Your Benefit Plan Document

HOW TO GET THE MOST FROM YOUR HumanaPPO PLAN

To obtain the highest level of benefits available through your HumanaPPO plan, be sure to use participating (network) providers - physicians, hospitals, pharmacists, and other health professionals in Humana's provider network.

Network Changes

Since the list of participating providers is constantly changing, it's a good idea to check with your physician to verify his or her participation in Humana's network - or call Customer Service at 1-800-4HUMANA to see whether your physician is in the network or to request an updated Provider Directory. For a listing of HumanaPPO network providers in your area, you may also visit our Web site, **www.humana.com.**

Remember, to make the best use of your HumanaPPO plan benefits, choose physicians and other health providers who participate in Humana's network.

Thank you for choosing Humana!

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.
Jacksonville, Florida 33520

Company Name

U F COLLEGE OF MEDICINE

Group Number: P5030 **Plan** 043 **Option** 998

CERTIFICATE OF INSURANCE

In accordance with the terms of the Group Policy Number P5030 issued to the Policyholder, Humana Health Insurance Company of Florida, Inc. certifies that an eligible person is insured for the benefits described in this booklet. This booklet becomes the Certificate of Insurance and replaces any and all certificates and riders previously issued.

This Certificate describes the benefits, provisions and limitations of the Group Policy. Nothing in this Certificate waives or alters any of the terms or conditions of the Group Policy. The final interpretation of any specific provision in this Certificate of Insurance is governed by the terms of the Group Policy. The benefits outlined in this Certificate are effective only if you are eligibl e for insurance, become insured and remain insured in accordance with the terms of the Group Policy.

Any changes in this Certificate must be approved by an officer of Humana Health Insurance Company of Florida, Inc. and endorsed on the Certificate or attached to it. Any verbal promise made by an officer or an employee of the insurance 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 CONTAINS A DEDUCTIBLE PROVISION

President

This Certificate has been amended. Refer to the last page(s) of this Certificate.

Administrative Office:
500 West Main Street
Louisville, Kentucky 40201-1438

HUMANA INSURANCE COMPANY

Group Policyholder:

U F COLLEGE OF MEDICINE

Group Policy Number: P5030 **Plan** 043 **Option** 998

CERTIFICATE OF INSURANCE

In accordance with the terms of the Group Policy issued to the Policyholder, Humana Insurance Company certifies that an eligible person is insured for the benefits described in this booklet. This booklet becomes the Certificate of Insurance and replaces any and all certificates and riders previously issued.

This Certificate is a companion to the Evidence of Coverage issued to you by Humana Health Plan, Inc. (HMO). The benefits, provisions, limitations and exclusions of coverage for services not provided by or obtained without a referral from your Primary Care Physician are explained in this Certificate.

Nothing in this Certificate waives or alters any of the terms or conditions of the Group Policy. The final interpretation of any specific provision in this certificate of Insurance is governed by the terms of the Group Policy. The benefits outlined in this Certificate are effective only if you are eligible for insurance, become insured and remain insured in accordance with the terms of the Group Policy.

Any changes in this Certificate must be approved by an officer of Humana Insurance Company and endorsed on the Certificate or attached to it. Any verbal promise made by an officer or an employee of the insurance 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.

Humana Insurance Company has the right to release to, or obtain from any physician, hospital, insurance company or other person or organization any claim information including copies of all related records. Any insured person seeking benefits under the Group Policy shall furnish any information which Humana Insurance Company may require. In addition Humana Insurance Company shall have the right to recover any overpayment it may have made from the insured person, any physician, hospital, insurance company, or other person or organization.

President

This Certificate has been amended. Refer to the last page(s) of this Certificate.

SCHEDULE OF BENEFITS

Plan 43 **Option** 998

INDIVIDUAL MAXIMUM BENEFIT $5,000,000

PRE-AUTHORIZATION PENALTY

If any required pre-authorization of services is not obtained, the benefit payable for any Medically Necessary Services, after any applicable Deductibles or Co-payments, will be reduced by $500. If services are not medically necessary, no benefits are payable at all. This out-of-pocket amount may not be used to satisfy any Out-Of-Pocket Expense Limits. This pre-authorization penalty will apply if you received the services from either a Participating or Non-Participating Provider.

ANNUAL DEDUCTIBLE CARRYOVER

If an insured person incurs covered medical expenses during the last 3 months of a calendar year which can be applied toward the satisfaction of the annual deductible for that year, those same expenses will be applied toward the satisfaction of the individual annual deductible of the next calendar year. This deductible carryover does not apply to the family limit deductible.

LEVEL 1 PROVIDER ANNUAL DEDUCTIBLE (Co-payments do not apply toward the Annual Deductibles.)

Single	$0	Per Calendar Year
Family	$0	Per Calendar Year

LEVEL 2 and NON PARTICIPATING PROVIDER ANNUAL DEDUCTIBLE (Co-payments do not apply toward the Annual Deductibles.)

Single	$1,000	Per Calendar Year
Family	$2,000	Per Calendar Year

MAXIMUM OUT-OF-POCKET EXPENSE LIMITS (Excluding deductibles, any out-of-pocket expenses for transplants, the treatment of mental illness and nervous disorders, alcoholism and chemical dependency.)

Participating Providers LEVEL 2

Single	$2,500	Per Calendar Year
Family	$5,000	Per Calendar Year

Non-Participating Providers

Single	$5,000	Per Calendar Year
Family	$10,000	Per Calendar Year

Level 1 Providers:
Hospitals: Shands Hospitals and Facilities and Sacred Heart Hospitals
Physicians: University of Florida College of Medicine Faculty Physicians

Level 2 Providers: (Humana/Choicecare)
Includes Shands Employed Physicians

HOSPITAL SERVICES

Inpatient

Level 1 Participating Hospital	100% Benefit Payable
Level 2 Participating Hospital	80% Benefit Payable
Non-Participating Hospital	60% Benefit Payable after Deductible

Outpatient Surgical Services

Level 1 Participating Hospital	100% Benefit Payable
Level 2 Participating Hospital	80% Benefit Payable
Non-Participating Hospital	60% Benefit Payable

Outpatient Non-Surgical Services

Level 1 Participating Hospital	100% Benefit Payable
Level 2 Participating Hospital	80% Benefit Payable
Non-Participating Hospital	60% Benefit Payable

Free Standing Surgical Center

Level 1 Participating Hospital	100% Benefit Payable
Level 2 Participating Hospital	80% Benefit Payable
Non-Participating Hospital	60% Benefit Payable

Birthing Center

Level 1 Participating Hospital	100% Benefit Payable
Level 2 Participating Hospital	80% Benefit Payable
Non-Participating Hospital	60% Benefit Payable

Emergency Room Visit*

Level 1 Participating Hospital	100% Benefit Payable
Level 2 Participating Hospital	80% Benefit Payable
Non-Participating Hospital	80% Benefit Payable

Pre-admission testing

Level 1 Participating Hospital	100% Benefit Payable
Level 2 Participating Hospital	80% Benefit Payable
Non-Participating Hospital	80% Benefit Payable

*Medical Emergency Services provided by a Non-Participating Hospital or a Non-Participating Physician will be covered at the Participating Provider level(s).

Urgent Care Center

Level 1 Center	100% Benefit Payable
Level 2 Center	80% Benefit Payable
Non-Participating Center	80% Benefit Payable

SCHEDULE OF BENEFITS (CONTINUED)

PHYSICIAN SERVICES

Office Services (Excludes diagnostic lab/x-rays; excludes Outpatient Surgery.)

Level 1 Participating Physician **	100% Benefit Payable
Level 2 Participating Physician **	100% Benefit Payable after $30 Co-Payment Per Visit
Non-Participating Physician	60% Benefit Payable after Deductible

Diagnostic Lab/ X-ray

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable

Inpatient surgery/anesthesia

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable

Radiology/Pathology-inpatient

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Radiology/Pathology-outpatient

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 Co-payment Per Visit
Non-Participating Physician	80% Benefit Payable

Maternity Lab and X-ray

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

PHYSICIAN SERVICES continued

Inpatient Services

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable after Deductible

Outpatient Services (Includes Surgery.)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable after deductible

Outpatient Pathology/Radiology

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 copayment
Non-Participating Physician	80% Benefit Payable after deductible

** Participating Physician's office visits for prenatal care are covered at 100% after the initial visit.

PHYSICIAN SERVICES (CONTINUED)

Second Surgical Option	
Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable
Non-Participating Physician	100% Benefit Payable
Emergency Room Visits*	
Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable
Allergy Testing (When received in Physician's office.)	
Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 Co-Payment Per Visit
Non-Participating Physician	60% Benefit Payable
Allergy Injections	
Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable
Allergy Serum	
Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable

*Medical Emergency Services provided by a Non-Participating Physician will be covered at the Participating Provider level(s).

PHYSICIAN SERVICES (CONTINUED)

Injections (other than routine)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 Co-Payment
Non-Participating Physician	60% Benefit Payable

Sterilization (In a Clinic)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 Co-Payment
Non-Participating Physician	60% Benefit Payable

Advanced imaging (In a Clinic)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable after Deductible

Surgery (In a Clinic)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 Co-Payment
Non-Participating Physician	60% Benefit Payable

Anesthesia (In a Clinic) including medical surgical supplies

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	60% Benefit Payable

MENTAL AND NERVOUS DISORDERS*

Inpatient Services (All par and non-par inpatient care and partial hospitalization is limited to a combined maximum of 90 days per Calendar Year.) (Two days of transitional treatment equals one inpatient day.)

Level 1Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable after Deductible

Inpatient Professional Services

Level 1Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	80% Benefit Payable

Outpatient Facility Services (All Par and Non-Par outpatient care for mental and nervous disorders is limited to a combined maximum of 52 visits per Calendar Year.)

Level 1Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	80% Benefit Payable

Outpatient Professional Services

Level 1Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	80% Benefit Payable

*Any out-of-pocket expenses for the treatment of mental and nervous disorders and alcoholism and chemical dependency services do apply towards the Maximum Out-of-Pocket expense limit.

Limitations on Mental Disorder, Chemical Dependence or Alcoholism Benefits

No benefits are payable under this provision for treatment of nicotine habit or addiction, or for treatment of being obese or overweight.

Treatment must be provided for the cause for which benefits are payable under this provision of the Policy.

SCHEDULE OF BENEFITS (CONTINUED)

ALCOHOLISM AND CHEMICAL DEPENDENCY SERVICES* (All par and non-par inpatient care is limited to a combined maximum of 90 days per Calendar Year.) (Two days of transitional treatment equals one inpatient day.)

Inpatient Services (Inpatient services limited to detoxification.)

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable after Deductible

Inpatient Professional Services

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable after Deductible

Outpatient Facility Services (All par and non-par outpatient care for alcoholism and chemical dependency services is limited to a maximum of 52 visits per calendar year.)

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating	80% Benefit Payable

Outpatient Clinic Services

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-Payment
Non-Participating	100% Benefit Payable after $30 Co-Payment

* Any out-of-pocket expenses for the treatment of mental and nervous disorders and alcoholism and chemical dependency services do not apply towards the Maximum Out-of-Pocket expense limit.

SCHEDULE OF BENEFITS (CONTINUED)

ADDITIONAL MEDICAL SERVICES

In addition to Hospital and Physician Services, benefits will be paid for the services listed below.

HOME HEALTH CARE (Limited to 60 visits per calendar year for all participating provider levels combined)

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable after Deductible
Non-Participating Provider	60% Benefit Payable after Deductible

DURABLE MEDICAL EQUIPMENT

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable

PROSTHESIS

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	80% Benefit Payable after Deductible

SKILLED NURSING FACILITY (Limited to a combined par and non-par maximum of 60 days per Calendar Year.)

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable

AMBULANCE*

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	80% Benefit Payable

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

*Medical Emergency Services provided by a Non-Participating Provider will be covered at the Participating Provider level.

SCHEDULE OF BENEFITS (CONTINUED)

Therapies - Radiation Therapy, Respiratory Therapy, Vision Therapy, Speech Therapy, Physical Therapy, Occupational Therapy and Accupuncture.

Office

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-payment
Non-Participating Provider	60% Benefit Payable after Deductible

Facility

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable after Deductible

Chemotherapy

Office and Facility

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-payment
Non-Participating Provider	60% Benefit Payable after Deductible

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

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

Phase I

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable after Deductible

Phase II

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-Payment
Non-Participating Provider	80% Benefit Payable after Deductible

SCHEDULE OF BENEFITS (CONTINUED)

Massage Therapy

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-payment
Non-Participating Provider	60% Benefit Payable after Deductible

Temporomandibular Joint Dysfuntion (TMJ) (unlimited benefit)

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-payment
Non-Participating Provider	60% Benefit Payable

Splint/Appliances

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-payment
Non-Participating Provider	80% Benefit Payable after Deductible

Birth Control Devices (Injections and Implant devices)

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-payment
Non-Participating Provider	80% Benefit Payable

Sexual Dysfunction / Impotence

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-payment
Non-Participating Provider	60% Benefit Payable after Deductible

Wigs - all medical conditions

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	80% Benefit Payable after Deductible

ADDITIONAL MEDICAL SERVICES (CONTINUED)

HOSPICE (Par and Non-Par/ Outpatient combined maximum benefit of $2,000 per year.)

Inpatient

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable after Deductible
Non-Participating Provider	60% Benefit Payable after Deductible

Outpatient

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable after Deductible
Non-Participating Provider	60% Benefit Payable after Deductible

Bereavement

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable after Deductible
Non-Participating Provider	60% Benefit Payable after Deductible

CHIROPRACTIC CARE (unlimited benefit) (Routine maintenance care not covered)

Exams

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-Payment Per Visit
Non-Participating Provider	60% Benefit Payable after Deductible

X-ray/Lab/Manipulations

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-Payment Per Visit
Non-Participating Provider	80% Benefit Payable

Therapy

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-Payment Per Visit
Non-Participating Provider	60% Benefit Payable after Deductible

SCHEDULE OF BENEFITS (CONTINUED)

ADDITIONAL MEDICAL SERVICES (CONTINUED)

Oral Surgeries

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable after Deductible

Dental Osteotomies/Dental Injuries

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	100% Benefit Payable after $30 Co-Payment
Non-Participating Provider	60% Benefit Payable after Deductible

PRIVATE DUTY NURSING (Limited to inpatient Hospital only.)

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable after Deductible
Non-Participating Provider	60% Benefit Payable after Deductible

INFERTILITY COUNSELING AND TREATMENT
Same as any other sickness depending on type of service and place of treatment.

ALL OTHER SERVICES LISTED IN THE ADDITIONAL MEDICAL SERVICES SECTION

Level 1 Participating Provider	100% Benefit Payable
Level 2 Participating Provider	80% Benefit Payable
Non-Participating Provider	60% Benefit Payable after Deductible

ALL OTHER COVERED SERVICES NOT AVAILABLE FROM PARTICIPATING PROVIDERS

100% Benefit Payable

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DEFINITIONS

Here are some terms used in this certificate. Other terms may be defined in the sections which follow.

ACCIDENT means an injury which is:

1. caused by an event which is sudden and unforeseen; and
2. exact as to time and place of occurrence.

ACTIVE SERVICE means that you are performing all of your regular duties on a full-time basis for your employer on a regularly scheduled work day. You will be considered to be in active service on a non-scheduled work day only if you were in active service on the last regularly scheduled work day.

CALENDAR YEAR means the period of time which begins on any January 1st and ends on the following December 31st. When a person first becomes insured by the Group Policy, the first calendar year begins for him or her on the effective date of his or her insurance and ends on the following December 31st.

CHILD means the employee's natural born child or legally adopted child. The term also includes any child who is dependent upon the employee for health care pursuant to a valid court order. A Pre-existing condition for an adopted child cannot be excluded once they become insured by the Group Policy. We have the right to request proof of the child's dependency status at any time.

CREDITABLE COVERAGE means prior coverage by a member under any of the following:

1. a group health plan, including church and governmental plans;
2. health insurance coverage;
3. Medicare or Medicaid;
4. the health plan for active military personnel, including CHAMPUS;
5. the Indian Health Services or other tribal organization program;
6. a state health benefits risk pool;
7. the Federal Employees Health Benefits Program;
8. a non-federal, public health plan;
9. a health benefit plan under section 5(e) of the Peace Corps Act.

Creditable coverage does not include any of the following:

1. accident only coverage, disability income insurance, or any combination thereof;
2. supplemental coverage to liability insurance;
3. liability insurance, including general liability insurance and automobile liability insurance;
4. worker's compensation or similar insurance;
5. automobile medical payment insurance;
6. credit-only insurance;

7. coverage for on-site medical clinics;
8. benefits if offered separately:
   a. limited scope dental and vision;
   b. long-term care, nursing home care, home health care, community based care, or any combination thereof, and
   c. other similar, limited benefits.
9. benefits if offered as independent, non-coordinated benefits:
   a. specified disease or illness coverage; and
   b. hospital indemnity or other fixed indemnity insurance.
10. benefits offered as a separate policy:
    a. Medicare supplement insurance;
    b. supplemental coverage to the health plan for active military personnel, including CHAMPUS;and
    c. similar supplemental coverage provided to group health plan coverage.

DEPENDENT means a person who is:
1. your lawful spouse; and
2. A child to the end of the calendar year in which the child reaches age 25 if the following conditions are met:
   a. the child is fully dependent upon you; and
   b. the child is living in your home; or
   c. the child is enrolled and actively attending an accredited learning institution as a part-time or full-time student.

   Semester breaks do not jeopardize a child's dependent status. However, if the child is not enrolled and attending an institution as a part-time or full-time student for the semester following the break, the child will no longer be considered a dependent for the purpose of insurance and insurance will end.

   Under no circumstances shall Dependent mean a great grandchild or an emancipated minor including where the great grandchild or emancipated minor meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

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

EMPLOYEE means a person who is in active service for the employer on a full-time basis. The employee must be paid by the employer for work done at the employer's usual place of business or some other location which is usual for the employee's particular duties, other than the employee's home.

EMPLOYER means the organization for whom the employee works.

ENROLLMENT DATE means the first day of coverage of an employee under the Group Policy or, if there is a waiting period, the first day of the waiting period (i.e., the date of hire).

FULL-TIME for an employee, means a work week of at least 20 hours.

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

GROUP MEMBER means you if you are eligible for the benefits of the Group Policy by reason of employment, membership or other established eligibility standard of the policyholder approved by us.

GROUP POLICY means the document describing the full plan of benefits we provide as contracted for by the policyholder.

HEALTH STATUS-RELATED FACTOR means any of the following:

1. health status or medical history;
2. medical condition, either physical or mental;
3. claims experience;
4. receipt of health care;
5. genetic information;
6. disability;
7. evidence of insurability, including conditions arising out of acts of domestic violence.

INJURY means accidental bodily loss or harm.

INSURED PERSON means you and any of your dependents who are enrolled for the benefits provided by the Group Policy and for whom premium payments are being made.

LATE ENROLLEE means an employee or dependent who requests enrollment in a health benefit plan after the initial 31 day enrollment period. An individual will not be considered a late enrollee if:

1. The person enrolls during his/her initial enrollment period under the Group Policy, or
2. The person enrolls in the Group Policy during a special enrollment period; or
3. A court orders that coverage be provided for a minor child under a covered employee's health benefits plan, but only as long as the person requests enrollment for such dependent within 31 days after the court order is issued.

MEDICAL COMPLICATIONS OF PREGNANCY means conditions needing hospital confinement where the diagnosis is different from pregnancy, but the diagnosed condition may be caused or affected by it. These conditions include acutenephritis, nephrosis, cardiac decompensation, missed abortion, puerperal infection and disease of the vascular system. Also included are serious medical and surgical conditions relating to pregnancy, such as hemopoietic nervous or endocrine systems, hyperemesis gravidarum, toxemia and eclampsia of pregnancy. It also includes non-elective cesarean section, miscarriage, and ectopic pregnancy which is terminated or the spontaneous termination of a pregnancy which occurs during a period of gestation in which a viable birth is not possible.

This term does not include conditions such as false labor, occasional spotting, bed rest prescribed by a physician, morning sickness or any similar problems caused by a difficult pregnancy which cannot be classified as distinct from the pregnancy.

MORBID OBESITY (clinically severe obesity) means a body mass index (BMI) of 40 kilograms per meter squared (kg/m2) or greater as of the date of service as determined by a health care practitioner.

PHYSICIAN means a licensed medical practitioner who is practicing within the scope of his or her license and whose services are required to be covered by the laws of the jurisdiction where the treatment is given.

POLICYHOLDER means the employer or organization who has signed a contract for this insurance to be provided.

SERVICE AREA means the geographic area designated by Us, or as otherwise agreed upon between the Policyholder and Us and approved by the Department of Insurance of the state in with the Group Policy is delivered, if such approval is required. The Service Area is the geographic area where the Participating Provider services are available to Insured Persons.

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

SMALL EMPLOYER means the small employer who has signed a policy with the Carrier, allowing this group health insurance coverage to be provided. To be eligible for Small Employer coverage under Florida Statutes, the employer must be a person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, an average of at least one but not more than 50 eligible employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year. For a sole proprietor, an independent contractor, or a self-employed individual to qualify as a small employer, all of the conditions and criteria of Florida Law must be met.

TOTAL DISABILITY OR TOTALLY DISABLED means your continuing inability, as a result of injury or sickness, to perform the material and substantial duties of any job for which you are or become qualified by reason of education, training or experience.

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

YOU or YOUR means the group member.

WE, US or OUR means the Humana Health Insurance Company of Florida, Inc.

EMPLOYEE ELIGIBLITY

You are eligible for coverage if the following conditions are met:

1. You are an employee who meets the eligibility requirements of the group; and
2. You are in active status.

Your eligibility date is your first day of employment with the group.

Eligible participants for coverage under the Group Policy include the following employees who must be appointed at .50 FTE or above.

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

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

Housestaff, Disabled employees, dependents of deceased employees, grandfathered retirees.

EFFECTIVE DATE OF INSURANCE FOR GROUP MEMBERS

If you are eligible for insurance, you may elect to be insured only by signing an enrollment form approved by and acceptable to us. The date your insurance begins depends on the date on which you enroll.

Subject to making any required premium contribution, your coverage will start as described in the paragraphs which follow:

1. If you are eligible for coverage on the effective date of the Group Policy, your coverage will start on the effective date of the Group Policy if you enrolled for coverage when you were first eligible for it, subject to completing any waiting period.

2. If you become eligible after the effective date of the Group Policy and you enroll on or before the date you first become eligible, your coverage will start on the date you become eligible, subject to completing any waiting period.

3. If you become eligible after the effective date of the Group Policy and you enroll within 31 days after the date you first become eligible, your coverage will start on the date you signed the enrollment application, subject to completing any waiting period.

4. If you do not enroll within 31 days after the date you first become eligible to do so, then you will be considered a late enrollee and your coverage will start on the first day of the calendar month coinciding with or next following the date your enroll but you will be subject to an 18 month pre-existing condition.

5. If the benefits of the Group Policy are being offered to you, along with similar coverage provided by a different carrier, you may choose to be insured under the Group Policy. If you elect the coverage provided by the Group Policy, your insurance becomes effective on the renewal date of the group's health benefit plan.

ACTIVE SERVICE REQUIREMENT

If you are not in active service on the date your insurance would become effective for any reason other than a health status-related factor, it will not become effective until you return to active service. This requirement will not apply to retirees covered under the Group Policy.

RETIREE COVERAGE

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

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

BECOMING ELIGIBLE FOR DEPENDENT INSURANCE

You are eligible for dependent insurance only if you are eligible for insurance under the Group Policy as a group member.

If you have one or more dependents, you are eligible for dependent insurance on the date you become eligible for insurance as a group member.

If you do not have any dependents on the date you become eligible as a group member, you do not qualify for dependent insurance. You will become eligible for it on the date you acquire a dependent.

If your dependent is eligible for insurance as a group member, you may not enroll him or her as both a group member and a dependent. In addition, no person can be enrolled as a dependent of more than one group member. An adopted child is eligible for coverage upon the date of placement in your home.

EFFECTIVE DATE OF DEPENDENT INSURANCE

If eligible, you may elect to insure your dependents only by signing an enrollment form approved by and acceptable to us. Subject to making any required premium contribution, dependent coverage will start as described in the paragraphs which follow:

1. If you are eligible for coverage on the effective date of the Group Policy, dependent coverage will start on the effective date of the Group Policy if you enrolled for dependent coverage when you were first eligible for it, subject to completing any waiting period.

2. If you become eligible after the effective date of the Group Policy and you enroll on or before the date you first become eligible, dependent coverage will start on the date you become eligible for dependent coverage, subject to completing any waiting period.

3. If you become eligible after the effective date of the Group Policy and you enroll within 31 days after the date you first become eligible, dependent coverage will start on the date you signed the enrollment application for dependent coverage, subject to completing any waiting period.

4. If you do not enroll within 31 days after the date you first become eligible to do so, then you will be considered a late enrollee and dependent coverage will start on the first day of the calendar month coinciding with or next following the date you enroll your dependents but your dependents will be subject to an 18 month pre-existing condition.

5. If the benefits of the Group Policy are being offered to you, along with similar coverage provided by a different carrier, you may choose to be insured under the Group Policy. If you elect dependent coverage provided by the Group Policy, dependent insurance becomes effective on the renewal date of the group's health benefit plan.

SPECIAL ENROLLMENT PERIODS

1. If you had other group coverage at the time you were first eligible to enroll in the Group Policy and, therefore, did not elect (in writing, if required) to be covered by the Group Policy at that time, but subsequently lost such other coverage, you and any of your dependents who were also covered under the other group plan will not be considered a late enrollee and can enroll in the Group Policy if you apply within 31 days of losing such other coverage, provided the other coverage was either: (a) COBRA coverage which was terminated, or (b) non-COBRA coverage which was cancelled due to a loss of eligibility (including legal separation, divorce, death, termination of employment, or a reduction of hours worked) or because the employer's contributions had ceased. **This is a Special Enrollment Period.** Coverage for you and any of your dependents will start on the first day following the date that your other coverage terminated.
2. If you are eligible for coverage under the Group Policy and dependent coverage is available to you, in the event you acquire a dependent (whether through marriage, birth, adoption or placement for adoption), you may enroll:
   a. yourself, if not already enrolled;
   b. your newly acquired dependent; and,
   c. any other dependent that did not enroll when initially eligible.

   You must apply within 31 days of acquiring the dependent. **This is a Special Enrollment Period.** Coverage for you and your dependent(s) becomes effective on the date of the qualifying event (marriage, birth, adoption, or placement for adoption).

NEWBORN CHILDREN

EFFECTIVE DATE OF INSURANCE A newborn child born to you or your covered family member will be insured from the moment of birth. Notice of the birth must be given to us no later than 31 days after the child's birth. This notice requirement also applies to a newborn adopted child and an adopted child. Coverage for a newborn child of a covered family member shall terminate eighteen months after birth of the child.

If notice is given within the 31 day period stated above, we will not charge additional subscription fees for coverage of the newborn child for the first 31 days of coverage. The applicable subscription fee for the child will be charged after the initial 31 days of coverage. If notice is given within 60 days of the birth of the child, we may not deny coverage for a child due to the failure of the insured to timely notify us of the birth of the child. If notice is not given within the 60 day period, you must wait until the Group's next Open Enrollment Period to enroll the child.

BENEFITS PAYABLE If a newborn dependent, while insured, incurs expenses as a result of an injury or sickness, we will pay for those expenses to the same extent as those payable for any other insured dependent. Benefits will also be payable for transportation charges to and from the nearest available facility staffed and equipped to treat the newborn dependent's condition. The transportation must be certified by a physician as medically necessary. The maximum amount payable for transportation charges for a newborn dependent will be no more than $1,000.

SICKNESS also includes medically diagnosed congenital defects, birth abnormalities or premature birth.

PREMATURE BIRTH Premature birth means a child born too early as determined by a physician.

CHANGES IN INSURANCE

The Group Policy may be revised to increase or decrease benefits after its effective date. For small employers, changes involving an increase in benefits can only be implemented if requested within 30 days of the policyholder's anniversary date. Changes involving a reduction in benefits can be made effective at any time during the year. You and your dependents become insured for the revised benefits on the effective date of the revision.

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE

If the Group Policy replaces the policyholder's prior plan of group medical coverage and a group member is totally disabled or has a pre-existing condition, the group member may have limited insurance under the Group Policy. To be eligible for this limited insurance:

1. the group member must have been covered by the prior plan of group medical coverage on the day before the Group Policy becomes effective for the group; and
2. the group member must be in an eligible class under the Group Policy on the date it becomes effective for the group.

Limited insurance will be provided as follows:

TOTAL DISABILITY - We will provide limited insurance for totally disabled persons covered under the prior plan's extension of benefits as follows:

1. the Group Policy will provide benefits only for those covered medical expenses not directly related to the totally disabling condition; and
2. the Group Policy will not cover medical expenses directly related to the totally disabling condition. These expenses may be covered under the prior plan's extension of benefits provision, if any.

Our limited benefits for the totally disabled person will continue until the earliest of the following dates:

1. the date the person's total disability ends. If the total disability ends before the prior plan's extension of benefits is exhausted, the person will be eligible for the full benefits of the Group Policy, provided the person:

   a. returns to active service, if he or she is a group member; or
   b. is not hospital confined, if he or she is a dependent.

   No waiting period or pre-existing condition limitation will apply.

2. the date the person's insurance under the Group Policy terminates in accordance with the termination provisions of the Group Policy; or

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE (CONTINUED)

3. the date the prior plan's extension of benefits for the disabling condition is exhausted.

PRE-EXISTING CONDITIONS -

1. If the group member satisfied the pre-existing condition waiting period while covered under the immediately preceding plan and any other prior creditable coverage during which time there was no break in any such coverage of 63 consecutive days, full benefits for the pre-existing condition will be provided under the Group Policy.

2. If the group member had not satisfied the pre-existing condition waiting period, we will credit the period of time the group member was covered under all prior creditable coverages, subject to the maximum 63 day break in coverage limitation. The group member must then satisfy the remainder of the pre-existing condition waiting period while insured under the Group Policy. There is a $2,000 pre-existing benefit that may be used during the pre-existing condition waiting period. Once the pre-existing condition waiting period is fully satisfied, full benefits for the pre-existing condition will be provided under the Group Policy.

SPECIAL PROVISIONS FOR THE REPLACEMENT OF INSURANCE (continued)

WAITING PERIOD CREDITS - If a group member had not satisfied the waiting period of the prior plan on the day that plan ended, any periods of time that were satisfied will be applied to the appropriate waiting period of the Group Policy, if any.

DEDUCTIBLE CREDIT - If a group member becomes insured by the Group Policy, we will reduce the deductibles of the Group Policy for the first calendar year by the amount of same or similar covered medical expenses incurred under the prior plan which were applied to that plan's current deductible before the prior plan ended. This credit will not apply if the Group Policy is replacing a health maintenance organization plan.

PERSONAL EXPENSE LIMITS - Any amounts applied to the prior plan's personal expense limit or stop-loss limit will be credited toward the satisfaction of any personal expense limits of the Group Policy.

HEALTH INSURANCE BENEFITS

DEFINITIONS

Here are some terms used in this benefit description .

ADMISSION means entry into a facility as a registered inpatient according to the rules and regulations of that facility. An admission ends when the Insured Person is discharged, or released, from the facility and is no longer registered as an inpatient.

AMBULANCE means a professionally operated vehicle equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's sickness or injury. Use of the ambulance must be medically necessary and/or ordered by a physician and must be the most reasonable method of transportation.

AMBULATORY SURGICAL CENTER means a public or private institution which meets all of the- following requirements

1. It must be operated by physicians and a medical staff which includes registered nurses.
2. It must have permanent facilities and equipment for the primary purpose of performing surgical procedures.
3. It must provide continuous physicians' services on an outpatient basis.
4. It must admit and discharge patients from the facility within the same work day.
5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be run as an ambulatory surgical center as defined by those laws.
6. It must not be used for the primary purpose of terminating pregnancies, or as an office clinic for the private practice of any physician or dentist.

BIRTHING CENTER means a public or private institution which meets all of the following requirements.

1. It must have permanent facilities and equipment for the primary purpose of child birth.
2. It must be staffed by licensed or certified nurse-midwives and have the services of a qualified physician available at all times.
3. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be run as a birthing center as defined by those laws.

BRAND NAME MEDICATION means a medication that is manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by Us.

BREAST RECONSTRUCTION means the reconstruction of a breast on which a Medically Necessary mastectomy has been performed and the reconstruction of the non-diseased breast to achieve symmetry. The term also includes prostheses required for such reconstruction and treatment of physical complication of all stages of mastectomy including lymphedema, in a manner determined in consultation with the attending Physician and the Insured Person. Modification relating to achieving symmetry after the initial reconstruction must be Medically Necessary.

CO-PAYMENT means that portion of covered medical expenses which must be paid by or on behalf of the Insured Person incurring the expenses.

DEDUCTIBLE means a specified amount of medical expenses that an Insured Person must incur before benefits will be paid under the Group Policy.

DIABETES EQUIPMENT includes but is not limited to blood glucose monitors, including monitors designed to be used by blind individuals; insulin pumps and associated appurtenances; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

DIABETES SUPPLIES includes but is not limited to test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; glucagon emergency kits; and alcohol swabs.

DIABETES SELF-MANAGEMENT TRAINING includes but is not limited to training provided to an Insured Person after the initial diagnosis or diabetes for care and management of the condition including nutritional counseling and use of diabetes equipment and supplies. It also includes training when changes required to the self-management regime and when new techniques and treatments are developed.

DURABLE MEDICAL EQUIPMENT means equipment, recognized as such by Medicare Part B, that meets all of the following criteria.

1. It can stand repeated use.
2. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.
3. It is usually not useful to a person in the absence of sickness or injury.
4. It is appropriate for home use.
5. It is related to the patient's physical disorder.
6. It is for temporary use only.
7. A physician as being medically necessary certifies it in writing.

ELECTIVE PROCEDURE means a medical procedure, which is not considered to be an emergency by nature or one which may be delayed by the insured person to a later point in time.

EXPERIMENTAL OR INVESTIGATIONAL means a drug, biological product, device, treatment or procedure that meets any one of the following criteria, as determined by Us:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and which lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information, or (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or is mandated by state law;

2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval;

3. Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;

4. Is subject of a National Cancer Institute (NCI) Phase I trial or a treatment protocol comparable to a NCI Phase I trial, or any trial not recognized by NCI regardless of the Phase.

FORMULARY means a list of drug products approved by Us, that are available for use by Insured Persons.

GENERIC MEDICATION means a drug that is manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard used by Us.

HOSPITAL means an institution which meets all of the following requirements.

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis.
2. It must provide or operate, either on its premises or in facilities available to the hospital on a pre-arranged basis, medical, diagnostic and surgical facilities.
3. Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24 hour basis and must be given by or supervised by registered nurses.
4. It must be licensed by the laws of the jurisdiction where it is located. It must be run as a hospital as defined by those laws.
5. It must not be primarily a:
   a. convalescent, rest or nursing home; or
   b. facility providing custodial, educational or rehabilitative care.

The term also includes licensed or accredited treatment facilities which are properly accredited to provide psychiatric, diagnostic and therapeutic services for the treatment of psychiatric disorders, alcoholism and drug dependency. In addition, if services specifically for the treatment of a physical disability are provided in a licensed hospital, services will not be denied solely because such hospital is primarily of a rehabilitative nature and lacks surgical facilities. However, the hospital must be accredited by one of the following:

1. the Joint Commission on Accreditation of Healthcare Organizations;
2. the American Osteopathic Hospital Association; or
3. the Commission on the Accreditation of Rehabilitative Facilities.

HOSPITAL CONFINEMENT means the number of days spent as a registered inpatient following each admission to a facility. If 7 days or more have not elapsed between the date of discharge from a facility and the date of the next admission, the days will be counted as one confinement. This occurs whether or not we provided benefits during the confinement. One confinement may consist of several admissions.

INTENSIVE CARE UNIT means a special unit of a hospital which:

1. treats patients with serious sickness or injuries;
2. can provide special life-saving methods and equipment;
3. admits patients without regard to prognosis; and
4. provides constant observation of patients by a specially trained nursing staff.

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

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

MEDICAL EMERGENCY AND MEDICAL EMERGENCY SERVICES means a physical condition for which services are required to provide an immediate diagnosis and treatment of a condition which occurs suddenly and unexpectedly and could become a threat to life or limb if medical services were not rendered immediately.

MEDICALLY NECESSARY SERVICES means services and supplies appropriate in the treatment of the patient's diagnosed Sickness or Injury. In order to be considered medically necessary, the services or supplies must be:

1. consistent with the symptom or diagnosis and treatment of the Insured Person's Injury or Sickness;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of an Insured Person, Physician, Hospital or Ambulatory Care Facility; and
4. the most appropriate supply or level of service which can be safely provided to the Insured Person. When applied to the care of an inpatient, it further means that the Insured Person's medical symptoms or conditions require that the services cannot be safely provided to the Insured Person on an Outpatient basis.

NON-PARTICIPATING HOSPITAL means a Hospital which has not been designated as a Participating Hospital by Us.

NON-PARTICIPATING PHYSICIAN means a Physician who has not been designated as a Participating Physician by Us.

NON-PARTICIPATING PROVIDER means a Hospital, Physician, or any other health services provider who has not been designated by Us to provide services to Insured Persons.

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

ORAL SURGERY means procedures to correct diseases, Injuries and defects of the jaw and mouth structures. These procedures include but are not limited to the following:

1. Surgical removal of full bony impactions.
2. Mandibular (staple) implant.
3. Maxillary or mandibular frenectomy.
4. Alveolectomy and alveoplasty.
5. Orthoganthic surgery.
6. Surgery for treatment of temporomandibular joint syndrome/dysfunction.
7. Periodontal surgery, including gingivectomies.

OUTPATIENT means that an Insured Person is not Hospital confined.

OUTPATIENT SURGERY means surgery that is performed in a Physician's office, Ambulatory Surgical Center, free-standing medical clinic or the Outpatient department of a Hospital.

PARTIAL HOSPITALIZATION SERVICES means those services offered by a program accredited by the Joint Commission of Accreditation of Healthcare Organizations or in compliance with equivalent standards. Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Healthcare Organizations or approved by the appropriate state are also considered to be partial hospitalization services.

PARTICIPATING HOSPITAL means a Hospital which has signed a direct agreement with Us as an independent contractor or has been designated by Us as an independent contractor to provide services to all Insured Persons. Participating Hospital designation by Us may be limited to specified services.

PARTICIPATING PHYSICIAN means a Physician who has signed a direct agreement with Us as an independent contractor or who has been designated by Us as an independent contractor to provide services to all Insured Persons. Participating Physician designation by Us may be limited to specified services.

PARTICIPATING PROVIDER means a Hospital, Physician, or any other health services provider who has signed a direct agreement with Us as an independent contractor or who has been designated by Us as an independent contractor to provide services to all Insured Persons. Participating Provider designation by Us may be limited to specified services.

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

PSYCHIATRIC DISORDER means neurosis, psychoneurosis, psychopathy or psychosis.

PSYCHIATRIC TREATMENT PROGRAM means licensed psychiatric treatment programs, licensed drug dependency rehabilitation programs and alcoholism rehabilitation programs. These programs must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or be in compliance with equivalent standards or be approved in the state where the program is run.

REASONABLE CHARGE for a covered service is the lesser of:

1. The fee charged by the provider for the services.
2. The fee that has been negotiated with the provider whether directly or through one or more intermediary, or shared savings contracts for the services.
3. The fee established by Us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographic area determined by Us.
4. The fee based on rates negotiated by Us or other payors with one or more participating providers in the geographic area determined by Us for the same or similar services.
5. The fee equal to the provider's costs for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid services (CMS) annually.

NOTE: The bill you receive for services from Non-participating providers may be significantly higher than the Reasonable Charge. In addition to your out-of-pocket deductibles and coinsurance, You are responsible for the difference between the Reasonable Charge and the amount the provider bills you for the services. Any amount You pay to the provider in excess of the Reasonable Charge will not apply to Your Out-of-pocket Maximum or Deductible.

ROOM AND BOARD means all charges made by a Hospital on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

ROUTINE NURSERY CARE means the charges made by a Hospital or birthing center for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. Physician visits are not considered routine nursery care. Treatment of an injury, Sickness, birth abnormality, congenital defect following birth and care resulting from prematurity is not considered routine nursery care.

SELF-ADMINISTERED INJECTABLE DRUGS means a FDA approved medication which a person may administer to himself/herself by mean intramuscular, intravenous, or subcutaneous injection, excluding insulin, and intended for use by the Insured Person or the Insured Person's family.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SURGICAL PROCEDURE means any of the following procedures (excluding oral surgical procedures):

1. incision, excision or electrocauterization of any organ or body part;
2. reconstruction of any organ or body part or the suture or repair of lacerations;
3. reduction of a fracuture or dislocation by manipulation;
4. use of endoscopic procedure to expore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter;
5. puncture for aspiration;
6. injection for contrast media testing; or
7. laser surgery.

WEEKEND NON-EMERGENCY HOSPITAL ADMISSION means an admission to a Hospital on a Friday, Saturday or Sunday at the convenience of the Insured Person or his or her Physician when there is no cause for an emergency admission and the Insured Person receives no surgery or therapeutic treatment until the following Monday.

HEALTH INSURANCE BENEFITS

WHAT WE PAY

We pay the applicable benefit amount or percentage shown in the Schedule of Benefits for covered expenses if they are:

1. medically necessary as a result of an injury or a sickness;
2. received by an insured person;
3. for services authorized by a physician.

The benefit payable will be subject to any co-payment, deductible and pre-existing condition limitation that applies to the covered expense and will not exceed:

1. reasonable charges; or
2. any applicable limitation or maximum amount for the covered expense.

Deductibles, co-payments and maximum amounts, if any, for each benefit are shown in the Schedule of Benefits. We calculate deductibles and co-payments by applying the dollar amount or percentage to net charges. Net charges are defined as gross billed charges less any discounts or fee negotiations that may have been arranged with participating providers. Gross charges means the amount the provider charges without giving consideration to any of the discounts or fee negotiations which we have arranged to receive from the provider.

We will pay participating physicians for covered expenses in accordance with the fee schedules of reasonable charges established between the participating physicians and us. For services rendered by participating physicians, the dollar amount of the deductible or benefit percentage that is your responsibility is calculated based on the fee schedule of the participating physician rendering the services. For services rendered by non-participating physicians, the dollar amount of the deductible or benefit percentage is calculated based on a reimbursement schedule established by us and agreed to by your employer. When using a non-participating physician, you are also responsible for any charges that exceed this reimbursement schedule and non-covered services.

A covered expense is deemed to be incurred on the date a covered service is performed or a covered supply is furnished. Charges are not considered to be covered expenses until any applicable deductibles or co-payments have been satisfied. If a benefit is payable for certain covered expenses under a particular benefit section of the Group Policy, those covered expenses will not be considered for payment under any other benefit section of the Group Policy unless specified otherwise. An expense will not be covered if it is incurred after your coverage under the Group Plan is terminated unless it is required to be covered by state law.

HEALTH INSURANCE BENEFITS (CONTINUED)

THE ANNUAL DEDUCTIBLE

An annual deductible is a specified dollar amount that an insured person must pay for covered medical expenses per calendar year before benefits will be paid under the Group Policy. There are single and family participating and non-participating provider deductible limits. Expenses incurred by an insured person which may be applied to any applicable deductible referenced under this paragraph will be applied equally toward the satisfaction of both the participating and non-participating provider deductibles. The deductible amounts for each insured person and each insured family are shown in the Schedule of Benefits and must be satisfied each calendar year. Co-payments do not apply toward any annual deductibles.

If two or more insured persons of the same family are injured in the same accident and incur covered medical expenses for those injuries, only one deductible will be deducted from the total covered expenses resulting from the accident in the calendar year in which the accident occurs.

Only one deductible will be deducted from the total covered medical expenses incurred as a result of a multiple birth of two or more dependents. The covered expenses must be incurred in the same calendar year as the birth and result from:

1. premature birth;
2. an abnormal congenital condition; or
3. an injury or sickness occurring within 31 days after the birth.

ANNUAL DEDUCTIBLE CARRYOVER

If an insured person incurs covered medical expenses during the last 3 months of a calendar year which can be applied toward the satisfaction of the annual deductible for that year, those same expenses will be applied toward the satisfaction of the individual annual deductible of the next calendar year. This deductible carryover does not apply to the family limit deductible.

HEALTH INSURANCE BENEFITS (CONTINUED)

OUT-OF-POCKET EXPENSE LIMIT

A Maximum Out-Of-Pocket Expense Limit is the amount of covered expenses, excluding expenses used to satisfy Deductibles and Co-Payments, that must be paid by each Insured Person before a benefit percentage will be increased. There are single and family Participating and Non-Participating Provider Out-Of-Pocket Expense Limits. After the single Participating Provider maximum out-of-pocket expense limit has been satisfied in a Calendar Year, the Participating Provider benefit percentage for covered expenses will be payable at the rate of 100% for the rest of the Calendar Year for the individual Insured Person. After the single Non-Participating Provider Maximum Out-Of-Pocket Expense Limit has been satisfied in a Calendar Year, the Non-participating Provider benefit percentages for covered expenses will be payable at the rate of 100% for the rest of the Calendar Year for the individual Insured Person. Benefit specific Co-Payments continue to be the responsibility of the Insured Person.

After the family Participating Provider Maximum Out-Of-Pocket Expense Limit has been satisfied in a Calendar Year, the Participating Provider benefit percentage for covered expenses will be payable at the rate of 100% for the rest of the Calendar Year for the remaining Insured Persons in that family. After the family Non-Participating Provider Maximum Out-Of-Pocket Expense Limit has been satisfied in a Calendar Year, the Non-Participating Provider benefit percentages for covered expenses will be payable at the rate of 100% for the rest of the Calendar Year for the remaining Insured Persons in that family. Benefit specific Co-Payments continue to be the responsibility of the Insured Person.

The Participating Provider Maximum Out-Of-Pocket Expense Limit does reduce the Non-Participating Provider Maximum Out-Of-Pocket Expense Limit. The maximum Out-Of-Pocket for Participating and Non-Participating Providers combined would not exceed $5,000 for single and $10,000 for family.

HEALTH INSURANCE BENEFITS (CONTINUED)

PRE-AUTHORIZATION PROVISIONS

All benefits payable under the Group Policy must be for services and supplies that are medically necessary. In order to determine whether services and supplies meet guidelines for medical necessity, they must be authorized by us in advance.

The Insured Person is responsible for alerting his or her Physician regarding the need for prior approval. The identification card will alert the Physician that pre-authorization is required and will show the telephone number to call to obtain the appropriate authorization. If prior approval of services or supplies is not obtained, benefits may be reduced or not paid at all.

The following benefits require Pre-Authorization:

BENEFIT	REQUIREMENTS	PENALTY
Inpatient Hospitalization	We must be notified before you are admitted. If the admission is on an emergency basis, We must be notified no later that 72 hours after you were admitted.	If the admission is not pre-authorized, benefits for the hospital or qualified treatment facility will be subject to a $500 penalty per confinement. The penalty does not apply to the deductible, coinsurance or out-of-pocket maximums.
Skilled Nursing Facility	We must be notified before you are admitted.	Notification is required for skilled nursing facility confinement. If skilled nursing facility confinement is not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Durable Medical Equipment $2,000 and above	We must be notified prior to services being rendered.	If durable medical equipment over $2,000 is not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Experimental Procedures	We must be notified prior to services being rendered.	If experimental procedures are not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Abdomino-plasty/Panniculectomy	We must be notified prior to services being rendered.	If abdomino-plasty/panniculectomy are not pre authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out- of-pocket maximums.

HEALTH INSURANCE BENEFITS (CONTINUED)

BENEFIT	REQUIREMENTS	PENALTY
Blepharoplasty	We must be notified prior to services being rendered.	If blepharoplasty are not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Cosmetic Procedures	We must be notified prior to services being rendered.	If cosmetic procedures are not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket.
Mandibular or Maxillary Osteotomy	We must be notified prior to services being rendered.	If mandibular or maxillary osteotomy are not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Orthoganthic Surgery	We must be notified prior to services being rendered.	If orthoganthic surgery is not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Orthotics $500 and above	We must be notified prior to services being rendered.	If orthotics over $500 is not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Penile Implants and revascularization	We must be notified prior to services being rendered.	If penile implants or penile revascularization are not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.
Scar Revisions	We must be notified prior to services being rendered.	If scar revisions are not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of pocket maximums.

HEALTH INSURANCE BENEFITS (CONTINUED)

BENEFIT	REQUIREMENTS	PENALTY
Sclerotherapy	We must be notified prior to services being rendered.	If sclerotherapy is not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.
Septoplasty/Submucous resection with or without rhinoplasty	We must be notified prior to services being rendered.	If Septoplasty/Submucous resection with or without rhinoplasty is not pre-authorized, benefits will be subject to a $500 penalty per occurrence. The penalty does not apply to the deductible or out-of-pocket maximums.

WHEN EMERGENCY HOSPITALIZATION IS REQUIRED

If a Medical Emergency requires that an Insured 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 admission. If the Insured Person has been admitted to a Non-Participating Hospital, and it has been determined that the Insured Person s condition has stabilized sufficiently to allow the Insured Person to be transferred safely to a Participating Hospital, We will request that the Insured Person and the Insured Person s Physician approve the transfer. If the transfer is not approved, the Non-Participating Hospital Deductible and Co-Payment amounts will be applied to the benefits payable for any days of Hospital confinement beyond the date the Insured Person s Medical Emergency was stabilized.

HEALTH INSURANCE BENEFITS (CONTINUED)

APPEALS PROCEDURE

If you are dissatisfied with our determination your claims, you may appeal the decision. Such appeals will be handled on a timely basis and appropriate records will be kept on all appeals.

You should appeal in writing to the address given on the denial letter received or by visiting our web site at www.humana.com. The appeal will be reviewed by us and a response sent to you no later than 30 days following receipt of the appeal.

All requests for review should be submitted in writing or by visiting our web site at www.humana.com. We have procedures for reviewing appeals and may conduct informal hearings about the appeal. If any hearing is to be held, you will be notified in advance. Resolution of the appeal will be completed within a reasonable amount of time. Our findings and recommendations will be final.

The appeal process does not preclude you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgement, or relief available under law, if the requirement of exhausting the process for appeal and review places your health in serious jeopardy. In all other situations, however, you must exhaust the process of appeal and review, including external review where applicable, before filing suit under the policy.

HEALTH INSURANCE BENEFITS (CONTINUED)

BASIC HOSPITAL BENEFIT

We will pay benefits for covered medical expenses incurred by an insured person while hospital confined. The hospital confinement must be ordered by a physician and be the result of an injury or sickness which occurs while insured under the Group Policy. The following services and supplies for which charges are made by a hospital on its own behalf will be considered covered medical expenses.

1. Room and board. Maternity benefits provide a minimum of 48 hours of inpatient care following a vaginal delivery and 96 hours following a delivery by cesarean section. This minimum benefit may be shortened after consultation between the attending physician and the patient and in accordance with the protocols and guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.
2. Medically necessary services and supplies, other than room and board, provided by a hospital to registered inpatients.
3. Confinement in an intensive care, cardiac care or neonatal care unit.
4. Services provided by a birthing center.
5. Routine nursery care for a newborn child for up to a maximum of 10 days.
6. Services provided in a hospital's outpatient department in connection with outpatient surgery.
7. Services provided in an ambulatory surgical center in connection with outpatient surgery.
8. Services provided in a hospital's emergency room.

Charges for physician's services in connection with surgical operations are not considered covered hospital expenses.

HEALTH INSURANCE BENEFITS (CONTINUED)

PHYSICIAN BENEFITS

We will pay benefits for covered expenses incurred by an insured person for physicians' charges. The insured person must incur physicians' charges as the result of an injury or a sickness which occurs while insured under the Group Policy. Reasonable charges for the following services and treatment will be considered as covered expenses.

1. Surgical procedures performed on an inpatient or outpatient basis. If several surgical procedures are performed through the same incision or body opening during one operation, we will pay the reasonable charge for the primary procedure. We will pay 50% of the reasonable charge for the other procedures. If several surgical procedures are performed through different incisions or body openings during one operation, we will pay the reasonable charge for each procedure.
2. Obstetrical services received on an inpatient or outpatient basis including medically necessary prenatal and postnatal care of the mother. These include the services of a nurse-midwife and midwife licensed pursuant to Chapter 467.
3. Care of a newborn child while the newborn is hospital confined immediately following birth.
4. Anesthesia administered by a physician or certified registered anesthetist attendant to a surgical procedure.
5. Radiation therapy received on an inpatient or outpatient basis.
6. Consultation charges requested by the attending physician during a hospital confinement. The benefit is limited to one consultation by any one consultant per specialty during a hospital confinement.
7. Surgical assistance provided by a physician, when medically necessary. The benefit for surgical assistance will be 20% of the reasonable charge for the procedure.
8. Inhospital medical services furnished by the attending physician to a hospital confined insured person.
9. Services of a pathologist during an inpatient confinement or when associated with a surgical procedure.
10. Services of a radiologist during an inpatient hospital confinement or when associated with a surgical procedure.

PHYSICIAN BENEFITS (CONTINUED)

11. Services performed on an emergency basis in a hospital if the injury or sickness being treated results in a hospital confinement.

Benefits will be subject to the benefit amounts or percentages shown in the Physician section of the Schedule of Benefits.

Charges for physicians' services which are payable as a hospital charge are not payable under this benefit.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

MENTAL AND NERVOUS DISORDER BENEFIT

Benefits are payable for covered expenses incurred by an Insured Person while undergoing treatment for mental and nervous disorders. All charges must be made by a Physician, or a Hospital or a Psychiatric Treatment Program, and benefits are payable as follows:

1. Inpatient Charges - Charges incurred by an Insured Person while confined as a registered bed patient in a Hospital or Psychiatric Treatment Program will be considered covered expenses. Benefits are limited to the maximum number of inpatient days per Calendar Year shown on the Schedule of Benefits. The number of days shown will be reduced by confinement in either a participating or non-participating facility provider.

2. Outpatient Charges - Charges incurred by an Insured Person while not confined in a Hospital or Psychiatric Treatment Program will be considered covered expenses. Benefits are limited to the maximum number of visits per Calendar Year and the Calendar Year maximum benefit shown on the Schedule of Benefits. The number of visits shown will be reduced by visits at either a Participating or Non-Participating Provider.

3. Partial Hospitalization - A combination of inpatient and outpatient services may be used for the treatment of mental and nervous disorders. The use of this partial hospitalization procedure must be under the direction of a Physician. The maximum benefit we pay for such services, including the prevailing physician fee in the community where the services are rendered, will not exceed the total benefit of the Mental and Nervous Disorders Inpatient Benefit shown in the Schedule of Benefits.

4. Benefit Percentage - All expenses incurred for the treatment of mental and nervous disorders are subject to the benefit amounts or percentages shown on the Schedule of Benefits.

HEALTH INSURANCE BENEFITS (CONTINUED)

ADDITIONAL MEDICAL EXPENSES

We will pay benefits for the following covered expenses for charges incurred by an insured person as the result of an injury or sickness which occurs while insured under the Group Policy. Benefits are subject to the applicable benefit amount or percentage and deductibles shown on the Schedule of Benefits.

Additional medical expenses include:

1. Services and supplies furnished by an ambulatory surgical center.
2. Medical care and treatment given by a physician which is not covered under any other benefit section of the Group Policy.
3. Outpatient medical care and treatment not covered under any other benefit section of the Group Policy.
4. Private duty nursing in a hospital by a nurse, if the physician certifies in writin g that it is needed.
5. Radium therapy, x-ray treatments and examination (other than dental x-rays), microscopic tests, or any lab tests or analysis made for diagnosis or treatment.

ADDITIONAL MEDICAL SERVICES(CONTINUED)

6. The following services and supplies:

   a. administration of whole blood and blood components.

   b. casts, splints, trusses, crutches and braces (excluding replacement braces, dental splints or dental braces);

   c. initial placement of a medically necessary prosthesis and its supportive device. We will also cover the replacement of such prosthesis if it is determined by the insured person's physician to be necessary because of growth or change;

   d. oxygen or rental of equipment for administration of oxygen;

   e. the initial pair of eyeglasses or contacts needed due to cataract surgery or an accident that occurs while insured under the Group Policy if the eyeglasses or contacts were not needed prior to the accident; and

   f. the purchase or rental of medically necessary durable medical equipment, including Diabetes Equipment. At our option, the cost or rental of durable medical equipment will be covered. If the cost of renting the equipment is more than an insured person would pay to buy it, only the cost of the purchase is considered to be a covered expense. In either case, total covered expense for durable medical equipment shall not exceed its purchase price. We do not pay for equipment or devices not specifically designed and intended for the care and treatment of an injury or sickness.

7. Services of a speech therapist or pathologist to restore speech loss or impairment resulting from trauma, stroke or a surgical procedure while insured under the Group Policy.

8. Services of a licensed audiologist to determine and measure hearing function loss which occurred while insured under the Group Policy.

9. Services of a licensed physical therapist for purposes of training to aid restoration of normal physical functions lost due to trauma, stroke or a surgical procedure while insured under the Group Policy.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

10. Professional ambulance services.

11. Services for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

HOME HEALTH CARE BENEFIT

HOME HEALTH CARE AGENCY means a home health care agency or a hospital which meets all of the following requirements.

1. It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses.
2. It must be run according to rules established by a group of professional medical people, including physicians and nurses.
3. It must maintain clinical records on all patients.
4. It must be licensed by the jurisdiction where it is located, if licensure is required. It must be run according to the laws of that jurisdiction which pertain to agencies providing home health care.

HOME HEALTH AIDE means a person who provides care of a medical or therapeutic nature. The home health aide must report to and be under the direct supervision of a home health care agency.

HOME HEALTH CARE PLAN means a plan of care and treatment of an insured person in his or her home. To qualify, the home health care plan must be established and approved by a physician. The physician must also certify that the insured person would otherwise require confinement in a hospital or skilled nursing facility if he or she did not have the care stated in the home health plan.

Benefits are payable for covered expenses incurred in connection with a home health plan. The home health care services must begin within 30 days after an insured person's discharge from a hospital or skilled nursing facility or may be provided in lieu of an admission. If confined, home health care must be for the same condition which caused the confinement or a related condition. If home health care services are to be provided instead of a hospital admission, the services must receive prior approval from us. All home health care services and supplies must be provided on a part-time or intermittent basis to an insured person in conjunction with a home health care plan.

Home health care services include:

1. nursing care by or under the supervision of an R.N. or L.V.N.;
2. physical, occupational, respiratory or speech therapy, medical social work, nutrition services and home health aide services;
3. medical appliances and equipment, laboratory services and special meals, if such services and supplies would have been covered by the Group Policy if the insured person had been in a hospital;
4. services of a home health aide including extension of therapy services, personal care, ambulation and exercise, household services essential to health care, assistance with medications that are ordinarily self-administered, reporting changes in the insured person's condition and needs and completing appropriate records.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

The Schedule of Benefits shows the benefit amount or percentage payable and the maximum number of visits allowed by a representative of a Home Health Care Agency. A combination of three (3) visits in a 24-hour period for all types of care will be considered a covered expense. A visit by any registered or licensed professional representative of a Home Health Care Agency, other than a Home Health Aide, will be one home health care visit. A visit by a Home Health Aide of four hours or less will be counted as one visit.

HOSPICE BENEFIT

HOSPICE CARE PROGRAM means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Insured Person and his or her insured family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their Illness and, as estimated by a Physician, are expected to live less than 6 months as a result of that Illness.

We pay benefits for charges for a Hospice Care Program which is submitted in writing and approved by Us. The Insured Person must submit in writing his or her intent to enroll in a hospice care program approved by Us. Hospice benefits are subject to the applicable Deductible and Co-Payment. The most We pay for inpatient and outpatient treatment and bereavement counseling received in a Hospice Care Program is shown on the Schedule of Benefits.

All outpatient hospice counseling must be received within a 12 month period. Benefits for bereavement counseling will be payable for counseling received during the 6 month period following the Insured Person's death.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

PRE-ADMISSION TESTING BENEFIT

PRE-ADMISSION TEST means a diagnostic test ordered by the attending or consulting physician in connection with a planned hospital admission or outpatient surgery and performed on an outpatient basis within 7 days before the insured person's admission or outpatient surgery.

A benefit will be payable for charges incurred by an insured person in connection with pre-admission testing when the following requirements are met:

1. The admission to the hospital or the scheduled outpatient surgery is confirmed in writing by the attending physician before the testing occurs.

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

3. The tests must be ordered by the attending physician.

4. 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.

5. The tests are not duplicated in the hospital.

6. The insured 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 insured person's health condition which would preclude the procedure.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

SECOND SURGICAL OPINION BENEFIT

SECOND SURGICAL OPINION means a consultation with a duly licensed surgeon after an insured 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 surgeon. The consulting surgeon must not be affiliated in practice with the surgeon who first recommended surgery.

A benefit will be payable for charges incurred by an insured person in obtaining a second surgical opinion, after he or she has received a recommendation to have elective surgery which is covered under the Group Policy. The charges will not be subject to a deductible or copayment if:

1. the consulting physician personally examines the insured person and we receive a copy of the written opinion; and

2. the consulting physician does not perform the surgery to correct the condition for which the original recommendation was given.

If both the conditions stated above are not met, the applicable deductible and benefit amount or percentage will be applied to the charges for the second opinion.

If the second opinion does not confirm the original recommendation, the insured person may consult another physician for a third opinion. The third opinion must be obtained, and benefits will be payable in the same manner as the second opinion.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

SKILLED NURSING FACILITY BENEFIT

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

1. It must provide treatment to restore the health of sick or injured persons.
2. The treatment must be given by or supervised by physicians. Nursing services must be given by or supervised by registered nurses.
3. It must qualify as a skilled nursing facility and as a provider of services under Medicare.
4. It must not primarily be a place of rest, a nursing home or a place of care for senility, drug addiction, alcoholism, mental retardation, psychiatric disorders, chronic brain syndromes or a place for the aged.
5. 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.

A benefit is payable for charges made by a skilled nursing facility for room and board, and necessary services, supplies and routine care. The insured person must be confined to the skilled nursing facility as an inpatient, based upon the written recommendation of a physician. The confinement must begin within 14 days after a discharge from the hospital confinement. In addition, the confinement must be due to the same condition which caused the hospital confinement or a related cause. If an insured person is discharged from the skilled nursing facility and again becomes an inpatient in such facility within 14 days of the original discharge, it is considered one period of confinement.

The benefit amount or percentage payable and the length of time for which we pay benefits is shown on the Schedule of Benefits.

ADDITIONAL MEDICAL SERVICES (CONTINUED)

BENEFITS FOR CLEFT LIP OR CLEFT PALATE

We will pay covered expenses for treatment of cleft lip and cleft palate for a covered Dependent under the age of eighteen. This coverage includes medical, dental, speech therapy, audiology, and nutrition services when prescribed by the treating Physician.

The Physician must certify that such services are Medically Necessary and consequent to treatment of the cleft lip or palate. This benefit is subject to all other terms and conditions applicable to other benefits.

HEALTH INSURANCE BENEFITS (CONTINUED)

LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITIONS LIMITATION

For Employers with two or more Employees or an Employer with less than two Employees who has had Creditable Coverage continuously:

A Pre-Existing Condition means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the Enrollment Date. A genetic condition is not a Pre-Existing Condition in the absence of a diagnosis of the condition related to the genetic information.

There is a $2000 benefit maximum for a Pre-Existing Condition, regardless of cause, until the earlier of the following dates:

(a) the date the Insured Person has been enrolled by the Group Plan for twelve (12) consecutive months; or
(b) eighteen (18) consecutive months after the Insured Person's Enrollment Date for a Late Enrollee.

The exclusion does not apply to: (a) pregnancy; or (b) newborn children or children adopted before the age of 18 if they are covered under the Group Plan within 63 days of the date of birth or date of placement for adoption.

The limitation period for such Pre-Existing Condition exclusion shall be reduced by all periods of **Creditable Coverage** , if any, applicable to the Insured Person as of his or her Enrollment Date that are not separated by a break in coverage of more than 63 days, not counting waiting periods. If on a particular day you have creditable coverage from more than one source, all the creditable coverage on that day will be counted as one day. Any day of the waiting period for a plan or policy is not counted as creditable coverage.

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

For Employers with less than two Employees who has had <u>no</u> Creditable Coverage continuously:

A Pre-Existing Condition means a condition which, during the 24-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as 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.

There is a $2000 benefit maximum for a Pre-Existing Condition, regardless of cause, until the earlier of the following dates:

(a) the date the Insured Person has been free of treatment for the Pre-Existing Condition for twenty-four (24) consecutive months; or
(b) the date the Insured Person has been enrolled by the Group Plan for twenty-four (24) consecutive months; or
(c) twenty-four (24) consecutive months after the Insured Persons effective date for a Late Enrollee.

The exclusion does not apply to newborn children or children adopted before the age of 18 if they are covered under the Group Plan within 63 days of the date of birth or date of placement for adoption. This exclusion will apply to a pregnancy.

LIMITATIONS AND EXCLUSIONS (CONTINUED)

OTHER LIMITATION AND EXCLUSIONS

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

1. A sickness or injury which is paid under any Workers' Compensation or employer's liability law or other legislation or similar law.

2. Any service or supply received in, or in connection with, a Veterans Hospital or other government facility or program due to, or in connection with, a condition or disability resulting from service in an armed force or military and for which the member has no legal liability for payment.

3. Any service the insured person would not be legally required to pay for in the absence of this insurance.

4. Sickness or injury for which the insured person is in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.

5. Education or training; medical services provided by the insured person's parent, spouse, brother, sister, or child.

6. Investigational or experimental drugs or substances not approved by us or the Food and Drug Administration; Drugs or substances used for other than Food and Drug Administration approved indications unless the drug is prescribed for treatment of cancer and that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature; or drugs labeled: "Caution-limited by Federal law to investigational use".

7. Non-prescription drugs or medicines; prescription drugs, including vitamins, and self-administered injectable drugs unless received by the insured: a. while an inpatient in a hospital or skilled nursing facility, b. from a physician during an office visit or from a home health care agency. This exclusion and limitation does not apply to Diabetes Supplies.

8. Treatment, services, supplies or surgery that is not medically necessary.

9. Purchase or fitting of hearing aids or advice on their care; implantable hearing devices.

10. Weekend non-emergency hospital admissions.

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

LIMITATIONS AND EXCLUSIONS (CONTINUED)

12. Any drug, biological product, device, medical treatment, or procedure which is experimental or investigational that is defined in this Group Policy, unless it is designated to no longer be experimental/investigational by the Agency for Health Care Administration of the State of Florida in a properly promulgated regulation pursuant to Florida Statue 627.4236; any drug, biological product, device, medical treatment or procedure which is not covered as experimental or investigational (or similar) by the HCFA Medicare Coverage Issues Manual; any drug, biological product, or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which lacks such approval at the time of its use or proposed use; or, any drug or biological product categorized as a Treatment Investigational New Drug (IND) by the U.S. Food and Drug Administration or by the U.S. National Cancer Institute at the time of its use or proposed use. Specifically excluded are: ambulatory blood pressure monitor, refractive keratoplasty or radial keratotomy, positron emission tomography (PET) scans, transurethral balloon dilation of prostate, immunotherapy for recurrent abortion, chemonucleolysis, biliary lithotripsy, home uterine activity monitor, immunotherapy for food allergy, and percutaneous lumbar discectomy.

13. Services for Cosmetic Services.

    Coverage will be extended for Breast Reconstruction when the Insured Person has had a Medically Necessary mastectomy, as determined by Us.

14. Treatment of the teeth or periodontium or occlusive realignment of the mandible and maxilla, unless the expenses are incurred in connection with an injury to sound natural teeth, except injury resulting from biting or chewing, sustained while the person is insured for these benefits unless specifically described in the schedule of benefits. The care and treatment must be provided within the 12-month period beginning on the date of the injury. Also, the insured person must remain insured under the Group Policy during the 12-month period while the care or treatment is being received. We will not cover any treatment related to the preparation or the fitting of dentures, including dental implants. We will not cover any treatment relating to routine dental extractions.

    This exclusion does not apply to hospitalization services and general anesthesia for dental treatment or surgery when provided to an insured person who:

    a) is under 8 years of age and who is determined by a licensed dentist and the child's physician to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven to be ineffective; or

    b) has one or more medical conditions that would create significant or undue medical risk in the course of treatment delivery if not rendered in a hospital or ambulatory surgical center.

LIMITATIONS AND EXCLUSIONS (CONTINUED)

15. Diagnosis or care and treatment of: (a) weak, strained, unstable or flat feet; or (b) toenails, except removal or a nail matrix.
16. Any: (a) superficial lesions of the feet, such as corns, calluses or hyperkeratoses; or (b) tarsalgia, metatarsalgia or bunion, except surgery which involves exposure of bones, tendons or ligaments.
17. Any service, supply or treatment connected with custodial care. We do not provide these services no matter who provides, prescribes, recommends or performs them. Custodial care means services designed to help an insured person meet the needs of daily living, whether or not he or she is disabled. These services include help in:
    a. walking or getting in or out of bed;
    b. personal care such as bathing, dressing, eating, or preparing special diets; or
    c. taking medication which the insured person would normally be able to take without help.
18. Sickness or injury caused by: (a) war, whether or not declared, or insurrection; or (b) military service.
19. Sickness or injury caused by the insured person's: (a) engaging in an illegal occupation; or (b) commission of or an attempt to commit a criminal act.
20. Enrollment in a health, athletic, or similar club; or a weight loss or similar program.
21. Purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds.
22. Purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or swimming pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.
23. Convenience or personal care services such as use of a telephone or television.
24. Any treatment to reduce obesity including, but not limited, surgical procedures unless qualified as morbid obesity.
25. Sickness or injury for which benefits are paid or payable under: (a) the mandatory provisions of any auto insurance policy written to comply with a "no-fault" insurance law; or (b) an uninsured motorist insurance law; or benefits which could have been paid under any auto insurance policy had the insured properly complied with the mandatory provisions of a "no-fault" insurance law.
26. Elective abortion unless:
    a. the physician certifies in writing that the pregnancy would endanger the life of the mother; or
    b. the pregnancy is a result of rape or incest; or
    c. the services are received to treat medical complications due to the abortion.

LIMITATIONS AND EXCLUSIONS (CONTINUED)

27. Homeopathic drugs as defined in the Homeopathic Pharmacopeia.

28. Acupuncture, unless the treatment is medically necessary and appropriate and is provided within the scope of the acupuncturist's license.

29. Vision analysis, testing or orthoptic training or the purchase of eye-glasses or contact lenses, except as specifically described in the schedule of benefits.

30. Services and supplies which are (a) rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation, or (c) for mental illnesses which, according to generally accepted professional standards, are not usually amendable to favorable modification.

31. A routine physical examination will not be covered if required by an employer, school or insurance company, except as otherwise stated in the Pediatric Care Benefit section of this policy.

32. Court ordered treatment for psychiatric disorders, alcoholism and drug dependency.

33. Maintenance care, which consists of services and supplies furnished mainly to:

    a. maintain, rather than improve, a level of physical or mental function; or
    b. provide a protected environment free from exposure that can worsen the insured person's physical or mental condition.

34. Care and treatment rendered by a provider whose services are not required to be covered by state law.

35. Care and treatment of complications of non-covered procedures, unless such care and treatment become medically necessary to save the life or limb of the insured person.

36. More than one prescription for the same drug or therapeutic generic medication prescribed by one or more physicians and dispensed by one or more pharmacies until at least 75% of the previous prescription has been used by the member. (Based on the dosage schedule prescribed by the physician.)

37. Expenses incurred prior to the effective date or after the termination date of your coverage under the Group Policy. Coverage will be extended under the Extension of Health Insurance provision, if such coverage is required by state law.

38. Any and all benefits related to organ or artificial organ transplants or organ donations, except as specifically provided in the Organ Transplant Benefit section of this Group Policy.

39. The policy does not provide benefits for services that are billed separately as professional services, when the procedure requires only a technical component (CPT code) that gives a numerical or self-explanatory result and does not require professional intervention or interpretation.

40. The policy does not provide benefits for services that are billed incorrectly or billed separately, but are an integral part of another billed services, as determined by us.

HEALTH INSURANCE BENEFITS (CONTINUED)

CONTINUATION OF COVERAGE FOR ACTIVE MILITARY SERVICE

COVERAGE AND PREMIUM

Continuation of coverage is available for an Employee and their covered Dependents while the Employee is called to Active Duty or State Active Duty. The Employee will have the same premium in effect for other Insured Persons under the same Group Policy.

NOTIFICATION

The Employee, or an appropriate military authority, must notify the Employer that the Employee wishes to continue coverage before reporting for Active Duty or State Active Duty.

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

REINSTATEMENT OF COVERAGE

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

CONTINUATION

If health insurance terminates:

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

DEFINITIONS

The following terms are used in this provision:

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

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

HEALTH INSURANCE BENEFITS (CONTINUED)

WHEN HEALTH INSURANCE TERMINATES

If health insurance ends:

1. it may be extended under the Extension of Health Insurance provision, if the insured person is totally disabled when the Group Policy terminates;
2. it may be converted to a plan of medical insurance as described in the Health Insurance Conversion provision;
3. it may be covered under the Optional Continuation of Health Insurance provision, if any.

A complete description of these provisions follows.

EXTENSION OF HEALTH INSURANCE WHEN THE GROUP POLICY TERMINATES

We extend limited health insurance benefits if the Group Policy terminates while an insured person is totally disabled as a result of a specific accident or illness incurred while this policy was in effect. The insured person must provide written notice to us of their intention to receive extended benefits within 31 days of the date the Group Policy terminates. Benefits are payable only for those expenses incurred for the same injury or sickness which caused the insured person to be totally disabled. While the insured person remains totally disabled, insurance for the disabling condition continues without premium payment, but not beyond the earliest of the following dates:

1. the date the insured person is no longer totally disabled; or
2. the date the insured person becomes covered by any medical insurance plan carried or sponsored by an employer if the assuming carrier has agreed to assume liability for such benefits per F.S. 627.667(6);
3. the date the insured person's Lifetime Maximum Benefit is reached; or
4. the last day of the 12 month period following the date the Group Policy terminated.

No insurance is extended to a child born as a result of an insured person's pregnancy which existed when the Group Policy terminated.

Benefits provided under the Group Policy for any dental expenses are extended for 90 days, without regard to total disability, but not beyond the date the insured person becomes covered by any medical or dental insurance plan providing similar benefits.

Benefits provided under the Group Policy for maternity expenses are extended for the duration of that pregnancy, without regard to total disability, but not beyond the date the insured person becomes covered by any medical insurance plan providing similar benefits.

HEALTH INSURANCE BENEFITS (CONTINUED)

HEALTH INSURANCE CONVERSION PRIVILEGE

WHO MAY CONVERT

If a person has been insured by the Group Policy and any plan it replaced for at least a total of 3 full calendar months, he or she may obtain a separate plan of health insurance (called the conversion plan). A conversion plan may be obtained by:

1. an insured group member if his or her insurance under the Group Policy terminates. The group member may also include in the conversion policy any dependents who were insured by the Group Policy on the date the group member's insurance ends. Conversion is not available to members of a group that have been terminated for failure to pay any required contribution.
2. the group member's insured spouse whose insurance under the Group Policy ends because of termination of the marriage or because of the group member's death.
3. the group member's insured child whose insurance under the Group Policy ends because he or she no longer qualifies as a dependent or because of the group member's death.
4. the group member's insured spouse whose insurance under the Group Policy ends by reason of his or her ceasing to be a qualified family member under the Group Policy while the group member remains insured.

HEALTH INSURANCE BENEFITS (CONTINUED)

5. the insured dependents of a group member whose insurance under the Group Policy ends and the group member cannot convert because he or she is eligible for Medicare; and
6. a retiring group member whose insurance under the Group Policy ends, provided he or she does not choose any available continuation option under the Group Policy.

No conversion plan is available if:

1. the insured person is eligible for Medicare;
2. issuance of the conversion plan would result in the insured person being overinsured.

A person will be considered to be overinsured if his or her insurance under the Group Policy is replaced by similar group coverage within 31 days of the date his or her insurance ends, or if the benefits of the conversion plan, when combined with similar benefits result in an excess of insurance. Similar benefits include:

1. those for which the person is covered by another hospital, medical or surgical or medical expense insurance policy or by a hospital or medical service subscriber contract, or by a medical practice or other prepayment plans;
2. those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or
3. those available for the person by or through any state, provincial or federal law.

HOW TO CONVERT

We will give all of the necessary information about conversion to an insured person who is entitled to convert so that application may be made. An insured person entitled to convert must apply in writing and pay the first premium on the conversion plan within 63 days after his or her insurance under the Group Policy terminates. Evidence of insurability will not be required to obtain a conversion plan.

HEALTH INSURANCE BENEFITS (CONTINUED)

CONVERSION COVERAGE

The conversion plan will be one we offer or arrange to offer at the time the first premium is received.

The conversion plan is issued to you if you are entitled to convert. It will insure you and any dependents you choose to convert if they were insured under the Group Policy. If you are not entitled to convert and your insured spouse and insured dependents are, the conversion plan is issued to your spouse and will insure all such dependents. If the conversion plan is for an individual dependent, it will be issued to that dependent.

The conversion plan takes effect on the day after the person's insurance under the Group Policy ends. The cost of the conversion plan on its effective date is based on:

1. the class of risk to which the person entitled to convert belongs;
2. that person's age; and
3. the benefits chosen.

The conversion plan may not exclude any pre-existing condition not excluded by the Group Policy. During the first 12 months that conversion coverage is in effect, the amount payable under the Extension of Health Insurance Benefit provision of the Group Policy is reduced so that total amount payable by the conversion plan and the Group Policy does not exceed the amount payable by the Group Policy if the person's insurance had not ceased.

ORGAN TRANSPLANT BENEFIT

We will pay benefits for the expense of a Covered Organ Transplant as defined below, incurred by an Insured Person for an organ transplant approved in advance by Us, subject to those terms, conditions and limitations described below and contained in the Group Policy. Please contact the company's Transplant Management Department when in need of these services.

Covered Organ Transplant means only the services, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by Us to be Medically Necessary services and which are not Experimental or Investigational, unless it is designated to no longer be experimental/investigational by the Agency for Health Care Administration of the State of Florida in a properly promulgated regulation pursuant to Florida Statute 627.4236. The Covered Organ Transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;
2. Lung(s);
3. Heart-lung;
4. Liver;
5. Kidney;
6. Bone Marrow;
7. Simultaneous pancreas/kidney;
8. Pancreas following kidney;
9. Any organ not listed above required by state or federal law.

The term **Bone Marrow** identified in the foregoing Covered Organ Transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. 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 or cord blood. If chemotherapy is an integral part of the treatment involving a Covered Organ Transplant of Bone Marrow, the term Bone Marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a Covered Organ Transplant of Bone Marrow approved by Us.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of the Group Policy.

For a Covered Organ Transplant to be considered fully approved, prior written approval from Us is required in advance of the Covered Organ Transplant. You or Your Physician must notify Us in advance of Your need for an initial evaluation for the Covered Organ Transplant in order for Us to determine if the Covered Organ Transplant will be covered. For approval of the Covered Organ Transplant itself, We must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

ORGAN TRANSPLANT BENEFIT (CONTINUED)

EXCLUSIONS

No benefit is payable for or in connection with a Covered Organ Transplant if:

1. It is Experimental or Investigational as defined elsewhere in the Group Policy, unless it is designated to no longer be experimental/investigational by the Agency for Health Care Administration of the State of Florida in a properly promulgated regulation pursuant to Florida Statute 627.4236.
2. We are not contacted for authorization prior to referral for evaluation of the Covered Organ Transplant, unless such authorization is waived by Us.
3. We do not approve coverage for the Covered Organ Transplant, based on Our established criteria.
4. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
5. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the Group Policy.
6. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by Us.
7. A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.
8. The Insured Person for whom a Covered Organ Transplant is requested has not met pre-transplant criteria as established by Us.

Once the Covered Organ Transplant is approved, We will advise the Insured Person's Physician. Benefits are payable only if the pre-transplant services, the Covered Organ Transplant and post-discharge services are approved by Us.

ORGAN TRANSPLANT BENEFIT (CONTINUED)

COVERED SERVICES

For approved Covered Organ Transplants, and all related complications, We will cover only the following expenses:

1. Hospital benefits shown in the Schedule of Benefits under the Hospital Benefit section of this Group Policy will be paid at: (a) 100% of Reasonable Charges if received at a Level 1 Participating Hospital designated by Us as an approved transplant facility; and (b) 80% of Reasonable Charges if received at a Level 2 Participating Provider Hospital designated by Us as an approved transplant facility; and (c) 60%; of Reasonable Charges after Annual Deductible if received at a Non-Participating Hospital.

   Physician benefits shown in the Schedule of Benefits under the Physician Benefits section of this Group Policy will be paid at (a) 80% of Reasonable Charges after Annual Deductible if received from a Level 1 Participating Physician designated by Us as an approved transplant provider; and (b) 80% of Reasonable Charges after Annual Deductible if received from a Level 2 Participating Physician designated by Us as an approved transplant provider; and (c) 80% of Reasonable Charges after Annual Deductible if received from a Non-Participating Physician.

   Any Maximum Out-of-Pocket Expense Limits in the Group Policy do not apply to the benefits shown in this section of the Group Policy.

   Par and Non-Par Organ Transplant Benefits are limited to a combined maximum of $300,000 per Calendar Year.

2. Organ acquisition and donor costs. However, donor costs are not payable under the Group Policy if they are payable in whole or in part by any other group plan, insurance company organization or person other than the donor's family or estate.

3. Direct, non-medical costs* for the Insured Person receiving the Covered Organ Transplant will be paid for: (a) transportation to and from the Hospital where the Covered Organ Transplant is performed, but no more than two round trips per Covered Organ Transplant; and (b) temporary lodging at a prearranged location. Transportation and lodging costs for the Insured Person to and from the Hospital where the Covered Organ Transplant is performed will be paid at: (a) 100% of Reasonable Charges. These direct, non-medical costs are only available if the Insured Person lives more than 100 miles from the transplant facility.

ORGAN TRANSPLANT BENEFIT (CONTINUED)

4. Direct, non-medical costs* for one member of the Insured Person's immediate family (two members if the patient is under age 18 years) will be paid for: (a) transportation to and from the approved facility where the Covered Organ Transplant is performed, but no more than two round trips per person per Covered Organ Transplant; and, (b) temporary lodging at a prearranged location during the Insured Person's confinement in a Hospital. Transportation and lodging costs for the Insured Person's immediate family member(s) to and from the Hospital where the Covered Organ Transplant is performed will be paid at: (a) 100% of Reasonable Charges. These direct, non-medical costs are only available if the Insured Person's immediate family member(s) live more than 100 miles from the transplant facility.

*All direct, non-medical expenses for the Insured Person receiving the Covered Organ Transplant and his/her family member(s) are limited to a combined maximum coverage of $10,000 per Covered Organ Transplant.

PROVISIONS APPLICABLE TO ALL HEALTH INSURANCE BENEFITS

COORDINATION OF BENEFITS

DEFINITIONS

Here are some terms used in this provision.

ALLOWABLE EXPENSE means any necessary, reasonable and customary item of expense at least a part of which is covered by any one of the plans that covered the person for whom claim is made. When the benefits from a plan are in the form of services, rather than cash payments, the reasonable cash value of each service is both an allowable expense and a benefit paid.

CLAIM DETERMINATION PERIOD means a calendar year or that part of a calendar year in which the person has been covered by our plan.

PLAN means the coverage of medical or dental expenses or services by:

1. any group insurance plan, on an insured or uninsured basis;
2. service plan contracts, group or individual practice or other pre-payment plans; or
3. labor-management trusteed plans, union welfare plans, employers organization plans or employee benefit organization plans.

The term does not include coverage under individual or franchise policies or contracts, an indemnity-type policy, an excess insurance policy, a specified disease or accident policy or a Medicare supplement policy. Each plan or part of a plan which has the right to coordinate benefits is considered to be a separate plan.

THIS PLAN means the benefits of the Group Policy which are subject to this coordination of benefits provision.

WHAT A COORDINATION OF BENEFITS PROVISION DOES

If a person is covered by this plan and by any of the other plans described above, a coordination of benefits provision will be used when the amount of benefits payable by this plan and the amount of benefits payable by any of the other plans for the same medical expenses would exceed the total amount of allowable expenses in a claim determination period. A coordination of benefit provision determines:

COORDINATION OF BENEFITS (CONTINUED)

1. the order in which all plans pay their benefits; and
2. when, depending on the order of benefit determination, a plan may reduce its benefit so that not more than 100% of the total amount of allowable expenses are paid jointly by all plans.

ORDER OF BENEFIT DETERMINATION

In order to administer this provision, it is first necessary to determine the order in which all of the plans pay their benefits. This order is shown below.

1. A plan which does not contain a coordination of benefits provision is considered to determine its benefits before a plan which does contain a coordination of benefits provision.
2. A plan which covers a person as an employee is considered to determine its benefits before a plan which covers a person as a dependent.
3. A plan which covers a person as the dependent of a person whose month and day of birth (excluding the year of birth) occurs earlier in the calendar year is considered to determine its benefits before a plan which covers the person as the dependent of a person whose month and day of birth (excluding the year of birth) occurs later in the calendar year. If either one of the plans does not have this "birthday rule" provision, then the plan without this provision is considered to determine the order in which benefits will be paid. In the case of divorced or legally separated parents, the order of payment is determined as shown below.

    a. If there is a court decree which establishes financial responsibility for a dependent child's health care expenses, the plan of the parent with that responsibility is considered to determine its benefits before the plan of the parent without the responsibility.
    b. If there is no such decree and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody is considered to determine its benefits before the plan of the parent without custody.
    c. If the parent with custody of the child has remarried:

COORDINATION OF BENEFITS(CONTINUED)

(1) the plan which covers the child as a dependent of the parent with custody determines its benefits first;
(2) the plan which covers the child as a dependent of the step-parent determines its benefits second; and
(3) the plan which covers the child as a dependent of the parent without custody determines its benefits third.

If the above rules fail to establish the order of payment, the plan which has covered the person for the longest time is considered to determine its benefits first. However, a person may be covered as an active employee by one plan and as a retired or laid-off person by another plan. In this case, if both plans contain a provision regarding retired or laid-off employees, the plan which covers the person as an active employee is considered to determine its benefits before the plan which covers the person as a retired or laid-off employee. If either one of the plans does not contain a provision for retired or laid-off employees, the order of benefit determination will be used to determine the order of payment by the plans.

HOW BENEFITS ARE COORDINATED

If, based on the order of benefit determination, the benefits of this plan are payable first, the benefits payable by the other plans are ignored when we determine the amount payable by this plan. If this plan's benefits are payable after those of any other plan, we add up the benefits payable by each of the plans in the order in which they pay and compare the total benefits payable to the total amount of allowable expenses. If this plan's payments would result in benefits being paid which exceed total allowable expenses, this plan's benefits are reduced. When coordination of benefits reduces the total amount otherwise payable in a claim determination period for a person covered by this plan, each benefit that would have been payable in the absence of coordination is reduced in proportion. The reduced amounts are charged against any applicable benefit limits of this plan. In no event will this plan's payment be more than it would have been in the absence of other plans.

COORDINATION OF BENEFITS(CONTINUED)

HOW BENEFITS ARE COORDINATED (continued)

We reserve the right to release to or obtain from any other insurance company or other organization or person any information which, in our opinion, we need for the purpose of coordination of benefits.

When payment which should have been made by this plan based on the terms of this provision have been made by any other plan, we have the right to pay to any organization making these payments an amount we consider to be warranted. Amounts paid in this manner are considered to be benefits paid by this plan. After we make such payments, we have no further liability.

When we have made an overpayment, we have the right to recover that payment to the extent of the excess. We may recover the overpayment from the person to whom it was made or from any other insurance company or organization.

PROVISIONS APPLICABLE TO ALL HEALTH INSURANCE BENEFITS

MEDICARE ELIGIBLES

DEFINITIONS

Here are some definitions of words used in this provision.

MEDICARE PART A means the Social Security program which provides hospital insurance benefits.

MEDICARE PART B means the Social Security program which provides medical insurance benefits.

For the purposes of determining benefits payable for any insured person who is eligible to enroll for Medicare Part B, but does not, we assume the amount payable under Medicare Part B to be the amount the insured person would have received if he or she enrolled for it.

An insured person is considered to be eligible for Medicare on the earliest date coverage under Medicare could become effective for him or her.

INTEGRATION WITH MEDICARE

When an employer employs less than 20 people, benefits under the Group Policy will be payable for an insured person who is age 65 or older and eligible for Medicare as shown below.

1. If expenses are incurred for which benefits are payable by both the Group Policy and Medicare Part A, benefits are payable by the Group Policy only for those expenses which exceed the amount payable by Medicare Part A.
2. If expenses are incurred for which benefits are payable by both the Group Policy and Medicare Part B, we reduce our benefit by the amount of benefits payable for those expenses by Medicare Part B.
3. The deductible of the Group Policy will apply only to eligible expenses incurred for prescription drugs and charges made by nurses.

For an insured person who is under age 65 and eligible for Medicare, the benefits payable by the Group Policy will be reduced so that not more than 100% of the expenses incurred are paid jointly by the Group Policy and Medicare.

When an employer employs 100 or more persons, the benefits of the Group Policy will be payable first for an insured person who is under age 65 and eligible for Medicare. The benefits of Medicare will be payable second.

MEDICARE ELIGIBLES(CONTINUED)

TEFRA OPTIONS

Where an employer employs 20 or more persons, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA), as amended, allows his or her actively working insured group members age 65 or older and their insured spouses who are eligible for Medicare to choose one of the following options.

OPTION 1 - The benefits of the Group Policy will be payable first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. The group member and his or her dependents, if any, will not be insured by the Group Policy.

The group must provide each insured group member and each insured spouse with the choice to elect one of these options at least one month before the insured group member or the insured spouse becomes age 65. All new group members and newly insured spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for a group member or dependent who is under age 65.

Under the TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the Group Policy differs for each category.

CATEGORY 1 Medicare Eligibles are:

1. actively working insured group members age 65 or older who choose Option 1;
2. their age 65 or older insured spouses; and
3. age 65 or older insured spouses of actively working insured group members who are under age 65.

MEDICARE ELIGIBLES(CONTINUED)

TEFRA OPTIONS (continued)

CATEGORY 2 Medicare Eligibles are any other insured persons entitled to Medicare, whether or not they enrolled for it. This category includes, but is not limited to:

1. retired group members and their spouses; or
2. insured dependents of an insured group member, other than his or her spouse.

CALCULATION AND PAYMENT OF BENEFITS

For insured persons in Category 1, benefits are payable by the Group Policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For insured persons in Category 2, Medicare benefits are payable before any benefits are payable by the Group Policy. The benefits of the Group Policy will then be reduced by the full amount of all Medicare benefits the insured person is entitled to receive, whether or not they were actually enrolled for.

CLAIMS

WE MUST BE NOTIFIED OF INTENT TO FILE A CLAIM

Notice of a claim for benefits must be given to us. The notice must be in writing. Any claim will be based on the written notice. The notice must be received by us within 30 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 30 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

WE FURNISH CLAIM FORMS

After we receive written notice of a claim, we provide claim forms. This form should be furnished within 15 days after we receive written notice. If we fail to furnish this form within 15 days, the claimant can meet the time period shown below for submitting proof of claim by submitting written proof which explains the reasons for the claim. Written proof should establish facts about the claim such as occurrence, nature and extent of the condition involved.

WHEN TO FILE PROOF OF CLAIM

Participating providers are responsible for submitting claims for covered expenses directly to us on the insured person's behalf. Health care providers who have entered into a reimbursement agreement with us have agreed not to bill you for an amount greater than the difference between reasonable charges and the benefit amount paid by us. You 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 your claim. Benefit payments for covered services received from a participating provider will be forwarded directly to the provider.

Written proof of claim for services rendered by a non-participating provider must be given to us within 90 days after the date of the injury or sickness for which claim is made. If proof of claim is not submitted and received by us within the required time period, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit within the time period and that the proof was submitted as soon as possible, the claim will not be reduced or invalidated.

WE MAY EXTEND TIME LIMITS

If the time limit we allow for giving notice of claim or submitting proof of loss is less than the law permits in the state where the claimant lives, we extend our time limits to agree with the minimum period specified by that state's laws. The law must exist at the time the Group Policy is issued.

CLAIMS (CONTINUED)

OUR RIGHT TO REQUIRE MEDICAL EXAMS

We have the right to require that a medical exam 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 have a right to request an autopsy in the case of death, if state law so allows.

TO WHOM BENEFITS ARE PAYABLE

All benefits are payable to the insured group member. However, with our consent, an insured person may direct us to pay all or any part of the medical benefits to the medical care provider on whose charge the claim is based.

If any insured person to whom benefits are payable is a minor or, in our opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her 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.

WHEN WE PAY

We will pay benefits for covered medical services after the insured person has satisfied any deductibles and co-payment amounts. No benefits are payable for charges which are discounted, waived or rebated by a provider of services simply because the insured person is insured. We shall have the right to recover from a provider of services or from an insured 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 an insured person dies while benefits remain unpaid, we may choose to pay benefits to:

1. any person or persons related to the insured person by blood or marriage who appears to be entitled to the benefits; or
2. the executors or administrators of the insured 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 the Group Policy until at least 60 days after written proof of claim has been filed with us. If action is to be 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.

CLAIMS (CONTINUED)

RIGHT OF RECOVERY

Our intention is to preserve and assert our rights to recover for sums paid or benefits provided where circumstances warrant the assertion of our rights, to the fullest extent allowed by the applicable laws of the jurisdiction involved. Each provision below shall be considered severable, and if any provision is determined to be unenforceable or void, the remaining provisions shall remain unaffected.

SUBROGATION

This provision applies when another party (person or organization) is, or may be, considered responsible for causing injury or for payment of benefits due to an insured person's injury or sickness for which benefits under the Group Policy have been provided or paid. To the extent of such benefits, we are subrogated to all rights and claims for recovery the insured person has against any party (including a health care carrier) responsible for the injury for payment to the insured person on accounts of the injury.

RIGHT OF REIMBURSEMENT

If payment (by settlement, judgment or any other manner) is made, or may be made, in the future by, or on behalf of, a responsible party to the insured person, expenses arising from the insured person's injury or sickness are not covered by us.

However, if we receive a claim for which benefits would be payable in the absence of a responsible party as described above, we will pay those benefits subject to the following conditions:

1. We will automatically have a lien to the extent of benefits advanced upon any recovery, by settlement, judgement or otherwise that you receive from the responsible party, or any person or organization making payment on behalf of the responsible party, including first party, underinsured and uninsured motorist coverage. The lien will be in the amount of benefits provided or paid by us for the treatment of the condition for which the third party is responsible.

2. You agree to notify us, in writing, within 60 days of your claim against the responsible party and to take such action, furnish such information, cooperate generally, and execute any documents as we may require to facilitate enforcement of our rights.

Exclusively at our option and choice, and without any waiver of any other rights of the Group Policy, in the event of prejudice, non-cooperation or breach of this Group Policy, we may withhold, deduct or retract payments to or on behalf of the insured person.

CLAIMS (CONTINUED)

DUPLICATION OF BENEFITS/OTHER INSURANCE

This provision is intended to prevent overpayment or duplication of benefits under this Group Policy when other health care coverage provides the same benefits. It applies when a person is covered by us and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay your medical expenses, except other group health carriers in which case coverage will be determined under Coordination of Benefits.

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

This provision applies whether or not the insured person has made a claim under other applicable coverage. When applicable, the insured person is required to provide us with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

COOPERATION REQUIRED

The insured person shall cooperate by providing information and executing any documents to preserve our right and shall have the affirmative obligation of notifying us that claims are being made against responsible parties to recover for injuries for which we have paid. If the insured person enters into litigation or settlement negotiations regarding the obligations of the other party, the insured person must not prejudice, in any way, our rights to recover an amount equal to any benefits we have provided or paid for the injury or sickness. Failure of the insured person to provide us such notice or cooperation, or any action by the insured person resulting in prejudice to our rights will be a material breach of this Group Policy and will result in the insured person being personally responsible to make repayment. In such an event, we may deduct from any pending or subsequent claim made under the Group Policy any amounts the insured person owes us until such time as cooperation is provided and the prejudice ceases.

Our right of reimbursement and our subrogation rights shall be to the fullest extent allowed by law and the provisions of this Group Policy shall control in the absence of any laws to the contrary. Any such right of reimbursement or subrogation provided to us under this Group Policy shall not apply or shall be limited to the extent that the Florida Statutes or the courts of Florida eliminate or restrict such rights.

TERMINATION PROVISIONS

TERMINATION OF YOUR INSURANCE

Your insurance will terminate on the earliest of the following dates:

1. the date you cease to be in a class of eligible group members or cease to qualify as a group member;
2. the last day for which you make any required premium contribution for your insurance;
3. the last day for which the policyholder has made any required premium contribution for insurance on your behalf;
4. the date your Lifetime Maximum Benefit is reached; or
5. the date the Group Policy is terminated.

TERMINATION FOR CAUSE

We will terminate a member's coverage for cause under the following circumstances:

1. If a member fails to pay or arrange to pay his or her co-payments.
2. If a member allows an unauthorized person to use his or her identification card or uses the identification card of another subscriber. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying us the reasonable charges for those services.
3. If a member or group perpetrates fraud and/or misrepresentation on claims or identification cards in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication and/or alteration of a claim or identification card.
4. If an insured person has committed an act of physical or verbal abuse which poses a threat to providers or any of our personnel, subject to written notice being furnished to the insured person.
5. If an insured person is disruptive for reasons unrelated to his or her use of medical services and the behavior prevents treatment to the insured person or other members of the Policy.

TERMINATION PROVISIONS (CONTINUED)

RETIREMENT

If your active service ends because you retire, insurance will be continued until the date the policyholder stops paying premiums for you or otherwise terminates your insurance.

Any continuation of insurance must be based on a plan which precludes individual selection.

TERMINATION OF DEPENDENT INSURANCE

A dependent's insurance will terminate on the earliest of the following dates:

1. the date your insurance terminates, except in the case of your death;
2. the date you cease to be in a class of group members eligible for dependent insurance;
3. the last day for which you make any required premium contribution for dependent insurance;
4. the last day for which the policyholder has made any required premium contribution for dependent insurance on your behalf;
5. the date the dependent insurance benefit or the Group Policy is terminated;
6. the date a dependent reaches his or her Lifetime Maximum Benefit; or
7. the date a dependent no longer qualifies as a dependent.

HANDICAPPED CHILDREN

If a dependent child who has reached the maximum age for a dependent meets all of the requirements shown below, we extend dependent health insurance for that child for as long as you remain insured for dependent insurance.

1. The child must be incapable of self-sustaining employment because of mental or physical handicap.
2. The child must rely on you for financial support.

If a claim is denied under the Group Policy because the child has reached the maximum age for a dependent, you must give us proof that the child is and continues to be handicapped in order for us to pay the claim.

DISCLOSURE PROVISIONS

SHARED SAVINGS PROGRAM

As a member of a Preferred Provider Organization Plan, You are free to obtain Services from providers participating in the Preferred Provider Organization network (Participating Providers), or providers not participating in the Preferred Provider Organization network (Non-Participating Providers). If You choose a Participating Provider, Your out-of-pocket expenses are normally lower than if You choose a Non-Participating Provider.

We have a Shared Savings Program that may allow You to share in discounts We have obtained from Non-Participating Provider.

Although Our goal is to obtain discounts whenever possible, We cannot guarantee that Services rendered outside the Preferred Provider Organization network will be discounted. The Non-Participating Provider discounts in the Shared Savings Program may not be as favorable as Participating Provider discounts.

In most cases, to maximize Your benefit design and minimize Your out-of-pocket expense, please access Your Preferred Provider Organization network of providers associated with Your Plan.

If You choose to obtain Services from a Non-Participating Provider, it is not necessary for You to inquire about a provider's status in advance. When processing Your claim, We will automatically determine if that provider is participating in the Shared Savings Program and calculate Your Deductible and Coinsurance on the discounted amount. Your Explanation of Benefits statement will reflect any savings with a remark code used to reference the Shared Savings Program.

However, if You would like to inquire in advance to determine if a Non-Participating Provider participates in the Shared Savings Program, please call 1-800-448-6262. Please note, provider arrangements in the Shared Savings Program are subject to change without notice. We cannot guarantee that the provider from whom You received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

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

MISCELLANEOUS PROVISIONS

ENTIRE CONTRACT

The entire contract is made up of the Group Policy, the application of the policyholder, a copy of which is attached to the Group Policy, and the applications of the group members, if any. All statements made by the policyholder or by a group member are considered to be representations, not warranties. This means that the statements are made in good faith. No statement will void the Group Policy, reduce the benefits it provides or be used in defense to a claim unless it is contained in a written application and a copy is furnished to the person making such statement or his or her beneficiary.

TIME LIMIT FOR CERTAIN DEFENSES

After two years from the effective date of the Group Policy, no misstatement made by the policyholder, except a fraudulent misstatement made in his application, may be used to void the Group Policy. After two years from a group member's effective date, no misstatement made by a group member, except a fraudulent misstatement made in his or her application, may be used to deny a claim for any loss or disability which begins after the end of the two year period.

THE POLICYHOLDER IS OUR AGENT FOR LIMITED PURPOSES

The policyholder is considered to be our agent only for these two events:

1. collecting premium; and
2. giving out certificates of insurance.

No agent has the power to change or waive any provision of the Group Policy.

MISSTATEMENTS

If any important facts about an individual in relation to his or her insurance are found to be mis-stated, we adjust the premium to the correct amount based on the true facts. If the misstatement affects the amount of an individual's insurance, the true facts are used to determine the correct amount of insurance.

MISCELLANEOUS PROVISIONS (CONTINUED)

CERTIFICATES OF INSURANCE

We issue certificates of insurance for each insured group member. These are delivered to the policyholder to be given to the group members. The certificate will describe the benefits provided under the Group Policy and the limitations of the Group Policy. Nothing in the certificate will change or void the terms of the Group Policy.

CHANGES IN GROUP POLICY

Changes may be made in the Group Policy by an amendment signed by the policyholder and by our President, Vice President, Secretary or Assistant Secretary.

INSURANCE INFORMATION

The policyholder provides us with the information we need to administer this insurance contract and compute the premium. Failure of the policyholder to provide this information will not void or continue a group member's insurance. We have the right to examine the policyholder's records on the benefits provided at any reasonable time while the Group Policy is in force. We also have this right until all rights and obligations under the Group Policy are finally determined.

WORKERS' COMPENSATION

The Group Policy does not affect or take the place of Workers' Compensation.

ASSIGNMENT

The Group Policy and its benefits may not be assigned by the policyholder.

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

PRESCRIPTION DRUG RIDER

This Rider is made part of the Group Policy to which it is attached. The effective date of this change is the latter of the effective date of the Certificate or the date this benefit is added to the Group Policy.

Notwithstanding any other provisions of the Group Policy, expenses covered under this Prescription Drug Rider are not covered under any other provision of the Group Policy. Any amount in excess of the maximum amount provided under this Rider, if any, is not covered under any other provision in the Group Policy.

All terms used in this Rider have the same meaning given to them in the Certificate unless otherwise specifically defined in this Rider.

DEFINITIONS

The following terms are used in this Rider:

CO-PAYMENT means the amount to be paid by the Insured Person toward the cost of each separate Prescription or refill of a covered Prescription drug when dispensed by a Pharmacy.

DISPENSING LIMIT means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition.

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

MAIL ORDER PHARMACY means a pharmacy that provides covered mail order Pharmacy services, as defined by Us, and delivers covered Prescriptions or refills through the mail.

MAXIMUM ALLOWABLE BENEFIT means the specified maximum amount of benefit payable by Us per Prescription or refill for a covered Prescription drug. The amount paid by Us may not be the actual cost to Us depending on any retrospective utilization pricing adjustments that may apply.

NON-PARTICIPATING PHARMACY means a Pharmacy that has not been designated by Us to provide services to Insured Persons.

PARTICIPATING PHARMACY means a Pharmacy that has signed a direct agreement with Us as an independent contractor or has been designated to provide services to all Insured Persons.

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 means a licensed medical practitioner who is practicing within the scope of his or her license and whose services are required to be covered by the laws of the jurisdiction where the treatment is given.

PRESCRIPTION means a direct order for the preparation and use of a drug, medicine or medication. This order must be given by a Physician to a Pharmacist for the benefit of and use by an Insured Person. The Prescription must be given by a Physician to a Pharmacist for the benefit of and use by an Insured Person for the treatment of an Injury or Sickness under this Plan. The drug, medicine or medication must be obtainable only by Prescription. The Prescription may be given to the Pharmacist verbally, electronically or in writing by the Physician. The Prescription must include:

1. the name of the Insured Person for whom the Prescription is intended;
2. the type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. the date the Prescription was prescribed; and
4. the name, address and DEA number of the prescribing Physician.

PRIOR AUTHORIZATION means the required prior approval from Us for the coverage of Prescription drugs, medicines and medications, including the dosage, quantity and duration, as appropriate for the Insured Person's diagnosis, age and sex. Certain Prescription drugs, medicines or medications may require Prior Authorization.

SELF-ADMINISTERED INJECTABLE DRUGS means a FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, excluding insulin, and intended for use by the Insured Person.

SPECIALTY OFFICE MEDICATIONS AND INJECTABLES

Your Physician has access to specialty office medications and injectables used to treat chronic conditions. These medications can be ordered specifically for you for administration in his/her office setting. This allows your physician a cost effective and convenient way to obtain high cost, high tech specialty medications and injectables. Additional information can be obtained through your Human Resources Department or by calling the toll free customer service phone number on the back of your ID card.

SPECIALTY PHARMACY means a Pharmacy that provides covered Specialty Pharmacy services, as defined by Us, to Insured Persons.

COVERAGE DESCRIPTION

We will cover Prescription drugs that are received by the Insured Person while he or she is covered under this Prescription Drug Rider. Benefits may be subject to Dispensing Limits and Prior Authorization requirements, if any.

Covered Prescription drugs are:

1. drugs, medicines or medications that under federal or state law, may be dispensed only by Prescription from a Physician; and
2. limited to a maximum of a 30-day supply based upon the FDA approved dosage regardless of manufacturer packaging, per Prescription or refill at a retail Pharmacy; and
3. limited to a maximum of a 90-day supply based upon FDA-approved dosage, regardless of manufacturer packaging, per Prescription or refill received from a Mail Order Pharmacy. Self-Administered Injectable Drugs are limited to a maximum of a 30 day supply per Prescription or refill received from a Mail Order Pharmacy; and
4. drugs, medicines or medications that are included on the Drug List; and
5. insulin and Diabetes Supplies when prescribed by a Physician which include:

   A. Strips;
   B. Glucose tabs;
   C. Lancets and lancet devices;
   D. Test solutions;
   E. Syringes;
   F. Alcohol swabs;
   G. Insulin delivery devices;
   H. Blood glucose monitors; and

6. hypodermic needles or syringes when prescribed by a Physician for use with insulin or Self-Administered Injectable Drugs; (Hypodermic needles and syringes used in conjunction with covered Level 3 and 4 Drugs may be available at no cost to the Insured Person); and
7. Self-Administered Injectable Drugs approved by Us; and
8. Spacers and/or peak flow meters for the treatment of asthma.

Notwithstanding any other provisions of the Group Policy, We may decline coverage or, if applicable, exclude from the Drug List any and all drugs, medicines, or medications until the conclusion of a review period not to exceed six (6) months following FDA approval for the use and release of the drug, medicine, or medication into the market.

PRESCRIPTION DRUG COST SHARING

You are responsible for any and all payments of the following, when applicable, according to the Schedule of Benefits-Prescription Drugs section of this Rider: the drug Deductible, the Co-Payment* and any amount in excess of the Maximum Allowable Benefit. Any expenses incurred under provisions of this Rider do not apply toward the Insured Person's Calendar Year Personal Expense Limits or Maximum Out-of-Pocket Expense Limits, if any.

*If the dispensing Pharmacy's charge is less than the Co-Payment, the Insured Person will be responsible for the lesser amount.

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

SCHEDULE OF BENEFITS - PRESCRIPTION DRUGS

The Insured Person is responsible for:

RETAIL PHARMACY/SPECIALTY PHARMACY

Generic Medication-$20* Co-Payment per prescription or refill per 30-day supply;
Brand Medication-$40* Co-Payment per prescription or refill per 30-day supply;

Some retail pharmacies participate in our program which allows you to receive a 90-day supply of a Prescription or refill. Your cost is 1 times the applicable Co-Payment as outlined above. Self-Administered Injectable Drugs and Specialty Drugs are limited to a 30-day supply from a retail Pharmacy or Specialty Pharmacy, unless otherwise determined by Us.

MAIL ORDER PHARMACY

For up to a 90-day supply of a Prescription or refill: 1 times the applicable Co-Payment, as outlined above under Retail/Specialty Pharmacy.

SPECIALTY OFFICE MEDICATION AND INJECTABLE DRUGS PER PRESCRIPTION**

For up to a 30 day supply	$0 Co-payment

*Prescription drug co-payment do not apply toward the Out-of-Pocket Limits.
**Specialty office medication and injectable drugs do not include self-administered injectable drugs.

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION

Participating Pharmacy

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

Non-Participating Pharmacy

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

Mail Pharmacy receipts to:

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

LIMITATIONS AND EXCLUSIONS

No benefit is provided for:

1. Legend Drugs which are not recommended and not deemed necessary by a Physician
2. Any drug prescribed for intended use other than for:
   A. Indications approved by the FDA; or
   B. Recognized off-label indications through peer-reviewed medical literature;
3. Any drug prescribed for a Sickness or Injury not covered under the Policy;
4. Any drug, medicine or medication labeled Caution-Limited by Federal Law to Investigational Use or any experimental drug, medicine or medication, even though a charge is made to the Insured Person;
5. Allergen extracts;
6. Therapeutic devices or appliances, including:
   A. Hypodermic needles and syringes (except needles and syringes for use with insulin, and Self-Administered Injectable Drugs whose coverage is approved by Us);
   B. Support garments;
   C. Test reagents;
   D. Mechanical pumps for delivery of medications (except insulin delivery devices); and
   E. Other non-medical substances;
7. Dietary supplements;
8. Nutritional products; except legend multi-vitamins
9. Fluoride supplements;
10. Minerals; except Calcium Acetate 667 mg tablets (Phoslo)
11. Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency;
12. Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;
13. Anabolic steroids;
14. Anorectic or any drug used for the purpose of weight control;
15. Any drug used for cosmetic purposes, including but not limited to:
   A. Tretinoin, e.g. Retin A, except if you are under the age of 25 or are diagnosed as having adult acne;
   B. Dermatologicals or hair growth stimulants; or
   C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
16. Any Drug or medicine that is
   A. Lawfully obtainable without a Prescription (over the counter drugs), except Insulin; or
   B. Available in prescription strength without a Prescription;
17. Compounded Drugs in any dosage form; except when at least one ingredient is a Legend Drug;
18. Progesterone crystals or powder in any compounded dosage form;
19. Abortifacients (drugs used to induce abortions);
20. Infertility Services including medications;
21. Any drug prescribed for impotence and/or sexual dysfunction, except Viagra; Limited to 12 doses per month or 36 doses per 90 days for mail order;
22. Any drug, medicine or medication that is consumed, or injected at the place where the Prescription is given, or dispensed by the Physician;
23. The administration of covered medication(s);
24. Prescriptions that are to be taken by or administered to the Insured Person, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
   A. Hospital;
   B. Rest home;
   C. Sanitarium;
   D. Skilled Nursing Facility;
   E. Convalescent Hospital; or
   F. Hospice Facility;

25. Injectable drugs, including but not limited to:
    A. Immunizing agents;
    B. Biological sera;
    C. Blood;
    D. Blood plasma; or
    E. Self-Administered Injectable Drugs for which coverage is not approved by Us;
26. Prescription refills:
    A. In excess of the number specified by the Physician; or
    B. Dispensed more than one year from the date of the original order;
27. Any portion of a Prescription or refill that exceeds a 90-day supply, received from a Mail Order Pharmacy or retail Pharmacy that participates in our program which allows the Insured Person to receive a 90-day supply of a Prescription or refill;
28. Any portion of a Prescription or refill that exceeds a 30-day supply, received from a retail Pharmacy that does not participate in our program which allows the Insured Person to receive a 90-day supply of a Prescription or refill;
29. Any portion of a Specialty Drug or Self-Administered Injectable Drug received from a retail Pharmacy or a Specialty Pharmacy that exceeds a 30-day supply, unless otherwise determined by Us;
30. Any portion of a Prescription or refill that:
    A. Exceeds Our drug specific Dispensing Limit, e.g. IMITREX; or
    B. is dispensed to an Insured Person whose age is outside the drug specific age limits defined by Us;
    C. Exceeds the duration-specific Dispensing Limit;
31. Any drug for which Prior Authorization is required, as determined by Us, and not obtained;
32. Any drug for which a charge is customarily not made;
33. Any drug, medicine or medication received by the Insured Person:
    A. Before becoming covered under this Rider; or
    B. After the date the Insured Person's coverage under this Rider has ended;
34. Any costs related to the mailing, sending or delivery of prescription drugs;
35. Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Insured Person;
36. Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
37. Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to Nicotine withdrawal therapies, programs, services or medications;
38. Treatment for Onychomycosis (nail fungus);
39. More than one Prescription for the same drug or therapeutic equivalent medication prescribed by one or more Physicians and dispensed by one or more Pharmacies until at least 75% of the previous Prescription has been used or should have been used by the Insured Person, unless the drug or therapeutic equivalent medication is a Maintenance Medication, purchased through mail order, in which case 66% of the previous Prescription must have been used or should have been used by the Insured Person. (Based on the dosage schedule prescribed by the Physician);

40. Any drug or biological that has received designation as an Orphan Drug, unless approved by Us;
41. Any Co-payment You paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription.
42. Antacids
43. Ostomy Supplies
44. Ribavirin powder

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

President

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

DOMESTIC PARTNER BENEFIT RIDER

This rider is made part of the Group Policy to which it is attached. The effective date of this change is the latter of the effective date of the Certificate or the date this benefit is added to the Group Policy.

This rider modifies the Group Policy as follows:

A. By adding the definition of Domestic Partner to the definition section of the Group Policy:

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

B. By deleting the definition of Dependent in the definition section of the Group Policy and replacing it with the following:

   DEPENDENT means a person who is:

   1. Your lawful spouse or Domestic Partner; and
   2. Your unmarried Child to the end of the month of his or her 25th birthday; and
   3. A Child of the Employee s Domestic Partner also qualifies as a dependent subject to the following conditions:
      a. Your Domestic Partner's Child must live in Your household;
      b. Your Domestic Partner's Child is not covered by any other medical plan;
      c. Your Domestic Partner's Child is not entitled to coverage through another medical plan because of a Qualified Medical Child Support Order;
      d. Your Domestic Partner's Child is subject to the same age limitations described under this definition for a Child; and
      e. Your Domestic Partner's Child can not qualify as a Dependent prior to the Your Domestic Partner becoming qualified as a Dependent.

C. By deleting the definition of Family Member in the definition section of the Group Policy and replacing it with the following:

   FAMILY MEMBER means You, Your spouse or Domestic Partner. It also means Your or Your spouse's child or Domestic Partner's child, brother, sister or parent.

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

DOMESTIC PARTNER BENEFIT RIDER

This rider is made part of the Group Policy to which it is attached. The effective date of this change is the latter of the effective date of the Certificate or the date this benefit is added to the Group Policy.

This rider modifies the Group Policy as follows:

A. By adding the definition of Domestic Partner to the definition section of the Group Policy:

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

B. By deleting the definition of Dependent in the definition section of the Group Policy and replacing it with the following:

DEPENDENT means a person who is:

1. Your lawful spouse or Domestic Partner; and
2. Your unmarried Child to his or her 25th birthday.

C. By deleting the definition of Family Member in the definition section of the Group Policy and replacing it with the following:

FAMILY MEMBER means You, Your spouse or Domestic Partner. It also means Your or Your spouse's child or Domestic Partner's child, brother, sister or parent.

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

AMENDMENT

This amendment becomes a part of the Group Policy to which it is attached.

Notwithstanding any provision of the Group Policy, any Maximum Out-of-Pocket Expense Limits in the Group Policy do not apply to the benefits shown in the Organ Transplant Benefit section of the Group Policy.

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

Michael B. McCallister
President

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

PREVENTIVE SERVICES AMENDMENT

This amendment becomes a part of the Group Policy to which it is attached. Notwithstanding any exclusions in the Group Policy, We will pay benefits for the following routine preventive services.

Annual Routine Adult Physical Exam Office Visit (Limited to Insured Persons 26 years of age or older. **Excludes** all laboratory tests and x-rays; medical examination and related expenses for treatment or diagnosis of an injury or sickness; medical examination or associated diagnostic laboratory charges caused by or resulting from pregnancy; eye examination for the purpose of prescribing corrective lens; dental examinations; hearing tests but not screenings; and expenses incurred for an employment physical or exams for the purpose of obtaining insurance.) ($500 maximum-Mammography, Pap smear, (PSA) Prostate antigen testing and Colonoscopy are not included in maximum)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Annual Routine Pap Smear (Limit 1 per calendar year)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Annual Routine Mammogram

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Routine Lab, X-ray, Prostate antigen testing

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Routine Immunizations (Limited to insured Persons 26 year of age or older; excludes immunizations given for or in connection with travel)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Routine Colonoscopy (includes proctosigmoidoscopy and sigmoidoscopy screenings) (outpatient, ambulatory surgical centers, or clinic location including related services)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	80% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Routine Immunizations (Limited to Insured Persons 25 years of age or younger; excludes immunizations given for or in connection with travel.)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 Co-Payment Per Visit
Non-Participating Physician	80% Benefit Payable

Routine Child Care Visits (Limited to Insured Persons 25 years of age or younger; visit intervals based on American Academy of Pediatric Guidelines.)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable after $30 Co-Payment Per Visit
Non-Participating Physician	80% Benefit Payable

Routine Lab/X-ray (In Physician's Office)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Routine Lab/X-ray (In Hospital)

Level 1 Participating Physician	100% Benefit Payable
Level 2 Participating Physician	100% Benefit Payable
Non-Participating Physician	80% Benefit Payable

Routine Hearing

EXAM

Level 1 Participating Physician	100% benefit payable
Level 2 Participating Physician	100% benefit payable after $30 Co-payment
Non-Participating Physician	60% after Deductible

Testing (Administered by Audiologist for diagnostic purposes)

Level 1 Participating Physician	100% benefit payable
Level 2 Participating Physician	100% benefit payable after $30 Co-payment
Non-Participating Physician	60% after Deductible

Routine Vision

EXAM (Refraction is NOT covered)

Level 1 Participating Physician	100% benefit payable
Level 2 Participating Physician	100% benefit payable after $30 Co-payment
Non-Participating Physician	60% after Deductible

TONOMETRY

Level 1 Participating Physician	80% benefit payable after Deductible
Level 2 Participating Physician	100% benefit payable after $30 Co-payment
Non-Participating Physician	60% after Deductible

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

President

AMENDMENT

Effective Date of Amendment: 01/01/2006

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

All terms used in this amendment have the same meaning given to them in the policy unless otherwise specifically defined in this amendment. Except as modified below all policy terms, conditions and limitations apply.

To whom benefits are payable

Notwithstanding any provision of the policy, the following applies to payment for services received from network and non-network providers:

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

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

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

Michael B. McCallister
President

AMENDMENT

This amendment is made part of the Group Policy to which it is attached. The effective date of this change is the latter of the effective date of the Group Policy or the date this amendment is added to the Group Policy.

All terms used in this amendment have the same meaning given to them in the Group Policy unless otherwise specifically defined in this amendment. Except as modified below all terms, conditions and limitations of the Group Policy apply.

LIMITATIONS AND EXCLUSIONS

The following exclusion is added to the Group Policy:

Services received in an emergency room unless required because of an Emergency Medical Condition.

PORTABILITY OF CREDITABLE COVERAGE

If the Group Policy has a Pre-Existing Condition limitation, the following applies to portability of Creditable Coverage:

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

Humana Health Insurance Company of Florida, Inc.

Michael B. McCallister
President

AMENDMENT

POLICYHOLDER NAME:
U F COLLEGE OF MEDICINE

GROUP POLICY NUMBER: P5030

The coverage provided under the Group Policy shown above, issued by Humana Health Insurance Company of Florida, Inc. has been amended by changing the limitation and exclusion regarding morbid obesity.

This Amendment becomes a part of the Group Policy to which it is attached and is subject to all provisions in the Group Policy issued to the Policyholder identified above.

Effective Date of Amendment: 08/01/2005

HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.

President

NOTICES

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

- **Women's Health and Cancer Rights Act**
- **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**
- **Medical Child Support Orders**
- **General Notice of COBRA Continuation of Coverage Rights**
- **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**
- **Family And Medical Leave Act (FMLA)**
- **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
- **Your Rights Under ERISA**

Privacy and Confidentiality Statement

Claims and appeals procedures

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures, Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA, should consult their benefit plan documents for the applicable claims and appeals procedures.

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits; and
- Resolve factual questions relating to coverage and benefits.

Definitions

Adverse determination means a decision to deny benefits for a *pre-service claim* or a *post-service claim* under a *group health plan*.

Claimant means a covered person (or authorized representative) who files a claim.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana".

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim.*

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim (expedited review) means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is an "*urgent-care claim*" will be treated as a "claim involving urgent care".

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

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

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an *urgent-care claim* will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- ***Pre-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- ***Urgent-care claims (expedited review)*** - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

  Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the *urgent-care claim*.

  If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information but not less than 48 hours.

  Humana will provide notice of the plan's *urgent-care claim* determination as soon as possible but no more than 48 hours after the earlier of:

  - The plan receives the specified information; or
  - The end of the period afforded the *claimant* to provide the specified additional information.

- ***Concurrent-care decisions*** - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

  Humana will decide *urgent-care claim*s involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- ***Post-service claims*** - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the *claimant* responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claim*s, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

NOTICES (continued)

Appeals of adverse determinations

A claimant must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A claimant, on appeal, may request an expedited appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the claimant by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim.

On appeal, a claimant may review relevant documents and may submit issues and comments in writing. A claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- ***Urgent-care claims*** - As soon as possible but not later than 72 hours after Humana receives the appeal request;
- ***Pre-service claims*** - Within a reasonable period but not later than 30 days after Humana received the appeal request;
- ***Post-service claims*** - Within a reasonable period but not later than 60 days after Humana receives the appeal request;
- ***Concurrent-care decisions*** - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*;
- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the claimant, free of charge, upon request;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the claimant's right to bring an action under §502(a) of ERISA;
- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the claimant will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the determination;
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

Exhaustion of remedies

Upon completion of the appeals process under this section, a claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the claimant may proceed to the next level in the review process.

After exhaustion of remedies, a claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Federal legislation

Women's health and cancer rights act of 1998
Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborns'and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

NOTICES (continued)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to at total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of continuation coverage*** - If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;

- ***Second qualifying event extension of 18-month period of continuation coverage*** - If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gob/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options:

- ***Option 1*** - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- ***Option 2*** - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- ***Category 1*** Medicare eligibles are:
  - Covered employees in active service who are age 65 or older who choose Option 1;
  - Age 65 or older covered spouses; and
  - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

- ***Category 2*** Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
  - Retired employees and their spouses; or
  - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under ERISA, all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information about the plan and benefits

Plan participants may:

- Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office;
- Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator;
- Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

NOTICES (continued)

Continue group health plan coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan. The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator;

- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;

- If the participant disagrees with the plan’s decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;

- If plan fiduciaries misuse the plan’s money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;
- For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

  The Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue N.W.
  Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Privacy and confidentiality statement

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

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

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

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

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

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

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

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