EMPLOYER GROUP HEALTH PLAN

HEALTHY CHOICE LIVING PLAN OPTION

This Healthy Choice Living Plan Option is attached to and made part of your Employer Group Health Plan.

You are covered under a high deductible health plan. Your employer selected this Plan Option in an effort to draw attention to and help you improve your health. Your voluntary participation in this program may reduce your Deductible.

DEFINITIONS

Alternate Standard: Means if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reduced deductible under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reduced deductible; then an Alternate Standard may be made available to qualify you for the reduced deductible. You will be given an opportunity to submit Alternate Standards (established by Your Physician) after receiving notification of the Healthy Choice deductible assignment from the Administrator.

Effective Date: Means the first date of the Employer Group Health Plan, or your effective date (whichever is later).

Health Index Score (HIS): Means the score as determined by your test results applied to the Health Index Scoring model utilized by the Administrator.

Participant(s): Means the employee (if employee only coverage), or the employee and spouse (if the spouse is covered under this Plan).

Plan Year: Means the employer's anniversary (renewal) date. Plan Year begins on the employer's anniversary date and ends twelve months following.

Policy Period: Means the 12-month period beginning on the Plan Year effective date or renewal date.

Required Forms: The following forms must be submitted in order to qualify for a reduced deductible. The forms include:

1) Form 1 - Healthy Choice Patient Testing Requirements: Must be completed by the Physician indicating all test results and lab reports. Non-Smokers are required to provide a negative nicotine lab report. Tests must be completed prior to or on the 60th day following the group or employee effective date.

2) Form 2 – Employee / Spouse Contact Information: This form must be completed by you and your spouse indicating current address, telephone and e-mail address(s). The form must be received prior to or on the 90th day following the Effective Date. It is your responsibility to notify the Administrator of any changes to the contact information.

Subsequent Testing: Means the tests necessary to determine the level of deductible applicable. The subsequent testing must be completed prior to or on the 60th day following the Employer Plan Year renewal date.

Participant Incentives: By participating in the Healthy Choice program, the Plan will pay you the incentives listed below. Incentives will are determined 90-days after the group renewal date. To receive incentive, coverage under the Healthy Choice program must remain in force.

Complete Healthy Choice Patient Testing:	
Blood Test/Exam and Initial Health Survey (1st Policy Year):	$40
Completion of Monthly Online Health Surveys:	$60.00 ($5.00 each - Maximum $60 Per Year)
Improve one or more levels or Maintain Level 1 on Subsequent Testing:	$200
Total Potential Incentive Per Participant:	$300 (not applicable for dependent children)

HOW THE PROGRAM WORKS

After your effective or renewal date, you and your spouse may voluntarily take the basic lab tests described on Form 1 - Healthy Choice Patient Testing Requirements. Tests may be taken at a clinic, physician's office or at the employer site. **THE TESTS MUST BE COMPLETED WITHIN 60 DAYS FOLLOWING THE EFFECTIVE/RENEWAL DATE.** The test results will be used to calculate your Health Index Score (HIS). Your HIS will determine your deductible for the Plan Year. Once results are received, your deductible will be adjusted in accordance with the schedule listed on the following page. This deductible will remain in effect for the Plan Year. Subsequent testing will be required upon group renewal to establish the next Plan Year deductible. **Subsequent testing must be completed prior to or on the 60th day following the Employer Plan Year renewal date.**

DEDUCTIBLES

Your deductible begins on the later of the following dates:

- The date this Plan Option goes into effect for the group.
- The date you become effective under this Employer's Group Health Plan that includes this Rider.

Your deductible ends at the end of the Plan Year. The program will re-start with the maximum deductible on the first date of the new Plan Year that is the Employer's renewal date. You will again have 60 days from the renewal date to complete the tests. You will have 90 days from the renewal date to submit your test results and Alternate Standards to establish your new HIS. If you do not take the tests within 60 days and submit within 90 days, your deductible will remain at the maximum level for the Plan Year. The deductible does not carryover from year to year. Deductibles will not be carried forward from the prior carrier that this Plan replaces.

EXAMPLE ($2500 DEDUCTIBLE RIDER): Plan Option is effective on May 1. Your deductible will be determined by your HIS calculated from the routine tests that you must take within the first 60 days of the Plan Option effective date. Your deductible applies for the period beginning May 1 and ending on April 30 of the following year. In this example, your test results establish that you have a HIS of 510. Based on this, your deductible is $1,000 for the Plan Year. This deductible will remain in effect until April 30 (the end of the Plan Year). On May 1, your deductible will be adjusted to $2,500. You will be required to take subsequent testing to establish your deductible for the next Plan Year.

If you do not take or submit results for subsequent testing, your deductible will increase to the maximum level effective on the first date of the new Plan Year.

Alternate Standard: Your physician **must** determine the Alternate Standard based on factors that may be contributing to your health status. A Healthy Choice Alternate Standard form will be included with the Deductible Assignment notice that will be mailed to you after receipt of your test results. The form, signed by the physician, must be received prior to or on the 90th day after the group Effective Date, or the date provided in our notification letter to you. At the beginning of the next Plan Year, you will need to re-take the Healthy Choice tests and if necessary, submit a new Alternate Standard form. Tests must be completed prior to or on the 60th day and received by the Administrator by the 90th day following the group renewal date. If you meet the Alternate Standard established by your physician for the prior Plan Year, you will be eligible for a deductible reduction for that prior Plan Year.

Initial Health Survey: To receive the $40 incentive, you must complete and submit the required Healthy Choice Patient Testing and complete the on-line Initial Health Survey. To receive the $40 incentive in future Plan Years You will be required to submit only the Healthy Choice Patient Testing. Directions to access the on-line survey are included in Your Healthy Choice folder provided on the effective date and at each group renewal.

On-Line Monthly Health Surveys: On-line surveys are e-mailed each month of the Plan Year to your designated email address allowing you to earn additional incentive payment. Completion of all twelve surveys will earn you $5 each, to a maximum of $60 per Plan Year. The Employee and Spouse must respond separately. Completion is required within 30 days from receipt of the e-mail. The Administrator is not responsible for bad or rejected e-mail addresses. Survey incentives are paid each month direct to the employee. Your coverage must be actively in force at the time of the incentive payment. The surveys are available only by email.

COVERAGE PROVISIONS

1) The initial test must be done following your Effective Date under this Plan Option. Tests must be completed within 60 days of the Effective Date and received by the Administrator within 90 days of the Effective Date.

2) Subsequent testing is required each year following the Employer's renewal date. Testing is to be completed within 60 days of the renewal date and received by the Administrator within 90 days of the renewal date.

3) Employee Only coverage: When you participate, you will take all tests as indicated. The deductible for the Plan Year will be determined as per the Deductible Schedule on the following page.

4) Employee & Spouse coverage: When you and your spouse participate, you and your spouse will take all tests as indicated. The deductible for the Plan Year will be determined separately as per the Deductible Schedule on the following page.

5) Employee, Spouse & Children (FAMILY) coverage: For employee and spouse, refer to #4 above. Dependent children are subject to a maximum Plan Year deductible listed on the Deductible Schedule.

6) If Your coverage terminates prior to completing the wellness surveys or submitting test results for Alternate Standard satisfaction, you will be subject to the deductible last established, or the deductible maximum listed on the Deductible Schedule if you did not participate during the testing period. COBRA participants will be treated same as active employees.

7) New Hires effective for coverage during the first six months (months 1-6) of the Policy Year: Refer to #3, #4 or #5 above. ALL tests must be taken within 60 days and results submitted within 90 days of Your Effective Date of coverage.

8) New Hires effective for coverage after the first six months (months 7-12) of the Plan Year - To Participate: ALL tests must be taken within the first 60 days of your Effective Date of coverage and submitted within 90 days of your Effective Date. Submission of testing will determine the deductible (as shown on the Deductible Schedule on the following page) for the balance of the Plan Year and the entire second Plan Year. Subsequent testing will not be required until the third Plan Year.

9) Failure to submit ALL test results and required physician documentation will void this Rider. Your deductible will be at the maximum level listed on the Deductible Schedule. Dependent children will be subject to the deductible as listed on the Deductible Schedule regardless of Your participation.

DEADLINE

Test must be taken within the first **60 days** following the effective date of this Plan Option or your effective date, if later. The Administrator must receive all results fully completed including lab reports within 90 days of the Effective Date of this Plan Option or your Effective Date, if later. Your deductible will not be reduced if information is received beyond the deadline. The Administrator will not accept late or incomplete information. Exception will be made only in the event you were totally incapacitated during the testing period.

DEDUCTIBLE REIMBURSEMENT

You are eligible for deductible reimbursement if you:

1. Remain active under this Employer's Group Health Plan.
2. Submit Subsequent Test results within 90-days of the Plan renewal date.
3. Improve one or more Health Index Score levels from the previous testing period.
4. Satisfied or exceeded your reduced deductible during the prior Plan Year. The "reduced deductible" is the lower deductible you qualify for based on the newest Subsequent Testing score.

Following 90-days after the Employer Plan's renewal date, the Administrator will calculate your deductible reimbursement based upon your new test results and HIS for the new Plan Year.

Example $2500 Deductible Plan Option: Your previous HIS was 350 and you were assigned a deductible of $1,500. After Subsequent Testing, your HIS is 450 with a deductible assignment of $1,000. You are eligible for a reimbursement of up to $500. Prior deductible $1500 minus new deductible $1000 equals $500. Your deductible reimbursement for the previous Plan Year will be up to $500 or the amount satisfied in excess of $1,000. If you did not exceed the "reduced deductible", no reimbursement is due.

Deductible reimbursements are payable to you. If you have unresolved claims from the prior Plan Year at the time reimbursements are calculated, the additional deductible credit will be paid to the provider when benefits are assigned.

HEALTHY CHOICE - HEALTH INDEX SCORE

TESTING REQUIREMENTS

TEST	ASSOCIATION	RANGE OF ACCEPTABILITY
For diabetic patients: A1c (HbA1c)	American Diabetes Association	< 7.0 Percent
Non-diabetic patients: Fasting Blood Glucose	American Diabetes Association	<100 mg/dL
Blood Pressure	National Heart, Lung & Blood Institute	120/80 or less
Cholesterol	American Heart Association	Less than 200
LDL	American Heart Association	Less than 100
HDL	American Heart Association	Males 40-50 Females 50-60
Nicotine	American Heart Association	Negative
Weight	National Institute of Health	Body Mass Index (BMI) of 25.0 or Less
Waist Measurement		Required
Hip Measurement		Required

YOUR RESPONSIBILITY

It is your responsibility to verify that the lab reports and physician results are fully completed and received by the Administrator within 90 days of your effective or renewal date.

A **NEGATIVE NICOTINE** lab report is required with all test submissions for non-smokers/tobacco users. If you indicate "Non-Smoker" but fail to provide the actual lab report, you will be considered as a smoker.

TESTING REIMBURSEMENT

The Plan will pay for the testing required under the Healthy Choice Living Benefit Rider at 100% (no deductible) under your Preventative Benefit. Payment is limited to the PPO Fee Schedule or the on-site negotiated fee. **Testing must be rendered by a PPO physician and laboratory or provided on-site by an organization approved by the Administrator.** Benefit payment is limited to the tests described in this Benefit Option only. Additional testing recommended by your physician may be covered under your Preventative Benefit as described in the Employer Group Health Plan. See "Preventative Benefits" for details.

The test results will be used to calculate your Health Index Score (HIS), which will be used to establish your deductible as outlined below: ***Non-Network deductible is two times the Network Adjusted Deductible***

HEALTH INDEX SCORE RIDER $1500

HEALTH INDEX SCORE (HIS)	NETWORK DEDUCTIBLE
525 - 600	$ -0-**
401 - 524	$ 500.00
301 - 400	$ 750.00
226 - 300	$ 1,000.00
125 - 225	$ 1,500.00

DEPENDENT CHILDREN	NETWORK DEDUCTIBLE
No testing required	$ 500.00*

HEALTH INDEX SCORE RIDER $2500

HEALTH INDEX SCORE (HIS)	NETWORK DEDUCTIBLE
525 - 600	$ 500.00
401 - 524	$ 1,000.00
301 - 400	$ 1,500.00
226 - 300	$ 2,000.00
125 - 225	$ 2,500.00

DEPENDENT CHILDREN	NETWORK DEDUCTIBLE
No testing required	$ 1,000.00

HEALTH INDEX SCORE RIDER $5000

HEALTH INDEX SCORE (HIS)	NETWORK DEDUCTIBLE
525 - 600	$ 1,000.00
401 - 524	$ 2,000.00
301 - 400	$ 3,000.00
226 - 300	$ 4,000.00
125 - 225	$ 5,000.00

DEPENDENT CHILDREN	NETWORK DEDUCTIBLE
No testing required	$ 2,000.00

***Non-Network deductible is two times the Adjusted Network Deductible**

**If the Network deductible equals -0- the Non-Network deductible is $250.00

Form #1

HEALTHY CHOICE PATIENT TESTING REQUIRMENTS

Patient Name:_____ **Employee Name:**_____

Employer Name:_____ **Group number:**_____

Member ID (Refer to Your ID Card):_____

Patient's Signature **Date**

FASTING REQUIREMENT: *Call Your physician prior to Your appointment and ask what fasting requirements are necessary.*

The above named patient is participating in a voluntary wellness plan that requires completion of the tests listed below. The results will assist the patient in better awareness of their current health status and through participation in the testing may reduce their health plan deductible.

Providing the patient is eligible for coverage, benefits will be payable based upon the PPO allowable fee. Benefit coverage for purposes of the Healthy Choice Rider are limited to the below tests only:

The Following Tests Must Be Completed

A1c (HbA1c) (for patients with diabetes)	_____
Fasting Blood Glucose Test (for non-diabetics)	_____
Blood Pressure Documented by the Physician	_____
Cholesterol	_____
LDL	_____
HDL	_____
Nicotine Test (Lab Report Required)	_____
Body Mass Index (BMI) Measured by the Physician	_____
Hip and Waist Measurement	_____
Office Visit	

>Do not return unless all tests are completed and the results are attached. The maximum Plan Year deductible will apply if the lab report is not submitted with Form 1.

Signature of Physician **Date**

Mail or Fax To: Liberty Union Life Assurance Company
P. O. Box 5047 Troy MI 48007
Fax (248) 583-4647 **Phone** (800) 482-0945

The above tests represent a limited view of a patients overall health status. These basic tests were selected to bring awareness to certain key areas that a healthy lifestyle may improve. The tests are not construed to represent the complete health of the patient nor replace any current medical management of the patient. The physician may require or recommend additional testing as necessary.

The signed HIPAA statement on file with the physician for release of medical information as record for this patient is sufficient documentation to release testing results to Liberty Union, as this documentation is necessary for payment consideration of a claim.

FORM 2

EMPLOYEE / SPOUSE CONTACT FORM

YOUR CONTACT INFORMATION

NAME:_____

EMPLOYER NAME &
GROUP NUMBER:_____

MEMBER ID (Found on ID Card):_____

YOUR HOME ADDRESS

STREET_____

CITY_____STATE_____ZIP_____

HOME PHONE NUMBER_____

CELL PHONE_____

***YOUR E-MAIL ADDRESS**_____

SPOUSE INFORMATION

SPOUSE'S NAME (If on this health Plan)_____

SPOUSE'S CELL_____

***SPOUSE'S E-MAIL ADDRESS**_____

E-mail addresses are required to receive cash incentives for participation and completion of the optional on-line wellness assessment and surveys.

RETURN FORM TO:
LIBERTY UNION LIFE ASSURANCE COMPANY
P.O. BOX 5047
TROY, MI 48007
FAX (248) 583-4647