supplies rendered subsequent to the Covered Person's termination date and prior to the date notice of coverage termination by the Insured. The Insured shall cooperate with and support such recovery efforts.

In the event that the Insured does not comply with the notice requirements set forth in the Premium Statement section, the Insured shall be solely liable to Us to the extent of any payment made on behalf of such Covered Persons for services or supplies rendered subsequent to the date notice of a Covered Person's termination was due.

MISSTATEMENTS

If information about a Covered Person is misstated, We may adjust the premium to correctly reflect the true information. If the misstatement affects the amount of the Covered Person's coverage, the true information may be used to determine the correct amount of coverage.

CHANGES TO THIS POLICY

No change to this Policy will be effective unless made by an amendment or rider that has been signed by Our officer. No agent may change this Policy or waive any of its provisions.

WORKERS' COMPENSATION

This Policy does not affect or take the place of Worker's Compensation.

ASSIGNMENT

Neither this Policy, nor the benefits provided under this Policy, may be assigned except as otherwise specifically described in this Policy.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Eligibility

After this Policy is in effect, the following Dependents are eligible for coverage:

1. the Insured's lawful Spouse; or

2. an unmarried child of the Insured under the age of 25. Under this Policy, the following are considered children of the Insured until the end of the calendar year in which the child reaches age 25, if the child is dependent on the Insured for support and is either living in the Insured's household or is a full-time or part-time student:

   a. natural children, or legally adopted children, or step-children residing with You; or any child who lives with the Insured in a normal parent-child relationship if the child qualifies at all times for the dependent exemption, as defined in the Internal Revenue Code and the Federal Tax Regulations. We have the right to request proof of the child's dependency status at any time.

   b. a newborn of You or Your Covered spouse, from the moment of birth; the newborn child of a covered family dependent child (e.g. the newborn of a covered daughter or son) for a period of 18 months from the moment of birth.

   c. a child You propose to adopt which is placed in compliance with Chapter 63, from the moment of placement in Your residence; a newly born infant adopted by You, from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event that the child is not ultimately placed in Your residence in compliance with chapter 63;

   d. a child for whom You are the legal guardian, who is residing with You and who is chiefly Dependent upon You (in accordance with Internal Revenue Service criteria) for support and maintenance; and

   e. An unmarried dependent handicapped child of the Insured or the Insured's spouse, regardless of age who is incapable of self-sustaining employment due to mental retardation or physical handicap incurred prior to age twenty-five (25).

Applying for Coverage

No person meeting eligibility requirements will be refused coverage under this Policy by Us because of a health condition, a need for health services or a pre-existing physical or mental condition, including pregnancy.

A person who becomes eligible as a Dependent due to marriage, birth, adoption or legal guardianship may apply for coverage by completing and submitting to Us a signed application within thirty (30) days of becoming eligible. Newborn and adopted children will be covered from the date of birth or date of placement. If you have family coverage the addition of a Dependent will not change Your contract type, although You must complete required forms within thirty (30) days of the event. If You have individual or two-person coverage, Your contract type and associated premium will change. You must submit any required additional premium payment.

Except for a newborn or adopted child, if an eligible Dependent does not apply for coverage in the time frame specified herein, We may, at Our discretion, either deny coverage or allow the individual to make application for coverage. Based on the current health status and health history of the individual, We may either issue coverage under this Policy and subject the individual to a pre-existing condition waiting period or deny coverage.

It is also Your responsibility to notify Us of any changes which will affect Your eligibility or the eligibility of Your Dependents within thirty (30) days of the event.

Effective Date of Coverage

This Policy's effective date is shown on the Policy Information Page. A newly eligible Dependent's coverage will begin as of the date of the event such as marriage, birth, adoption, guardianship only, if the Dependent's application is received within thirty (30) days of the event. Coverage will not be denied a newborn or an adopted child for failure to notify within the time frame specified.

The term **Effective Date** means to the entire Policy, and the Covered Persons covered when the Policy first becomes effective, 12:01 a.m. on the date specified on the Policy Information Page; and with respect to a Covered Person who is subsequently covered, 12:01 a.m. on the date on which coverage will commence for that Covered Person as specified in the Effective Date Section of this Policy.

COVERAGE FOR NEWBORN CHILDREN

All health coverage applicable for children under this Policy will be provided for the newborn child of the Insured or to an Insured's Covered Dependent from the moment of birth if the Insured has dependent coverage. However, with respect to the newborn child of a Covered Dependent of the Insured other than the Insured's spouse, the coverage for the newborn child terminates eighteen (18) months after the birth of the newborn.

The coverage for newborn children shall consist of coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity, and the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage for transportation costs may not exceed allowed charges of $1,000.

We must be notified, in writing, within 30 days after the birth. If timely notice is given, no additional premium will be charged for coverage of the newborn child for the duration of the notice period. If timely notice is not received, We will charge the applicable premium from the date of birth. The applicable premium for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for a newborn child due to the Covered Person's failure to provide notice within the 30-day period of the birth of the child.

COVERAGE FOR ADOPTED CHILDREN

All health insurance benefits applicable to children will be payable with respect to a child adopted by the Insured if the Insured has dependent coverage:

A. When the child is placed in compliance with Florida Statutes, Chapter 63, prior to the child's 18th birthday, from the moment of placement in the Insured's residence; and

B. For a newborn child, from the moment of birth, if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not ultimately placed in the Insured's residence.

Notice of the birth or placement of the child must be given to Us in writing, no later than 30 days after the occurrence. If timely notice is given, no additional premium will be charged for coverage of the adopted child for the duration of the notice period. If timely notice is not received, We will charge the applicable premium from the date of birth for the newborn and the date of placement for the adopted child. The applicable premium for the child will be charged after the

initial 30-day period in either case. Coverage will not be denied for a child due to the Covered Person's failure to provide timely notice of birth or placement of the child.

COVERAGE FOR FOSTER CHILDREN

Coverage for a foster child or a child otherwise placed in the Insured or the Insured's Covered spouse's custody by a court order, prior to the child's 18th birthday, will be provided from the date of placement if on the date of placement the Insured has dependent coverage. This coverage will be subject to the pre-existing condition waiting period of 12 months for any conditions manifested or treated in the six month period prior to the date of the court ordered custody. No coverage will be provided under this provision for the child who is not ultimately placed in the Insured's home. For children in the Insured's custody, coverage will terminate the date the Insured no longer has legal custody.

HANDICAPPED CHILDREN

If a child attains the limiting age for a Covered Dependent (see the Eligibility provision), coverage will not terminate while that person is, and continues to be, both:

A. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

B. Chiefly dependent on the Insured for support and maintenance.

If a claim is denied for the stated reason that the child has reached the limiting age for dependent coverage, the Insured has the burden of establishing that the child is and has continued to be handicapped as defined above.

The coverage of the handicapped child may be continued, but not beyond the termination date of such incapacity or such dependence. This provision shall in no event limit the application of any other provision of this Policy terminating such child's coverage for any reason other than the attainment of the applicable limiting age.

THIS POLICY AND OTHER PAYMENT ARRANGEMENTS

COORDINATION OF BENEFITS

When a Covered Person is covered under this Policy and another health coverage policy, We reserve the right to coordinate the benefits of this Policy with the benefits of that other policy. This provision explains how that coordination will take place.

Coordination of benefits is designed to avoid the costly duplication of payment for health care services and/or supplies under multiple health coverage plans. Because of this provision, the sum of the benefits that would be payable under all policies, in the absence of this coordination provision and similar provisions in the other policies, will not exceed 100% of the total allowed expenses actually incurred.

POLICIES AFFECTED

If any of the other health coverage policies a Covered Person has cover at least a portion of a health care service or supply which is covered under this Policy, coordination may take place. Not all health coverage policies will be considered in this coordination process. The policies that will be considered are the following:

A. Any group insurance, group-type self-insurance or HMO policy; including coverage under labor-management, trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;

B. Any service policy contracts, group practice, individual practice, or other prepayment coverage on a group basis;

C. Any policy, program or insurance established pursuant to worker's compensation legislation or other legislation of similar purpose; or an insurance policy, including an automobile insurance policy, provided any non-policy contains a coordination of benefits provision;

D. Any coverage under governmental programs including Medicare, and any coverage required or provided by any statute.

Each policy or other arrangement for benefits or services that the Covered Person has will be considered separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other programs into consideration in determining its benefits and that portion which does not.

When a policy provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed as a benefit paid.

ORDER OF BENEFIT DETERMINATION

If the health benefits of all of the health coverage policies the Covered Person is covered under would have exceeded the actual cost of the services or supplies rendered in the absence of this provision, this coordination process will reduce the payment by one or more of the policies to eliminate the excess payment. To determine the order in which companies will be considered and policy benefits reviewed to determine the appropriate benefit payment, the following guidelines will be used:

A. The first guideline is dependent status. The benefits of the policy which covers the person on whose expense the claim is based as an employee shall be determined before the benefits of the policy which covers the person as a dependent;

B. The second guideline is parent birth date. Except for cases where the person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of the policy which cover the person on whose expenses the claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be determined before the benefits of the policy which covers the person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either policy does not have a similar "birthday rule" provision regarding dependents, which results either in each policy determining its benefits before the other or in each policy determining its benefits after the other, the criteria shall not be applied, and the rule set forth in the policy which does not have the "birthday rule" provision shall determine the order of benefits.

C. In the case of a person for whom claim is made as a dependent child, whose parents are separated or divorced:

1. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the policy which cover the child as a dependent of the parent with custody of the child will be determined before the benefits of the policy which cover the child as a dependent of the parent without custody.

2. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a program which cover that child as a dependent of the parent with custody shall be determined before the benefits of a policy which cover that child as a dependent of the step-parent; and the benefits of a policy which cover that child as a dependent

of a step-parent will be determined before the benefits of a policy which covers the child as a dependent of the parent without custody.

3. If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a policy which cover the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other program which cover the child as a dependent child.

D. When rules A, B or C do not establish an order of benefit determination, the benefits of a policy which has covered the person on whose expenses the claim is based for the longer period shall be determined before the policy which has covered such person the shorter period of time, provided that:

1. The benefits of a policy covering the person on whose expense claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other policy covering such person as an employee, other than a laid-off or retired employee or dependent of such person; and

2. If either program does not have a provision regarding laid-off or retired employees, which results in each program determining its benefits after the other, then the provisions of 1. above shall not apply.

E. When this coordination process reduces the total amount of benefits otherwise payable to a Covered Person under this policy, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Policy.

SUBROGATION

Sometimes, the situations that cause a Covered Person to need the benefits and supplies provided under this Policy also result in actions by the Covered Person to recover damages related to that situation. Such actions may often result in duplicate payments for the services and supplies that We have already provided to the Covered Person.

To protect Us from this type of duplicate payment, We reserve the right to get involved in that recovery process. Our right to get involved is called **"subrogation"**.

A. If We have paid for services or supplies to a Covered Person under this Policy, the Covered Person will, to the extent of such services or supplies rendered, have subrogated Us to all causes of action and rights of recovery that the Covered Person may have or has against any persons and/or organizations that are related to the incident that necessitated the rendering of the services or supplies. These subrogation rights extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.

B. The Covered Person must promptly execute and deliver instruments and papers related to these subrogation rights as may be requested by Us. Further, the Covered Person shall promptly notify Us of any settlement negotiations prior to entering into a settlement agreement affecting Our subrogation rights.

C. In no event should a Covered Person fail to take any action where action is appropriate, or take any action that may prejudice Our subrogation rights. No waiver, release of liability, settlement, or other documents executed by a Covered Person without prior notice to and approval by Us, shall be binding upon Us.

D. We retain the right to recover such payments and/or the reasonable value of the benefits provided from any person or organization to the fullest extent permitted by law.

RIGHT TO RECEIVE AND RELEASE INFORMATION

We have the right to receive and release necessary information. By accepting coverage under this Policy, the Insured gives permission for Us to obtain from or release to Our employees or other organization or person any information necessary to determine whether this provision or any similar provision in other policies applies to a claim and to implement such provisions. We may obtain or release this information without consent from or notice to anyone. Any person who claims benefits under this Policy agrees to furnish to Us information that may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payment which should have been made by Us is made to any other person, Policy, or organization, We shall have the right to pay to that other person, Policy or organization any amounts We determine to be necessary under this provision. Amounts paid to another Policy in this manner will be considered

benefits paid under this Policy. We are discharged from liability under this Policy to the extent of any amounts so paid.

RIGHT OF RECOVERY

If We make larger payments than is required under this Policy, then We have the right to recover any excess benefit payment from any person to or for whom such payments were made, or any other person We may determine.

NON-DUPLICATION OF GOVERNMENT PROGRAMS

The benefits of this Policy shall not duplicate any benefits to which Covered Persons are paid under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Act, to the extent allowed by law. In any event, if this Policy has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to Us to the extent of such duplication.

NON-DUPLICATION OF OTHER COVERAGE

The benefits under this Policy do not duplicate any benefits to which Covered Persons are entitled by law, and/or for which they are eligible under any extension of benefits and/or coverage provisions of any other policy, program, or contract.

COOPERATION OF COVERED PERSONS

Each Covered Person shall cooperate with Us and shall execute and submit to Us such consents, releases, assignments, and other documents as may be requested by Us in order to administer and exercise its rights under the subrogation provision or to process claims. Failure to do so may result in the reduction of benefit payments under this Policy.

NOTICE OF CLAIM

Notice of a claim for benefits must be given to Us. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by Us within 20 days after the start of the loss on which the claim is based. If notice is not given in time , the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 20 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

CLAIM FORMS

After We receive written notice of a claim, it will provide claim forms to the Covered Person. This form should be furnished within 15 days after We receive the written notice. If forms are not given to the claimant within 15 days of the date We receive notice of claim, the claimant will meet the proof of loss requirements by giving Us written statement of the nature and extent of the loss within the time limit stated in the Proof Of Loss provision.

[PROOF OF LOSS

Written proof of loss must be given to Us within 90 days after the date of injury or sickness for which claim is made. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.]

[PROOF OF LOSS

For services rendered by Participating Providers, no written proof of loss from the Covered Person is needed. Participating providers are responsible for submitting claims for covered expenses directly to Us on the Covered Person's behalf. Also, health care providers who have entered into a reimbursement agreement with Us have agreed not to bill the Covered Person an amount greater than the difference between allowed charges and the benefit amount paid by Us. The Covered Person will need to complete and sign all necessary papers and authorize participating providers to release those medical records which may be necessary to complete the processing of the claim. Benefit payments for covered services received from a participating provider will be forwarded directly to the provider.

For services rendered by Non-Participating Providers, written proof of loss must be given to Us within 90 days after the date of injury or sickness for which claim is made. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later that 1 year from the time specified unless the claimant was legally incapacitated.]

TIME OF PAYMENT OF CLAIMS

After receiving written proof of claim, We will reimburse all claims or any portion of any claim from a Covered Person or a Covered Person's assignees, for payment under this Policy within 45 days. If a claim or portion of a claim is contested by Us the Covered Person or the Covered Person's assignees will be notified, in writing, that the claim is contested, within 45 days after the receipt of the claim by Us. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting

the claim.

We, upon receipt of additional information requested from a Covered Person or the Covered Person's assignees, 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 the claim.

Payment will be treated as being made on the date a draft or 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 10 percent per year.

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

RIGHT TO REQUIRE MEDICAL EXAMS

We have the right to require medical exams be performed on any claimant for whom a claim is pending as often as We may reasonably require. If We require a medical exam, it will be performed at Our expense. We also has the right to request an autopsy in the case of death, if state law so permits.

PAYMENT OF CLAIM

[For services rendered by Participating Providers, benefits are payable directly to the provider]. For services rendered [by Non-Participating Providers], benefits are payable to the Covered Employee or other person as required by law. However, We may pay all or a portion of any medical benefits to the medical care provider on whose charge the claim is based unless the Covered Person directs otherwise in writing by the time proofs of loss are filed with Us.

In the event that payment to the Covered Employee is not possible, and the Covered Person to whom benefits would otherwise be payable is a minor or, in the opinion of Us, is not able to give a valid receipt for any payment due him or her, such payment will be

made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, We may, at Our option, make payment to the person or institution appearing to have assumed his or her custody and support.

We will pay benefits for covered medical services after the Covered Person has satisfied any deductibles and coinsurance amounts. No benefits are payable for charges which are discounted, waived or rebated by a provider of services simply because the Covered Person is insured. We have the right to recover from a provider of services or from a Covered Person any excess benefits paid for charges which were discounted, waived or rebated.

All benefits will be paid when we receive proper written proof of claim.

If a Covered Person dies while benefits remain unpaid, We may choose to pay benefits to:

A. Any person or persons related to the Covered Person by blood or marriage who appears entitled to the benefits; or

B. The executors or administrators of the Covered Person's estate, based on our selection.

We will be discharged of liability to the extent of any such payments made in good faith.]

LEGAL ACTIONS AND LIMITATIONS

No action at law or in equity may be brought to recover under this Policy until at least 60 days after written proof of claim has been filed with Us. If action is taken after the 60 day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of claim was required to be filed.

RIGHT TO REQUIRE MEDICAL EXAMS

We have the right to require medical exams be performed on any claimant for whom a claim is pending as often as We may reasonably require. If We requires a medical exam, it will be performed at Our expense. We also have the right to request an autopsy in the case of death, if state law so permits.

COVERAGE PROVISIONS

This section provides important information on the coverage provided under this Policy, explaining:

A.How Calendar Year Deductibles, Allowance determinations, Coinsurance Percentages, Maximum Coinsurance Out-Of-Pocket Expense limits and Lifetime Maximum Benefit amounts all impact what this Policy will pay;

B.The Pre-Authorization procedures that must be followed, and rules related to Emergency Care;

C.The benefits that are covered under this Policy; and

D.The benefits that are not covered under this Policy.

UNDERSTANDING THIS HEALTH INSURANCE PLAN

The Policy is a health insurance expense reimbursement plan. This means that We either pays the Health Care Provider directly for Covered Benefits or pays the Covered Person directly when he or she has incurred expenses related to Covered Benefits that have been provided.

In general, the determination of coverage for expenses under this Policy can be understood as follows:

A.The deductible must be satisfied. (See the Calendar Year Deductible provision.)

B.The Covered Person pays a percentage share of the Allowance. (See the Coinsurance Percentage and Allowance provisions.)

C.When out-of-pocket expenses reach a specified limit amount, the Policy pays 100% of the Covered Benefit Allowance. (See the Maximum Coinsurance Out-of-Pocket Limit Provision.)

D.Coverage ends if expenses reach the Lifetime Maximum Benefit. (See the Lifetime Maximum Benefit provision.)

E.All services rendered must be Medically Necessary as defined in this Policy and must not be specifically excluded, limited, or restricted in this Policy. (See the Medical Necessity and the Exclusions and Limitations provisions).

[PREFERRED PROVIDER COVERAGE

This Policy is a Preferred Provider plan. This means that We have entered into an agreement with an established network of Health Care Providers to allow Us to control the cost of Covered Benefits for Covered Persons. The Health Care Providers in Our network are called Participating Providers. Covered Persons are free to obtain services from Health Care Providers of their choice, but the level of coverage of expenses for services received from Participating Providers are higher than those received from Non-Participating Providers.]

[PREFERRED PROVIDER COVERAGE

This Policy is a Preferred Provider plan whereby the Covered Person selects a Primary Care Physician from an established network of Health Care Providers who coordinates the Covered Person's health care needs. The Health Care Providers in Our network are called Participating Providers. The Primary Care Physician is a participating provider [e.g. family practice, general practice, internal medicine, pediatric physician, OBGYN, etc.]. Covered Persons are free to obtain Covered Benefits from Health Care Providers of their choice, but the level of Covered Benefits for services coordinated by a Participating Primary Care Physician will be higher than for Covered Benefit charges incurred for services received from Non-Participating Providers or Participating Providers not referred by Primary Care Physician]

[CHOOSING A PRIMARY CARE PHYSICIAN

The first and most important decision each Covered Person must make under this Policy is the selection of a Primary Care Physician. This decision is important since it is through this Physician that all other health services, particularly those of specialists, are obtained. The Covered Person is free to choose any Primary Care Physician listed in Our published list of Primary Care Physicians whose practice is open to additional Covered Persons. This choice should be made when the Covered Person enrolls. If the Covered Person fails to choose a Primary Care Physician when enrolling, We will assign one to the Covered Person and notify the Covered Person of that assignment. Some important rules apply to the Covered Person's Primary Care Physician relationship:

A. The Primary Care Physician selected by the Covered Person will maintain a Physician-patient relationship with the Covered Person, and will be solely responsible for providing, authorizing and coordinating all medical services for the Covered Person

B. The Covered Person must look to the Primary Care Physician to direct his/her care, and should accept procedures and/or treatment recommended by the Primary Care Physician.

C. Except for Emergency Medical Conditions, all services must be received from the Covered Person's Primary Care Physician, [Participating Providers] or on referral from the Primary Care Physician, or through another Health Care Provider designated by the [Carrier][Covered Person's Primary Care Physician]. If services are not received in this manner and the Covered Person uses a Health Care Provider that is not part of Our Participating Provider network or a Participating Provider that has not been referred by a Primary Care Physician, Covered Benefits are payable at the Non-Participating Benefit level shown in the Schedule of Benefits.

D. We want the Covered Person and the Primary Care Physician to have a good relationship. To be certain this relationship is conducive to effective health care, both the Covered Person and the Primary Care Physician may request a change in the Primary Care Physician assignment:

1. The Covered Person may request transfer of his or her health care to another Primary Care Physician whose practice is open to enrollment of additional Covered Persons. The Covered Person shall be limited to not less than four (4) transfer requests within a calendar year. The transfer of care to the newly selected Primary Care Physician shall be effective [the first day of the calendar month following the date of receipt by Us of the request.]

2. Instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with the Covered Person. In such a circumstance, the Primary Care Physician may request that the Carrier assist the Covered Person in the selection of another Primary Care Physician.

E. If the Primary Care Physician selected by the Covered Person terminates his or her agreement with Us or is unable to perform his or her duties or is on a leave of absence, We may assist the Covered Person in selecting another Primary Care Physician whose practice is open to new Covered Persons.]

[SPECIALTY CARE

The Primary Care Physician selected by the Covered Person will [, with Our authorization,] refer the Covered Person to Participating specialists or facilities when Medically Necessary, using a referral form authorized by Us. The referral form will identify a course of treatment or specify the number of visits authorized for the diagnosis or treatment of the Covered Person's Condition.

[Once the [approved] referral form has been obtained, the Covered Person may make an appointment with the specialist at his/her convenience [provided it is within sixty (60) days from the date of issue of the referral].]

When additional services or visits are suggested by the specialist, Covered Persons should first consult with their Primary Care Physician to obtain additional authorization/referrals.

The Covered Person's Primary Care Physician will consult with Us and the specialist and coordinate the Covered Person's care. This procedure provides the Covered Person with continuity of treatment by the Physician who is most familiar with the Covered Person's medical history and who understands the Covered Person's total health profile.

If a specialist beyond those participating with Us is required, the Primary Care Physician will authorize such treatment only if authorized by Us. An agreed upon treatment plan will then be implemented.]

[A Covered Person does not need to obtain a referral or prior authorization for dermatologic office visits or minor procedures and testing performed by a Participating dermatologist. A Covered Person is limited to five (5) visits every twelve (12) months with a Participating dermatologist.] ***EPO PLANS ONLY***

[EMERGENCY CARE

The procedure the Covered Person should follow for Emergency Care, as defined in this Policy, depends on whether the treatment is rendered inside or outside the Service Area.]

[Within The Network

If Emergency Care services are required within the Service Area, the Covered Person must notify Us, [his/her Primary Care Physician] prior to receiving care. Prior approval is not required for life-threatening emergencies. The Covered Person should, in the instance of a life-threatening emergency, seek Emergency Care for the life-threatening Condition. If a Covered Person is admitted to a Hospital for an Emergency Care Condition by a Physician other than the

Covered Person's Primary Care Physician, the Covered Person, a member of a Covered Person's family or the attending physician must notify Us [Primary Care Physician] at the earliest time reasonably possible to allow the Primary Care Physician to coordinate any necessary follow up care.

Any Emergency room services without prior approval from Us [the Primary Care Physician] are the Covered Person's responsibility, except where a life-threatening Condition is present. The Primary Care Physician cannot make a referral after non-emergency treatment is provided.]

[Out of Network

Emergency Care services provided outside Our Service Area will be covered if the Covered Person sustains an accidental injury or becomes ill while temporarily away from the Service Area.

If the Covered Person requires treatment for **Emergency Care** while outside the Service Area, medical treatment may be sought without first contacting Us [the Primary Care Physician]. Initial treatment only is covered without Our [the Primary Care Physician's] approval. The Covered Person shall notify [the] Us[Primary Care Physician] within 24 hours of provision of such treatment, or as soon thereafter as is practical, so that the Primary Care Physician [and We] may initiate necessary follow up care.

If the Covered Person is admitted to a Hospital for Emergency Care by a Physician other than the Covered Person's Primary Care Physician, the Covered Person, a member of the Covered Person's family, or the attending physician must notify Us and the Primary Care Physician at the earliest time reasonably possible to allow the Primary Care Physician to coordinate any necessary follow up care.]

[IN-NETWORK BENEFITS

The Benefit level this Policy will pay depends on the Health Care Provider the Covered Person uses:

A. If the Health Care Provider used is part of Our Participating Provider network, Benefits are payable at the Participating Provider Benefit level shown in the Schedule of Benefits. The Health Care Provider's network status can be determined by reviewing the Participating Provider directory provided by Us.

B. If the Health Care Provider used is not part of Our Participating

Provider network, Benefits are payable at the Non-Participating Benefit level shown in the Schedule of Benefits.

C. There are two important exceptions:

1. If the Covered Person requires Emergency Care while in the Network Service Area or while traveling outside the Network Service Area, and travel to a Participating Provider location would jeopardize the health of the Covered Person, or if sent to the Non-Participating Provider at the direction of a Participating Provider, those Emergency Care services rendered by a Non-Participating Provider will be payable at the Participating Provider Benefit level.

2. If a required service is not available through a Participating Provider in Our network, those services rendered by a Non-Participating Provider will be payable at the Participating Provider Benefit level.]

[OUT-OF-NETWORK BENEFITS

For Covered Persons who reside outside of Our Service Area, all Benefits under this Policy are payable at the Non-Participating Provider level. If the Covered Person travels into the Service Area and has services provided by a Participating Provider, the Participating Provider Benefit level will be paid.]

THE CALENDAR YEAR DEDUCTIBLE

Individual Calendar Year Deductible Requirement

Before We will begin paying expenses for Covered Benefits, the Covered Person must satisfy the Calendar Year Deductible. The deductible is a flat dollar amount, and must be satisfied each calendar year.

The Calendar Year Deductible for each Covered Person must be satisfied by each Covered Person each calendar year, as determined by Us before any payment will be made by Us for any claim. Only those expenses submitted on claims received by Us for Covered Benefits will be credited by Us toward the Calendar Year Deductible, and only up to the applicable Allowance. At that point, the Calendar Year Deductible will be considered satisfied. Expenses that are not related to Covered Benefits will not be counted toward the satisfaction of the Calendar Year Deductible.

Family Calendar Year Deductible Requirement Limit

Each Covered Person must satisfy a separate Individual Calendar Year Deductible. In a two person family, each individual must satisfy their Individual Calendar Year Deductible. However, in a family policy covering more than two family members, one Covered Person must satisfy their Individual Calendar Year Deductible and the remaining Covered Persons in that family must satisfy together an amount equal to two times the Individual Calendar Year Deductible, before no further deductible satisfaction will be required for the Covered Persons in that family for the remainder of the Calendar Year.

Annual Deductible Carryover

Any charges credited by Us toward a Covered Person's Calendar Year Deductible requirement during the last three months of this Policy's prior Calendar Year, will be carried over to reduce the Calendar Year Deductible requirement for that Covered Person for the next Calendar Year under this Policy. This Deductible expense carryover does not apply to the Family Calendar Year Deductible.

ALLOWANCE GUIDELINES

Once the Calendar Year Deductible is satisfied, We will pay a percentage of the charges for Covered Benefits (see Coinsurance Percentage provision below). With most expenses, the plan will first determine if the charge by the Provider is within Our Allowance. If the Provider's charges exceed the Allowance, the excess amount will not be paid by Us. This excess amount will be the Covered Person's responsibility and should be discussed with the Health Care Provider.

[IN-NETWORK ALLOWANCE

Within Our Service Area, We have established a contractual relationship with a wide range of Health Care Providers, and have negotiated with those Health Care Providers to accept specific schedules of payment for various services as payment in full. Because these negotiated schedules of payment are accepted by all of those Health Care Providers, We have determined it to be appropriate to use these schedules of payment as its guideline for determining Allowances for services provided in the Service Area. Allowance means those charges that do not exceed these negotiated schedules of payment.

We will review all Health Care Provider charges, from both Participating and Non-Participating Providers, that are provided in the Service Area, using these Participating Provider payment schedules as the guideline for the Allowance .]

[OUT-OF-NETWORK ALLOWANCE

In the event that a Covered Person receives services outside of the Service Area, Allowance levels will be determined using health care charge data compiled by the Health Insurance Association of America(HIAA) to determine the Usual and Customary Charge. [HIAA collects data from its member companies, of which We are one, analyzes the data and compiles the Usual and Customary Charge by procedure code and by specified zip code range. The data collected spans a one year period. We apply the 80th percentile for surgical procedure codes and the 90th percentile for miscellaneous procedure codes, office services, pathology and radiology.]

THE COINSURANCE PERCENTAGE

The Covered Person is responsible for paying a percentage of Covered Benefits in addition to the deductible in any one calendar year. This percentage that the Covered Person is responsible for is called the Coinsurance Percentage. The Coinsurance Percentage for this Policy is shown in the Schedule of Benefits.

[Because this Policy is a Preferred Provider Plan, different Coinsurance Percentages apply to services and supplies rendered from Participating Providers and Non-Participating Providers.]

[When charges are incurred for covered services or supplies provided by Participating Providers, We calculate all coinsurance amounts by applying the Coinsurance Percentage to the amount the Participating Provider has agreed to accept for that service or supply in the negotiated schedule of payment. This means that the Coinsurance Percentage(s) that the Covered Person is responsible for when using a Participating Provider is less than the Coinsurance Percentage that the Covered Person is responsible for when using a Non-Participating Provider.]

MAXIMUM COINSURANCE OUT-OF-POCKET EXPENSE LIMITS

Because the Covered Person is responsible for paying a percentage of the Covered Benefit expenses, out-of-pocket expenses that the Covered Person is personally responsible for can grow rapidly. The Covered Person will be directly responsible for all expenses not covered by the Policy.

[If Participating Providers are used, the Covered Person's out-of-pocket expenses will be those expenses used to satisfy the Calendar Year Deductible and the Coinsurance Percentage, plus any services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits. If Non-Participating Providers are used, the Covered Person's out-of-pocket expenses will be those expenses used to satisfy the Calendar Year

Deductible, the Coinsurance Percentage, plus any services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits, and any charge amounts that exceed this Policy's Allowance determinations.]

Under this Policy, the out-of-pocket expenses that the Covered Person has that relate to the Coinsurance Percentage will be limited. All other out-of-pocket expenses noted above are not limited, and are the Covered Person's responsibility.

INDIVIDUAL MAXIMUM COINSURANCE OUT-OF-POCKET LIMIT

The Individual Maximum Coinsurance Out-of-Pocket Expense Limit is the maximum amount of Out-of-Pocket coinsurance expenses that must be paid in a calendar year by each Covered Person before this Policy pays Covered Benefits at 100%. Out-of Pocket expenses related to expenses used to satisfy the Coinsurance Percentage [or, if Non-Participating Providers are used, at any charge amounts that exceed this Policy's Allowance determinations] will count toward satisfying the Individual Maximum Coinsurance Out-of-Pocket Expense Limit.

Out-of-pocket expenses related to charges for services not covered by this Policy, expenses used to satisfy the Calendar Year Deductible, or expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits will not count toward satisfying the Individual Maximum Coinsurance Out-of-Pocket Expense Limit.

After the Individual Maximum Coinsurance Out-of-Pocket Expense Limit has been satisfied in a Calendar Year, benefits for additional Covered Benefit expenses become payable at a rate of 100% of this Policy's Allowance determination for the remainder of that calendar year for that Covered Person. The application of any specific service limits or specific benefit maximums noted in the Covered Benefits section or in the Schedule of Benefits is not affected by the action of out-of-pocket maximums. These specific service provisions will still apply after the out-of-pocket maximums are satisfied.

FAMILY MAXIMUM COINSURANCE OUT-OF-POCKET LIMIT

There is also a Family Maximum Coinsurance Out-of-Pocket Expense Limit. After the Family Maximum Coinsurance Out-of-Pocket Expense Limit has been satisfied in a calendar year, expenses for additional Covered Benefits become payable at a rate of 100% of this Policy's Allowance determination for the remainder of that calendar year for all Covered Persons in that family. Out-of-

Pocket expenses related to expenses used to satisfy the Coinsurance Percentage [or, if Non-Participating Providers are used, any charge amounts that exceed this Policy's allowance determinations] will count toward satisfying the Family Maximum Coinsurance Out-of-Pocket Expense Limit.

Out of Pocket expenses related to charges for services not covered by this Policy, expenses used to satisfy the Calendar Year Deductible, or expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits will not count toward satisfying the Family Maximum Coinsurance Out-of-Pocket Expense Limit.

After the Family Maximum Coinsurance Out-of-Pocket Expense Limit has been satisfied in a Calendar Year, benefits for additional Covered Benefit expenses become payable at a rate of 100% of this Policy's Allowance determination for the remainder of that calendar year for that Covered Person. The application of any specific service limits or specific benefit maximums noted in the Covered Benefits section or in the Schedule of Benefits is not affected by the action of out-of-pocket maximums. These specific service provisions will still apply after the out-of-pocket maximums are satisfied.

LIFETIME MAXIMUM BENEFIT

The total amount of all Covered Benefit expenses payable under this Policy, while this Policy remains in force, for each Covered Person shall not exceed the Lifetime Maximum Benefits shown in the Schedule of Benefits, regardless of the fact that some expenses for Covered Benefits may have separate Benefits Maximums.

MEDICALLY NECESSARY

Except for any preventive care benefits specifically described in the Covered Benefits section, this Policy does not provide benefits for any service rendered or any supply furnished by a Health Care Provider which, in the opinion of the [Carrier] [Covered Person's Primary Care Physician], is not Medically Necessary, as defined in the Glossary. We [Covered Person's Primary Care Physician] will make the decision whether hospitalization or other health care services or supplies are/were Medically Necessary, and therefore eligible for payment under the terms of this Policy. In some instances, this decision is made by Us [the Covered Person's Primary Care Physician] after the Covered Person has been hospitalized or has received other health care services or supplies and after a claim for payment has been submitted.

[PRE-CERTIFICATION

In order to determine whether services and supplies meet guidelines for Medical Necessity, We will require the Covered Person to obtain pre-certification from Us in advance for some Covered Benefits. When required, the Covered Person is responsible for alerting his or her Health Care Provider regarding the need for such pre-certification.

A. For hospitalization, if pre-certification is not obtained from the Us, a penalty will be assessed to the Covered Person. The amount of the Hospital pre-certification penalty is shown in the Schedule of Benefits.

B. For other services and supplies, where the need for pre-certification is noted in this Policy, or where We inform the Covered Person of required pre-certification in a separate notice, if prior approval is not obtained, benefits may be reduced by the pre-certification penalty shown in the Schedule of Benefits.]

[EMERGENCY HOSPITAL CARE

If Emergency Care requires that a Covered Person be admitted to a Hospital, We must be advised by the Hospital of the admission immediately or as soon as reasonably possible. We will then review the Medical Necessity of the Hospital admission.

If Emergency Care required the Covered Person to be admitted to a Non-Participating Hospital, and We have determined that the Covered Person's Condition has stabilized sufficiently to allow the Covered Person to be transferred safely to a Participating Hospital, We will request that the Covered Person and the Covered Person's Physician approve the transfer. If the transfer is not approved, the Non-Participating Provider Coinsurance Percentage will be applied to the benefits payable for any days of Hospital Confinement beyond the date the Covered Person's Condition was stabilized.]

DISCRETIONARY AUTHORITY

We have discretionary authority to determine eligibility, to construe terms of this Policy, and to make decisions concerning claims for benefits under the terms of this Policy.

COVERED SERVICES

This section describes the Benefits that are covered under the Policy and those

that are not covered. It is important that this whole section be reviewed to be sure both Covered Benefit details and the Limitations and Exclusions are understood. Also, important information is contained in the Schedule of Benefits. ALL OF THESE PROVISIONS SHOULD BE READ CAREFULLY TO UNDERSTAND THE BENEFITS PROVIDED UNDER THIS POLICY.

Covered Benefits

Expenses for the services and supplies listed below will be considered Covered Benefits under this Policy if the service is:

A. Required for a Condition;

B. Rendered while coverage under this Policy is in force; and

C. Not specifically limited or excluded under this Policy.

The Coinsurance Percentages for which the Covered Person is responsible for each category of Covered Benefits listed below are shown in the Schedule of Benefits. The payment of expenses for Covered Benefits is subject to Our Allowance guidelines [and Medical Payment Guidelines] (See the Allowance [and Medical Payment Guidelines] provision).

HOSPITAL SERVICES

The services and supplies listed below shall be considered Covered Services when furnished to a Covered Person at a Hospital on an inpatient or outpatient basis, and the Hospital services are Medically Necessary:

A. Room and board for semi-private accommodations, unless We have determined that private accommodations are Medically Necessary;
B. Confinement in an intensive care unit, cardiac care unit or a neonatal care unit;
C. Miscellaneous hospital services;
D. Services provided by a birthing center licensed pursuant to Florida Statutes, chapter 383.30-383.335.;
E. Routine nursery care for a newborn child;
F. Drugs and medicines administered by the Hospital;
G. Respiratory therapy (e.g., oxygen);
H. Rehabilitative services, when hospitalization is not primarily for rehabilitation.
I. Use of operating room and recovery rooms;
J. Use of emergency rooms;

K. Intravenous solutions;
L. Dressings, including ordinary casts, splints and trusses;
M. Anesthetics and their administration;
N. Transfusion supplies and equipment;
O. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG));
P. Chemotherapy treatment for proven malignant disease; and
Q. Other Medically Necessary services and supplies.

AMBULATORY SURGICAL CENTER SERVICES AND OTHER OUTPATIENT MEDICAL TREATMENT FACILITIES

The services and supplies listed below will be considered Covered Services when furnished to a Covered Person at an Ambulatory Surgical Center or any other outpatient medical treatment facility or health care provider's office:

A. Use of operating room and recovery rooms;
B. Respiratory therapy (e.g., oxygen);
C. Administered drugs and medicines;
D. Intravenous solutions;
E. Dressings, including ordinary casts, splints or trusses;
F. Anesthetics and their administration;
G. Transfusion supplies and equipment;
H. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG));
I. Chemotherapy treatment for proven malignant disease; and
J. Other Medically Necessary services and supplies.

MEDICAL SERVICES

The medical services and supplies listed below will be considered Covered Services if provided to the Covered Person by a Health Care Provider when functioning within the scope of his or her license (unless the service descriptions specifically requires Physician care):

Allergy treatment, [subject to the applicable Medical Payment Guidelines] including allergy testing, desensitization therapy and allergy immunotherapy, including hyposensitization serum.

Ambulance services, when needed to transport a Covered Person from:

A. A Hospital which is unable to provide proper care to the nearest Hospital that can provide proper care;

B. A Hospital to a Covered Person's nearest home or Skilled Nursing Facility; or

C. The place a medical emergency occurs to the nearest Hospital that can provide proper care.

Ambulance services by boat, air, plane or helicopter will be reimbursed at the Allowance level for a ground vehicle unless:

A.The pick-up point is inaccessible by ground transportation;

B.Speed in excess of ground vehicle speed is critical; or

C.The travel distance involved in getting the Covered Person to the nearest Hospital that can provide proper care is too far for medical safety, as determined by Us.

Anesthesia services, when administered by a Health Care Provider when necessary for a surgical procedure.

Blood, including whole blood, blood plasma, blood components, and blood derivatives, unless replaced._

Breast Cancer Treatment is defined as routine follow-up care to determine whether a breast cancer has recurred in a covered person who has been previously determined to be free of breast cancer and is not considered medical advice, diagnosis, care, or treatment for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

Coverage for breast cancer treatment includes inpatient hospital care and outpatient post-surgical follow-up care for mastectomies when medically necessary in accordance with prevailing medical standards. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include the hospital, treating physician's office, outpatient center, or the Covered Person's home. Inpatient hospital treatment for mastectomies will not be limited to any period that is less than that determined by the treating physician.

Coverage for mastectomies includes coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy which reestablishes symmetry between the two breasts due to the removal of all or part of the breast for

medically necessary reasons.

The coverage for breast cancer treatment is subject to applicable Deductible and Coinsurance provisions specified in the Schedule of Benefits.

Cancer diagnosis and treatment, unless otherwise excluded, on an inpatient or outpatient basis, including chemotherapy treatment, x-ray, cobalt, and other acceptable forms of radiation therapy, microscopic tests or any lab tests or analysis made for diagnosis or treatment.

Casts, splints, and trusses, when part of treatment in a health care provider facility or office or in a Hospital emergency room. This does not include the replacement of any of these items, or dental splints.

Child health supervision services when ordered and performed by a Provider for health maintenance and preventive care. Services include physician-delivered or physician-supervised visits from birth to 16 years which include a history, a physical examination, developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Services and periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Benefits payable, as specified in the Schedule of Benefits, will be limited to one visit payable to one provider for all of the services provided at each visit, and will not be subject to the Calendar Year Deductible.

Concurrent Physician care, including surgical assistance, provided a) the care is authorized by Us; b) the additional Physician actively participates in the Covered Person's treatment; c) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and d) the Physicians have different specialties or have the same specialty with different sub-specialties.

Congenital or developmental abnormality treatment, provided the treatment, or plastic and reconstructive surgery is for the restoration of bodily function, or the correction of a deformity resulting from disease, injury or congenital or developmental abnormalities.

Consultations, provided the Covered Person's attending [Primary Care] Physician requests the consultation and the consulting Physician prepares a written report.

Dental services for the treatment of an Accidental Dental Injury to sound natural teeth if the Injury occurs, and the services are rendered, while the Covered Person's covered and the treatment is received within six (6) months of the accident (Note: This Benefit does not include coverage for expenses for services related to an injury occurring while, and as a result, of biting or chewing).

Diabetes including all medically appropriate and necessary equipment, supplies and diabetes outpatient self-management training and educational services used to treat diabetes, when the Covered Person's physician that specializes in the treatment of diabetes certifies that such services are necessary and We approve the service in writing. We may require that diabetes outpatient self-management training and educational services be provided under the direct supervision of a certified diabetes instructor or a board-certified endocrinologist. We may require that nutrition counseling be provided by a licensed dietitian.

Diagnostic procedures, lab tests or x-ray exams, including their interpretation, for the treatment of a Condition.

Durable medical equipment that is specifically listed below and when determined by Us to be Medically Necessary for the care and treatment of a Condition covered under this Policy. The specified durable medical equipment will not, in whole or in part, serve as a comfort or convenience item for the Covered Person. Supplies and service to repair medical equipment may be a Covered Benefit only if the Covered Person owns the equipment or is purchasing the equipment. Our allowance for durable medical equipment is based on the most cost effective durable medical equipment which meets the Covered Person's needs, as determined by Us [Covered Person's Primary Care Physician]. At Our option, the cost of either renting or purchasing will be covered. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service. The only equipment that is covered is as follows:

Canes/crutches, walkers, Hospital beds, commode chairs, bedpans/urinals, decubitus care equipment, ostomy and urinary products, LSO and TLSO braces, traction equipment, and standard wheelchairs.

Eye care, limited to the following:

A. Aphakic patients and soft lenses or sclera shells intended for use in the treatment of a Condition,

B. Initial glasses or contact lenses following cataract surgery, and

C. Following an Injury to a Covered Person's eyes, while a Covered Person.

Hemodialysis for renal disease, including the equipment, training and medical supplies required for effective home dialysis.

Immunizations, when Medically Necessary, including flu shots, or which are necessary in the course of other medical treatments of a covered condition.

Insulin, including the needles and syringes needed for insulin administration when dispensed by a [Participating] Pharmacist. However, the Covered Person must have a Physician's authorization for such supplies on record with the pharmacy where the supplies are purchased.

Mammograms performed for breast cancer screening, but limited to the following:

A. A baseline mammogram for women age 35 through 39;

B. A mammogram for women age 40 through 49, every two years or more frequently based upon a Physician's recommendation;

C. A mammogram every year for women age 50 and over.

D. 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. a personal or family history of breast cancer;
b. a history of biopsy-proven benign breast disease;
c. having a mother, sister or daughter who has had breast cancer; or
d. 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 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 and Rehabilitative Services for breast cancer screening. Benefits are **[not]** subject to the Calendar Year Deductible and Coinsurance Percentage provisions, [but are] [and] subject to all other terms and conditions applicable to other benefits.

Newborn child care services received on an inpatient or outpatient basis following birth. These services include post-delivery care which includes newborn assessments, physical assessments, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards. Post-delivery care may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Coverage include the services provided in a licensed birthing center and the services of certified nurse-midwives and midwives licensed pursuant to Florida Statutes, chapter 467.

Obstetrical and maternity care received on an inpatient or outpatient basis including medically necessary prenatal and postnatal care of the mother. This also includes post delivery care including a postpartum assessment of the mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Coverage include the services provided in a licensed birthing center and the services of certified nurse-midwives and midwives licensed pursuant to chapter 467.

Oxygen, including the use of equipment for its administration. However, We reserve the right to monitor a Covered Person's use of oxygen to assure its safe and medically appropriate use.

Pap smears, when Medically Necessary. Pap smears that are provided as a preventive service are covered as part of a periodic health assessment exam in the Preventive and Reproductive Care Services Benefit below.

Pathologist services on an inpatient or outpatient basis.

Prosthetic or orthotic devices, if Medically Necessary, including the initial placement of the most cost effective prosthetic or orthotic device, fitting, adjustments, and repair. We will also cover the replacement of such prosthetic or orthotic devices if it is determined by the treating Physician to be necessary because of growth or change.

Radiologist services on an inpatient or outpatient basis.

Surgical procedures performed on an inpatient or outpatient basis.

SPECIAL SERVICES

The special services and supplies listed below will be considered Covered Services if [authorized by Us and] provided by or authorized by the Covered Person's [Primary Care] [Participating] Physician, subject to the service limitations described below or in the Schedule of Benefits.

Home health care services are covered when provided by a home health agency, through a licensed nurse registry or by an independent nurse licensed under Florida Statutes Chapter 464, if:

A. The Covered Person is confined at home and requires Home Health Care Visits;

B. The treating Physician sends Us [Covered Person's Primary Care Physician] a home health care plan of treatment; and

C. We [Covered Person's Primary Care Physician] approve[s] the plan of treatment in writing as being Medically Necessary and that the services are being provided in lieu of hospitalization or continued hospitalization.

We [The Covered Person's Primary Care Physician] will review the Covered Person's Condition to determine the medical necessity for home health care services. If the Covered Person's Condition does not warrant the services provided by a home health agency, nurse registry or independent nurse, benefits will be denied. At such time as documentation is provided for and services are found to be Medically Necessary and in lieu of hospitalization or continued hospitalization, benefits will be reinstated.

Home health services include:

A. Part-time or intermittent nursing care by a registered nurse or licensed practical nurse;

B. Physical therapy, by a registered physical therapist; occupational therapy, by an occupational therapist; and speech therapy, by a speech-language pathologist.

C. Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by a Physician or other Health care provider and other services provided by or for a home health care agency, through a licensed nurse registry or by an independent nurse licensed under Florida Statutes Chapter 464, to the extent that they would have been

covered if the Covered Person had been confined in a Hospital;

The covered home health care services under this Benefit do not include any service that would not have been covered had the Covered Person been confined in a Hospital.

Hospice services, when hospice services are the most appropriate and cost effective treatment, as determined by Us [the Covered Person's Primary Care Physician]. Covered Persons who are diagnosed as having a terminal illness with a life expectancy of one year or less may elect hospice care for such illness instead of the traditional services covered under this Policy.

To qualify for coverage, the attending Physician must (1) certify that the patient is not expected to live more than one year; (2) submit a written hospice care plan or program and (3) submit a life expectancy certification. All hospice care expenses must be approved in writing by Us. Covered Persons who elect hospice care under this provision are not entitled to any other Benefits under this plan for the terminal illness while the hospice election is in effect. Under these circumstances, the following services are covered.

A. Home Hospice Care, comprised of:

1. Physician services and part-time or intermittent nursing care by a registered nurse or licensed practical nurse;
2. Home health aides;
3. Inhalation (respiratory) therapy;
4. Medical social services;
5. Medical supplies, drugs and appliances;
6. Medical counseling for the terminally ill Covered Person; and
7. Physical, Occupational and Speech Therapy, if approved by the Us [Covered Person's Primary Care Physician] as appropriate for special circumstances.

B. Inpatient hospice care in a hospice facility, Hospital or Skilled Nursing Facility, if approved in writing by Us, including care for pain control or acute chronic symptom management. However, the Allowance for such inpatient care will not exceed the Allowance for the same or similar care when administered on an outpatient basis.

Covered hospice services do not include bereavement counseling, pastoral counseling, financial or legal counseling, or custodial care.

The hospice treatment program must:

A. Meet the standards outlined by the National Hospice Association; and

B. Be recognized as an approved hospice program by Us; and

C. Be licensed, certified, and registered as required by Florida law, and

D. Be directed by a Physician 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.

Mental and Nervous Disorders Treatment

Expenses for the services and supplies listed below for the treatment of Mental and Nervous Disorders will be considered Covered Benefits if provided to the Covered Person:

A. Inpatient confinement in a Hospital or a psychiatric facility for the treatment of a Mental and Nervous Disorder. Coverage is limited as shown in the Schedule of Benefits. Coverage includes visits from a psychiatrist or Physician during confinement.

B. Outpatient treatment provided by a licensed psychiatrist, psychologist, clinical social worker, marriage and family therapist, or mental health counselor, for a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy. Coverage is limited as shown in the Schedule of Benefits.

Pre-admission tests, if Medically Necessary and when ordered or authorized by the by a Physician [Covered Person's Primary Care Physician] [or other Health care provider]. However, the following conditions must be met:

A. The admission to the Hospital or the scheduled outpatient surgery must be confirmed in writing by the [attending Physician] [Covered Person's' Primary Care Physician] before the testing occurs.

B. The tests must be performed within 7 days before admission to the Hospital or the outpatient surgery.

C. The tests must be ordered [by the attending Physician] [or authorized by the Covered Person's Primary Care Physician].

D. The tests are performed in a facility accepted by the Hospital in place of the same tests which would normally be done while Hospital confined.

E. The tests are not duplicated in the Hospital to confirm diagnosis.

F. The Covered Person is subsequently admitted to the Hospital or the outpatient surgery is performed, except if a Hospital bed is unavailable or because there is a change in the Covered Person's health Condition which would preclude the procedure.

Prescription drugs are covered when prescribed by a Physician or other Health Care Provider authorized to prescribe drugs within the scope of their license, and are received by the Covered Person. Prescription drugs purchased from a [Participating] Pharmacy are subject to the following provisions:

[When prescription drugs are purchased from a Participating Pharmacy, the Covered Person's Out-of-Pocket expense is limited to a flat dollar Copayment. The Calendar Year Deductible and Coinsurance Out-of-Pocket Expense Limit provisions do not apply to this benefit when a Participating Pharmacy is used.]

[The prescription drug Copayment is shown in the Schedule of Benefits, and is printed on the Covered Person's ID card. The Covered Person's ID card must be presented to a Participating Pharmacy each time a prescription is filled or refilled. The Copayment must be paid by the Covered Person each time a prescription is filled or refilled at a Participating Pharmacy.]

[When prescription drugs are purchased from a Non-Participating Pharmacy, the Covered Person must first satisfy the Calendar Year Deductible. Covered prescription drugs are then subject to the Non-Participating Provider Coinsurance Percentage shown in the Schedule of Benefits.]

[The Copayment covers only generic drugs if a generic is available. If a generic drug is not available, and the Covered Person is dispensed a brand name prescription drug, the Covered Person is only responsible for the Copayment amount for a generic prescription drug as shown in the Schedule of Benefits.]

[If a generic drug is available and a more expensive brand name prescription drug is dispensed at the request of the Covered Person or the prescribing Health Care Provider, the Covered Person must pay the Copayment amount for a **brand** name drug plus pay the Pharmacist 100% of the additional cost for the more expensive brand name prescription drug.]

[When prescription drugs are purchased, the Covered Person must first satisfy the Calendar Year Deductible. Covered prescription drugs are subject to the Coinsurance Percentage shown in the Schedule of Benefits.]

[The prescription drug benefit covers only generic drugs if a generic is available. If a generic is not available, and the Covered Person is dispensed a brand name prescription drug, the Covered Person is subject to the Coinsurance Percentage for the Allowance for the generic prescription drug.]

[If a generic drug is available and a more expensive brand name prescription drug is dispensed at the request of the Covered Person or the prescribing Health Care Provider, the Covered Person is subject to the Coinsurance Percentage for the Allowance for the brand name prescription drug and any charge amounts that exceed the Allowance determination for the more expensive brand name prescription drug.]

Covered prescription drugs:

A. Include any drug, medicine, medication, or oral contraceptives that, under Federal or state law, may be dispensed only by prescription from a prescribing Health Care Provider, or any compounded prescription containing such drug, medicine or medication;

B. Must be prescribed by a Physician or other Health Care Provider authorized to prescribe drugs within the scope of their license for the treatment of a Condition;

C. Must be dispensed by a Pharmacist;

D. Must be a generic medication when both a generic and a more expensive brand name drug are available and equally effective;

E. Are limited to the lesser of a 31 day or 100 unit dose supply per prescription;

F. Include prescription refills, but will not be covered until at least 75% of the previous prescription has been used by the Covered Person, (based on the dosage schedule prescribed by the physician); and

[G. Must be included in the Formulary approved by Us].

H. Injectable drugs and biologicals only if:

1. Such injectables cannot be self-administered and are furnished incidental to a Health Care Provider's covered professional services;
2. They are reasonable and necessary for the diagnosis or treatment of the covered illness or injury for which they are administered according

to accepted standards of Us];
3. They have not been determined by the FDA to be "less-than-effective";
4. The injection is considered the indicated effective method of administration according to the accepted standards of medical practice for the Covered Condition;
5. The frequency, amount, and duration of the course of injectable drug or biological meets accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections;
6. They are a cost-effective alternative for an otherwise Covered Service as determined by Us [the Covered Person's Primary Care Physician];
7. [They are included in a Formulary approved by Us].

"Incidental to a Health Care Provider's professional service" means that the injectables are furnished as an effective integral, although incidental, part of the Health Care Provider's personal professional services in the course of diagnosis or treatment of a specific injury or illness. In addition, the injection must be given by the Physician or under the Physician's supervision. This does not mean, however, that to be considered "incidental to", each injection must always be at the occasion of the actual rendition of a personal professional service of the Health Care Provider. Such injections could be considered to be "incidental to" when furnished during a course of treatment where the Health Care Provider performs the initial service and subsequent services of a frequency which reflect his active participation in and the management of the course of treatment. Infusions of cancer chemotherapy drugs are considered to be procedures and not injections.

When a Health Care Provider gives the Covered Person a subcutaneous, intramuscular, intravenous or intraarterial injection, no additional payment will be made for the administration of the injection. Payment is made separately for the drug or biological injected, but the cost of the other supplies and the administration of the drug or biological is included in the payment for the visit or other services rendered.

I. Home administered and self-injectable drugs and biologicals only if:

1. Injection is considered the indicated effective method of administration for which the drug or biological is prescribed according to accepted standards of Us for the covered condition;
2. The drug or biological can be safely self-administered based upon accepted standards of medical practice;
3. They are not immunizing agents;

4. They are reasonable and necessary for the specific or effective treatment of the Covered Condition according to accepted standards of medical practice;
5. They have not been determined by the FDA to be "less-than-effective";
6. The frequency, amount and duration of the prescribed course of injectable drug or biologicals meets accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections; and
7. They are a cost-effective alternative for an otherwise Covered Service as determined by Us [the Covered Person's Primary Care Physician].
8. [They are included in a formulary approved by Us].

No coverage is provided for:

A. Any drug, medicine or medication that is consumed at the place where the prescription is given or that is dispensed by a Health Care Provider;

B. Any portion of a prescription or refill that exceeds a 31-day supply or a 100 unit dose, whichever is less;

C. Prescription refills in excess of the number specified by the prescribing Health Care Provider or dispensed more than 6 months from the date of the original order;

D. The administration of covered medication unless otherwise covered herein;

E. Prescriptions that are to be taken by or administered to the Covered Person, in whole or in part, while he or she is a patient in a Hospital, Skilled Nursing Facility, convalescent Hospital, inpatient hospice facility or other facility where drugs are ordinarily provided by the facility on an inpatient basis;

F. Prescriptions that may be properly received without charge under local, state, or federal programs, including Worker's Compensation;

G. Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision in this Policy;

H. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use." Any experimental drug or drug used for non-

FDA approved indication or prescribed for use by a route of administration that is not approved by the FDA even though a charge is made to the Covered Person;

I. Immunizing agents, biological serums or allergy serums, unless otherwise covered herein;

J. Any drug or medicine that is lawfully obtainable without a prescription

K. Therapeutic devices or appliances, including hypodermic needles/syringes unless otherwise covered herein; support garments, and other non-medical substances, regardless of intended use;

[L. Prescriptions filled at a Non-Participating Pharmacy, except for prescriptions required during an emergency;]

M. Any costs related to the mailing, sending or delivery of prescription drugs.

Preventive medical and reproductive care services, limited to the services listed below. Coverage is subject to the Calendar Year Preventive Medical and Reproductive Care Services Benefit Maximum shown in the Schedule of Benefits. Expenses for these services are not subject to the Calendar Year Deductible. [, but are subject to the Coinsurance Percentage requirements.] [Your responsibility will also be based on the Copayment amount or the Allowance, whichever is less]:

A. A periodic health assessment examination performed or authorized by the Covered Person's Primary Care Physician, which includes

1. A health history;
2. A physical examination;
3. Laboratory tests which include urinalysis for blood, sugar, and acetone, and hemoglobin and hematocrit tests;
4. A stool for occult blood;
5. A tuberculin skin test;
6. Tests for sexually transmitted diseases;
7. Vision screening; and
8. Hearing screening.

For women, this examination may be a gynecological exam that also includes a manual breast exam, a pelvic exam, and a pap smear.

This does not include exams required for travel, or those needed for school, employment, insurance, or governmental licensing, unless the service is within the scope of, and coinciding with, the periodic health assessment exam. Only one exam per Calendar Year is allowed.

B. Injectable contraceptives [which are subject to the per prescription Copayment shown in the Schedule of Benefits in addition to the Copayment for a Provider Office Visit].

C. Contraceptive appliances, including an IUD or diaphragm appliance and its insertion, and Norplant insertion and removal [which are subject to the Copayment shown in the Schedule of Benefits]. However, this Policy will not cover any related reconstructive surgery if needed.

Rehabilitative Services, limited to the therapy categories listed below. We [The Covered Person's Primary Care Physician] must specifically approve a written plan of treatment submitted by the Covered Person's Physician and agree that the Covered Person's Condition will improve significantly within 60 days of the date therapy begins.

A. Services of a licensed speech-language pathologist to aid in the restoration of speech loss or an impairment resulting from Injury, stroke or a surgical procedure while this coverage was in force.

B. Services of a licensed audiologist to determine and measure the hearing function loss and aid in the restoration of hearing function loss, if such loss has occurred while this coverage was in force.

C. Services of a licensed physical therapist, occupational therapist, or respiratory or inhalation therapist for the purpose of aiding in the restoration of normal physical function lost due to Injury, stroke or a surgical procedure while this coverage was in force.

Rehabilitative services provided while the Covered Person is Hospital confined will be covered for the duration of the Hospital confinement, subject to the conditions listed above. Outpatient rehabilitative services are limited as shown in the Schedule of Benefits.

Rehabilitative services do not include other therapy types, or any service or supply:

A. Provided to a Covered Person as an inpatient in a Hospital or other facility, where the admission is primarily to provide rehabilitative services.

B. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Covered Person's Condition within a 60 day period.

[Second surgical opinions from a Physician [who is participating in Our second surgical opinion program] after a Covered Person has received a recommendation to have surgery. This consultation includes the physical examination, laboratory work and x-rays not previously performed by the original Physician. The consulting Physician must [be a participant in the Our second surgical opinion program and] not be affiliated in practice with the surgeon who first recommended surgery.

A Benefit will be payable for Allowances incurred by the Covered Person in obtaining a second surgical opinion, after he or she has received a recommendation to have elective surgery which is covered under this Policy. Those Allowances will not be subject to the Calendar Year Deductible or Coinsurance Percentage requirements if:

A. The consulting Physician personally examines the Covered Person and [the] We [Covered Person's Primary Care Provider] receives a copy of the written opinion; and

B. The consulting Physician does not perform the surgery to correct the Condition for which the original recommendation was given.

If both of the conditions stated above are not met, the Allowances for the second opinion will be subject to the Calendar Year Deductible and Coinsurance Percentage requirements.

If the second opinion does not confirm the original recommendation, the Covered Person shall consult another Physician for a third opinion. The third opinion must be obtained, and the Benefit will be payable in the same manner as the second opinion.]

Skilled nursing facility services expenses are covered only if We [Covered Person's Primary Care Physician] approve a written plan of treatment submitted by the Physician and only if the [We] [Covered Person's Primary Care Physician] agrees that such skilled level services are being provided in lieu of hospitalization or continued hospitalization. If provided in the Skilled Nursing Facility, covered expenses include room and board; respiratory therapy (e.g., oxygen); drugs and medicines administered while an inpatient; intravenous solutions; dressings, including ordinary casts; anesthetics and their

administration; transfusion supplies and equipment; diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG)); chemotherapy treatment for proven malignant disease; and other Medically Necessary services and supplies. Services must be skilled level services, and must be ordered by and provided under the direction of a Physician.

Spine and Back Disorder Treatment, consisting of Medically Necessary non-surgical spine and back disorder treatments, subject to all plan provisions and limited as shown in the Schedule of Benefits.

Transplantation of a covered tissue and organ transplant, as defined below, [if approved by the [Us] [Covered Person's Primary Care Physician] and if performed at a facility approved by Us, subject to those conditions and limitations described below.]

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. We will pay benefits only for services, care and treatment received for or in connection with the approved transplantation of the following human tissue or organs:

A. Cornea;
B. Heart;
C. Liver, but only for covered persons through age 17 with biliary atresia;
D. Kidney;
E. Bone marrow, but only for acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, or Stage II, III, or IV breast cancer. We will not cover bone marrow transplants for treatment of cancers or diseases of any other organ or system.

As used in this Policy, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

[For a transplant procedure to be considered approved for this transplant benefit, prior approval from Our [Medical Affairs Department] is required in advance of the procedure. Corneal transplants are considered to be tissue transplants and

do not require prior approval. The Covered Person or the Covered Person's Physician must notify Us in advance of the Covered Person's initial evaluation for the procedure in order for Us to determine if the transplant services will be covered. For approval of the transplant itself, Our [Medical Affairs Department] must be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval will be based on written criteria and procedures established by Our [Medical Affairs Department]. If approval is not given, benefits will not be provided for the transplant procedure.]

No benefit is payable for or in connection with a transplant if:

A. The organ or diagnosis involved is not listed above.

B. Our [Medical Affairs Department] is not contacted for authorization prior to referral for transplant evaluation of the procedure.

C. Our [Medical Affairs Department] does not approve coverage for the procedure.

D. The transplant procedure is performed in a facility that has not been designated by Our [Medical Affairs Department] as an approved transplant facility].

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

F. The expense relates to the transplantation of any non-human organ or tissue.

G. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by Us.

H. A denied transplant is performed; this includes follow up care, immunosuppressive drugs, and complications of such transplant.

The following services/supplies/expenses are also not covered:

A. Artificial heart devices used as a bridge to transplant.

B. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use.

C. Transplant expenses that exceed the Lifetime Transplant Benefit Maximum.

Once the transplant procedure is approved, Our [Medical Affairs Department] will advise the Covered Person's Physician of those facilities that have been approved for the type of transplant procedure involved. Benefits are payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in an approved facility.

For approved transplant procedures, and all related complications, We will pay benefits only for the following covered expenses, up to a Transplant Benefit Maximum for all transplant procedures shown in the Schedule of Benefits:

A. Hospital expenses and physician's expenses will be paid under the Hospital Services benefit and Physician Services benefit in this Policy in accordance with the same terms and conditions as We will pay benefits for care and treatment of any other covered Condition.

B. Transportation costs for the Covered Person to and from the approved facility where the transplant is to be performed if the facility is more than 100 miles from the Covered Person's home.

C. Direct, non-medical costs for one member of the Covered Person's immediate family (two members if the patient is under age 18) for (a) transportation to and from the approved facility where the transplant is performed, but no more than one round trip per person per transplant and (b) temporary lodging at a prearranged location during the Covered Person's confinement in the approved transplant facility, not to exceed $75 per day. Direct, non-medical costs are only payable if the Covered Person lives more than 100 miles from the approved transplant facility. There is a $5,000 maximum for these direct, non-medical expenses, subject to the maximum stated above.

D. Organ acquisition and donor costs. However, donor costs are not payable under this Policy if they are payable in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

[MEDICAL PAYMENT GUIDELINES]

[Our payment for Covered Benefits is limited by Our medical payment guidelines

then in effect. These guidelines apply to Covered Benefits only and are not in addition to all of the other provisions, limitations and exclusions contained in this Policy. These guidelines include, but are not limited to, the following:]

[A. The payment of expenses for Covered Benefits is limited to payment for services and supplies which, in the opinion of Us, are the most cost-effective setting, procedure, treatment, supply or service. For example, Benefits are limited to the most cost-effective prosthetic device, orthotic device, or durable medical equipment which, in the opinion of Us, will restore to the Covered Person the function lost due to the Condition.]

[B. Multiple surgical procedures are more than one surgical procedure performed on the same or different areas of the body during the same operative session. Thus includes bilateral procedures and all surgical procedures performed on the same date of service. The Allowance for all such procedures, other than the primary procedure, will be [50%] of the Allowance for that procedure(s).]

[C. Incidental surgical procedures are one or more than one surgical procedure performed through the same incision or operative approach as the primary surgical procedure which, in the opinion of the insurer, are not clearly identified and/or do not add significant time or complexity to the surgical session. Our payment is limited to the Allowance for the primary surgical procedure, and there is no additional Allowance for any incidental procedure.]

[D. The Allowance for services rendered by a Physician acting in a surgical assistant role is limited to [16%] of the Allowance for the surgical procedure; provided no intern, resident, or other staff Physician is available. Surgical assistant services must be rendered by a Physician to be eligible for payment.]

[E. The Allowance for allergy testing is based upon the type and number of tests performed by the Physician or other medical Health Care Provider. The Allowance for allergy immunotherapy is based upon the type and number of doses per vial.]

[F. Our payment for many services and/or supplies is included within the Allowance for the primary procedure and therefore no additional amount is payable by Us or the Covered Person for any services and/or supplies. Examples include, but are not limited to:

1. Payment for Physician or Health Care Provider services (e.g., Physician

office and Hospital visits) is included in the Allowance for the procedure with which the service is associated. Examples include but are not limited to surgical procedures; obstetrical care; electric shock therapy; dialysis, and therapeutic/diagnostic radiology services.

2. When multiple visits are provided by the same Physician on the same date, payment is limited to one visit which was the highest allowance.

3. Payment for debridement, wound repair, splinting, strapping, unna boot, cast application and removal, and other related services is included in the Allowance for fracture care, dislocation treatment, or other surgical services.

4. Payment for a pathology consultant provided during surgery is included in the Allowance for a frozen section examination.

5. Our payment for a service includes all components of the service when the service can be described by a single procedure code, or when the service is an essential part of the associated therapeutic/diagnostic service. For example, an RBC is part of a complete blood count, and a KUB is part of a barium enema.]

[G. Our payment is based on the Allowance for the actual service rendered (for example, not based on the Allowance for a service which is more complex than the service actually rendered), and is not based on the method utilized to perform the service nor the day of the work or time of day the procedure is performed.]

[H. Payment for psychological testing is limited to 50% of the Allowance for each hour of testing after the first two hours of testing, not to exceed 8 hours during a 12 month period.]

[I. For services rendered by a Physician during Hospital Critical Care, after the first hour of such care, is limited to 16.6% of the critical care Allowance for each additional 1/2 hour, and further limited to 4 1/2 hours of critical care.]

[CASE MANAGEMENT PROGRAM

This program will be administered by Us for those Covered Persons who have a catastrophic or chronic Condition. Under this program, We may elect to (but is not required to) extend presently Covered Benefits beyond the Benefit limitations described in the Covered Benefits section, [cover alternative benefits for cost-

effective health care services and supplies which are not otherwise covered under this Policy]. The decision to provide extended benefits [alternative benefits] may be made available on a case-by-case basis to Covered Persons who meet the program criteria then in effect. Any decision regarding the provision of extended or alternative benefits under this program will be made solely by Us. Such extended or alternative benefits, if any, will be provided in accordance with a treatment plan with approved by Us. The Covered Person or the Covered Person's representative, and the Covered Person's Physician agree in writing.

Our offering to provide or providing of any extended or alternative benefits in no way obligates Us to continue to provide such benefits or to provide extended or alternative benefits to the Covered Person or any other Covered Person at any other time. Nothing contained in this provision shall be deemed a waiver of Our right to enforce the provisions of this certificate of coverage in strict accordance with its terms. The terms of this certificate of coverage apply to any extended or alternative benefits, except as specifically modified in writing by Us when administering this program for the Covered Person.]

EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITION LIMITATIONS

A pre-existing condition is any condition that during the twenty-four (24) month period immediately preceding the individual's effective date of coverage under this Policy had manifested itself in such a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received; or a pregnancy existing on the effective date of coverage. Coverage will not be excluded for a period beyond twenty-four (24) months following the individual's effective date of coverage.

If an individual eligible for this Policy applies for coverage in a timely manner (See Eligibility Section), credit may be given for the partial satisfaction of a pre-existing condition limitation waiting period if that person was subject to a pre-existing condition limitation under previous coverage and had not satisfied a 12 month pre-existing condition waiting period.

EXCLUSIONS AND LIMITATIONS

In addition to the Pre-existing Condition limitations noted above, the following services and/or supplies are excluded from coverage, and are not Covered Benefits under this Policy Expenses related to the excluded services and supplies cannot be used for any purpose under this Policy.

Covered Persons must remember that services that are provided or received without having been prescribed, directed or authorized in advance by [Carrier]'s Medical Director or his or her designee, or if the service is beyond the scope of practice authorized for that Health Care Provider under state law, except in cases of Emergency Care as described in this Policy, are not covered unless such services otherwise have been expressly authorized under the terms of this Policy.

Abortion, including any service or supply related to an elective abortion. However, spontaneous abortions are not excluded. Also, abortions performed for reasons when Medically Necessary for the pregnant Covered Person or when the pregnancy would result in the birth of an infant with grave malformation, are not excluded.

Alcoholism or substance abuse services in conjunction with the abuse of or addiction to alcohol and drugs (including detoxification services, long-term rehabilitation services for treatment of alcoholism and drug addiction, and including prolonged rehabilitation in a specialized inpatient or residential facility).

Ambulance services other than those specifically provided for in the Covered Services section.

Arch supports, orthopedic shoes, sneakers, or support hose, or similar type devices/appliances regardless of intended use.

Autopsy or postmortem examination services, unless specifically requested by Us.

Biofeedback services and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, and pain control.

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition which arises as a complication of a non-covered service (e.g., services or supplies to treat a complication of a pre-existing condition or cosmetic surgery are not covered under this Policy).

Contraceptive appliances, except as specifically provided for in the Preventive Medical and Reproductive Care Services Benefit or Prescription Drug Benefit.

Cosmetic surgery (plastic and reconstructive surgery) and other services and supplies to improve the Covered Person's appearance or self-perception, such as procedures or supplies to correct baldness or the appearance of skin (wrinkling). The restoration of bodily function, or the correction of a deformity resulting from disease, Injury, or congenital or developmental abnormalities, is covered.

Costs incurred by Us related to the following:

A. Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance Policy.

B. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the Covered Person in the activities of daily living. This includes rest homes, home health aides (sitters), home mothers, domestic maid services, and respite care.

Dental care; routine dental procedures including, but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment including palatal expansion devices, bruxism appliances, dental x-rays and routine intra-oral surgical procedures are not covered, except as otherwise covered under the Accidental Dental Injury provision or the Congenital or Developmental Abnormality provision.

Likewise, all procedures, expenses, services, and supplies related to the treatment of malocclusion or malposition of the teeth or jaws (orthognathic treatment), as well as temporomandibular joint (TMJ) syndrome or craniomandibular jaw (CMJ) disorders are excluded unless determined to be Medically Necessary by Us.

Dietary regimens or treatments for reducing or controlling weight

Durable Medical Equipment, other than the equipment specifically listed in the Covered Services section. This exclusion includes, but is not limited to, electric wheelchairs, modifications to motor vehicles and or homes such as wheelchair lifts or ramps; water therapy devices such as jacuzzis or hot tubs; and exercise equipment.

Experimental and Investigational treatment as defined in this Policy.

Eye care, including:

A. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the Covered Services section.

B. Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

C. Training or orthoptics, including eye exercises.

unless otherwise covered by a rider or endorsement attached to this coverage document.

Family Planning services, other than those services specifically described in the Covered Services section.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, unless determined by Us to be Medically Necessary.

Hearing aids (external or inplants) and services related to the fitting or provision of hearing aids, including tinnitus maskers.

Home infusion therapy; except for prescription drugs.

Hospice services, except as described in the Covered Services section.
Hypnotism or hypnotic anesthesia.

Immunizations and physical examinations, when required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements; or immunizations necessary in the course of other medical treatments of a Covered Sickness or Injury.

Infertility treatment, services and supplies, including infertility testing, treatment of infertility, diagnostic procedures and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes in-vitro fertilization, ovum or embryo placement or transfer, gamete

intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

Mental health services and supplies which are (a) rendered in connection with a Condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation, (c) for marriage and juvenile counseling, (d) court ordered care or testing or required as a condition of parole or probation; (e) testing for aptitude, ability, intelligence or interest, or (f) cognitive remediation.

Military service-connected medical care for which the Covered Person is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the Covered Person.

Non-prescription drugs, including any non-prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods.

Obesity treatment, including surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be Medically Necessary by Us.

Orthomolecular therapy, including nutrients, vitamins, and food supplements.

Personal comfort, hygiene or convenience items, including services and supplies deemed not to be Medically Necessary by Us and not directly related to the care of the Covered Person, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services or other transportation services that are specifically provided for in the Covered Services section, motel/hotel accommodations, air conditioning humidifiers or physical fitness equipment.

Private duty nursing care, except as related to covered home health care services.
Rehabilitative therapy services, including speech, occupational and physical therapy, except as described in the Covered Services section. This exclusion includes any services or supplies:

A. Provided to a Covered Person as an inpatient in a hospital or other facility, where the admission is primarily to provide rehabilitative services.

B. Services that maintain rather than improve a level of physical function, or where it has been determined that the services will not result in significant improvement in the Covered Person's Condition within a 60 day period.

Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies.

Services or supplies that are:

A. Determined not to be Medically Necessary;

B. Not specifically listed in Covered Services section unless such services are specifically required to be covered by state or federal law. This Policy will provide coverage on a primary or secondary basis as required by state or federal law.

C. Court ordered care or treatment, unless otherwise covered in this Policy.

D. For the treatment of a Condition resulting from:

1. War or an act of war, whether declared or not;

2. Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;

3. Engaging in an illegal occupation;

4. Services in the armed forces;

5. Intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Covered Person; or

6. Being under the influence of alcohol or any narcotic unless taken on the specific advice of a Physician.

G. Received prior to a Covered Person's effective date or received on or after the date a Covered Person's coverage terminates under this Policy, unless coverage is extended in accordance with the Extension of Benefits provision in the Administrative Provisions section.

H. Provided by a Physician or other Health Care Provider related to the

Covered Person by blood or marriage.

I.Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

J.Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change.

K.Supplied at no charge when insurance coverage is not present, and any charges associated with the Calendar Year Deductible and Coinsurance Percentage requirements which are waived by a Health Care Provider.

Sexual reassignment or modification services, including any service or supply related to such treatment, including psychiatric services.

Skilled nursing facility services not provided in lieu of hospitalization.

Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and nicorette gum.

Training and educational programs, including programs primarily for pain management, the management of diabetes, or vocational rehabilitation.

Transplantation or implantation services and supplies, including the transplant or implant, other than those specifically listed in the Covered Services section. This exclusion includes:

A.Any service or supply in connection with the implant of an artificial organ, including the implant of the artificial organ.

B.Any organ which is sold rather than donated to the Covered Person.

C.Any service or supply relating to any evaluation, treatment, or therapy involving the use of high dose chemotherapy and autologous bone marrow transplantation, autologous peripheral stem cell rescue, or autologous stem rescue for the treatment of any Condition other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, or Stage II, III, or IV breast cancer.

D.Any service or supply in connection with identification of a donor from a

local, state or national listing.

Transportation service that is non-emergency transportation between institutional care facilities, or to and from the Covered Person's residence.

Volunteer services or services which would normally be provided free of charge to a Covered Person.

Voluntary sterilization, including tubal ligations and vasectomies, unless Medically Necessary.

Weight control/loss programs, including but not limited to, food supplements, appetite suppressants, dietary regimens or treatments, exercise programs, or equipment.

Wigs or cranial prosthesis, except when related to restoration after cancer or brain tumor treatment.

Work related condition services to the extent the Covered Person is covered **or required to be covered** by a workers' compensation law. If the Covered Person enters into a settlement giving up rights to recover past or future medical Benefits under a workers' compensation law, this Policy will not cover past or future medical services that are the subject of or related to that settlement. In addition, if the Covered Person is covered by a workers' compensation program that limits Benefits if other than specified Health Care Providers are used and the Covered Person receives care or services from a Health Care Provider not specified by the program, this Policy will not cover the balance of any costs remaining after the program has paid.

GLOSSARY

This section defines many of the terms used in this Policy. Defined terms are capitalized and have the meanings set forth in this section. Additionally, certain important terms and phrases, not appearing in this section, which describe aspects of this Policy, may be capitalized.

ACCIDENTAL DENTAL INJURY is an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional, and unexpected event or force. It does not include injuries to natural teeth caused by biting or chewing.

ACCIDENTAL DENTAL INJURY is an injury to the mouth or structures within

the oral cavity, including teeth, caused by a sudden unintentional, and unexpected event or force. It does not include injuries to natural teeth caused by biting or chewing.

ALLOWANCE means Medicare Allowable Prevailing Fee in the location of service or similar location.

AMBULATORY SURGICAL CENTER is a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or other state's applicable law, the primary purpose of which is to provide elective surgical care to a patient, admitted to and discharged from such facility within the same working day, and which is not part of a Hospital.

CALENDAR YEAR is a period of one year which starts on January 1 and ends December 31.

COINSURANCE is the sharing of Covered health care expenses between Us and the Covered Person, as specifically set forth in the Schedule of Benefits. The coinsurance is expressed as a percentage rather than as a dollar amount.

COINSURANCE PERCENTAGE is the percentage of covered health care expenses shared by the Covered Person.

CONDITION means any sickness, injury, bodily dysfunction or pregnancy of a Covered Person. For any preventive care benefits provided in this Policy, Condition includes the prevention of sickness.

CONFINEMENT is an approved Medically Necessary covered stay as an inpatient in a Hospital that is:

A. Due to a Condition; and
B. Authorized by a licensed medical Health Care Provider with admission privileges.

Each "day" of confinement includes an overnight stay for which a charge is customarily made.

COVERED BENEFITS means those Medically Necessary services and supplies described in the Covered Benefits section of this Policy and any rider or endorsement attached to it.

COVERED OR COVERAGE means inclusion of an individual for payment of expenses related to Covered Benefits expenses under this Policy.

COVERED PERSON means the Eligible Insured or any Eligible Dependent included for coverage under this Policy. Eligibility requirements are specified in the Eligibility section of this Policy.

EMERGENCY CARE means care for a Condition of unpredictable onset which has the capability, or is perceived to have the capability, of producing severe pain, loss of consciousness, excessive bleeding or becomes a threat to life or limb if medical care is not received immediately.

Conditions that would warrant emergency care would include, but are not limited to, the following Conditions: a penetrating wound such as a knife or gunshot wound; a foreign body in the throat; burns involving blisters over a large portion of skin; displaced limbs; head injuries accompanied by drowsiness, vomiting, confusion, blurred vision or bleeding from the ears or throat; sudden or severe continuous chest pain; sudden breathing difficulty; sudden loss of vision or hearing; persistent or sudden bleeding from the nose, mouth or vomiting of blood; seizure occurring for the first time or recurrent frequent seizures unresponsive to current medication; suspected or confirmed overdose of drugs accidentally or intentionally; suspected or confirmed swallowing or breathing of a poisonous substance; or unconsciousness.

Conditions that would not warrant emergency care include, but are not limited to, the following Conditions: colds, sore throat or flu; arthritis that is recurrent; chronic less severe pain such as an earache, headache, sore "pulled muscles" or indigestion; small bruises or scrapes of the skin.

EXPERIMENTAL AND INVESTIGATIONAL TREATMENT means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by Us:

A. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and Rehabilitative Services, and approval for marketing has not, in fact, been given at the time such is furnished to the Covered Person;
B. Reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I, or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question.

C. Reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question.

D. Reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for the treatment of the Condition in question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

E. There is no consensus among practicing Physicians that the treatment, therapy or device is safe or effective for the treatment in question; or

F. Such evaluation, treatment, therapy, or device is not the standard treatment, therapy or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

Reliable evidence means (as determined by Us)

A. Reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;

B. Published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;

C. The written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

D. The written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

E. The records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy or device for the Condition in question.

HEALTH CARE PROVIDER or PROVIDERS means the physicians, physician's assistants, nurses, nurse clinicians, nurse practitioners, pharmacists, marriage and family therapists, clinical social workers, mental health counselors, speech-language pathologists, audiologists, occupational therapists, respiratory therapists, physical therapists, ambulance services, hospitals, skilled nursing facilities, or other health care providers properly licensed in the State of Florida.

HOME HEALTH CARE VISIT means a period of up to 4 consecutive hours of home health care services in a 24-hour period. The time spent by a person providing services under the home health care plan, evaluating the need for, or developing such plan, will be a home health care visit.

HOSPITAL means a facility properly licensed pursuant to Chapter 395 of the Florida statutes, or other state's applicable laws, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an ambulatory surgical center, a skilled nursing facility, stand-alone birthing centers; facilities for diagnosis, care and treatment of mental and nervous disorders or alcoholism and drug dependency; convalescent, rest or nursing homes; or facilities which primarily provide custodial, education, or rehabilitative care.

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 this Policy. It only expands the setting where Covered Benefits may be performed.

INJURY means an accidental bodily injury that:

A.Is caused by a sudden unintentional, and unexpected event or force;
B.Is sustained while the Covered Person's coverage is in force; and
C.Results in loss directly and independently of all other causes.

INSURED means the named or primary insured to whom this policy is issued.

MEDICALLY NECESSARY - A medical service or supply that is required for the identification, treatment, or management of a Condition is Medically Necessary if, in Our opinion it is: (1) consistent with the symptom, diagnosis, and treatment of the Covered Person's Condition; (2) widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence; (3) universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment; (4) not Experimental or Investigation; (5) not for cosmetic purposes; (6) not primarily for the convenience of the Insured, the Insured's family, the Physician, or other Provider, and (7) the most appropriate level of service, care or supply which can safely be provided to the Covered Person. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Insured in an alternative setting.

MEDICARE means the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

MENTAL AND NERVOUS DISORDER means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. Examples include, but are not limited to, attention deficit hyperactivity, bulimia, anorexia-nervosa, bipolar affective disorder, autism, mental retardation, and Tourette's disorder.

NURSING SERVICES means services that are provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or a license vocational nurse (L.V.N.) who is:

A.Acting within the scope of that person's license; or
B.Authorized by a Physician; and
C.Not a member of the Covered Person's immediate family.

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

PHARMACY means a licensed establishment where prescription medications are dispensed by a Pharmacist.

PHYSICIAN is a person properly licensed to practice medicine pursuant to Florida law, or another state's applicable laws, including:

A.Doctors of Medicine (MD) or Doctors of Osteopathy (D.O.);
B.Doctors of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.);
C.Doctors of Chiropractic (D.C.);
D.Doctors of Optometry (O.D.);
E.Doctors of Podiatry (D.P.M.).

POLICY refers to this health benefit Policy issued to the Insured.

PRESCRIPTION means a direct order for the preparation and use of a medication. This order may be given by a Physician to a Pharmacist for the benefit of and use by a Covered Person. The medication must be obtainable only by prescription. The prescription may be given to the Pharmacist verbally or in writing by the Physician.

PSYCHIATRIC FACILITY means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For the purposes of this Policy, a psychiatric facility is not a Hospital, as defined in this Policy.

SICKNESS means bodily disease for which expenses are incurred while coverage under this Policy is in force.

SKILLED NURSING FACILITY means an institution which meets all of the following requirements:

A.It must provide treatment to restore the health of sick or injured persons;

B.The treatment must be given by or supervised by a Physician. Nursing services must be given or supervised by a registered nurse.

C.It must not primarily be a place of rest, a nursing home or place of care for senility, drug addiction, alcoholism, mental retardation, psychiatric disorders, chronic brain syndromes or a place for the aged.

D.It must be licensed by the laws of the jurisdiction where it is located. It must be run as a skilled nursing facility as defined by those laws.

WE, US, OUR means Trustmark Insurance Company (Mutual).

YOU, YOUR means the Named or Primary Insured.