

***Ardent Technologies, Inc.
Lumenos Health Savings Accounts Option 2 with Rx Option Z
Summary of Benefits , Effective 06/01/2010***

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. Network and Non-Network deductibles are combined.	Single: \$1,500 Family: \$3,000	Single: \$1,500 Family: \$3,000
Out-of-Pocket Limit	Single: \$2,500 Family: \$5,000	Single: \$5,000 Family: \$10,000
Physician Home and Office Services · Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing screenings, Routine Mammograms. · Physician Home and Office Visits · Other Outpatient Services @ Hospital/Alternative Care Facility	No Cost Share	30% 30%
Emergency and Urgent Care · Emergency Room Services @Hospital (facility/other covered services) <i>(copayment waived if admitted)</i> · Urgent Care Center Services	0% 0%	0% 30%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 100 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment and Orthotics (Network/Non-network combined) \$4,000 benefit maximum (excluding Prosthetic Devices and Limbs and Medical Supplies) · Prosthetic Devices \$4,000 benefit maximum · Prosthetic Limbs: \$10,000 benefit maximum · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care · Ambulance Services	0% 0% 0%	30% 0% 0%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> · Physician Home and Office Visits · Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> · Physical therapy: 20 visits · Occupational therapy: 20 visits · Manipulation therapy: 12 visits · Speech therapy: 20 visits · Cardiac Rehabilitation: 36 visits · Pulmonary Rehabilitation: 20 visits · Accidental Dental: \$3,000 Limit 	0% 0%	30% 30%
Behavioral Health Services: Non Biologically Based Mental Illness and Substance Abuse (1) (limits and maximums apply) <ul style="list-style-type: none"> · Inpatient Facility Services · Physician Home and Office Visits · Other Outpatient Services @ Hospital/Alternative Care Facility Inpatient: 30 Network days (includes inpatient mental health Non-Network) Outpatient: 30 Network visits 10 Non-Network mental health visits Combined Inpatient and outpatient Alcoholism \$550 Non-Network Combined Inpatient and outpatient Non-Alcoholism related Substance Abuse Services \$550 Non-Network <i>(Substance abuse rehabilitation programs are limited to two per lifetime Network and Non-Network combined.)</i>	0% 0% 0%	30% 30% 30%
Human Organ and Tissue Transplants <ul style="list-style-type: none"> · Acquisition and transplant procedures, harvest and storage. 	0%	30%
Prescription Drugs: <ul style="list-style-type: none"> · Network Retail Pharmacies: (30 day supply) Includes diabetic test strip · Anthem Mail Service: (90 day supply) Includes diabetic test strip - *4th Tier per script max-\$150 30 day supply. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. - Member may be responsible for additional cost when not selecting the available generic drug. 	\$10 / \$30 / \$50 / 25% \$150 max* out of pocket maximum \$10 / \$75 / \$150 / 25% \$150 max* out of pocket maximum	50% , min \$75(2) Not Covered
Lifetime Maximum (Combined Network and Non-Network) (3)	\$5 million	\$5 million

Notes:

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drug cost shares. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
- Network and Non-network deductibles are combined. Network and Non-network coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to the end of the calendar year in which the child attains age 19; or to the end of the calendar year in which the child attains age of 24 if the child qualifies as a full-time student.