A UnitedHealthcare Company

7600 Corporate Center Drive, Miami, Florida 33126

Please call 305-715-2500 or toll free at 1-800-354-0222 for assistance regarding claims and information about coverage

Florida Small Group Health Benefit Plan
Basic HMO Co-payment Plan

(herein called the Group Plan)

Neighborhood Health Partnership (hereinafter called NHP), agrees to provide the health care services described under the provisions of this Group Plan to all Covered Employees of the Small Employer and their Covered Dependents. The provision of services is subject to all of the terms on this page and those that follow, including any limitations, restrictions or exclusions, as well as any amendments made a part of this Group Plan.

The Small Employer may act on behalf of all eligible employees and dependents. Every act by, agreement made with, or notice given to the Small Employer will be binding on all Covered Employees and Covered Dependents.

This Group Plan is issued in consideration of the application of the Small Employer and payment of Premium in advance by the Small Employer at NHP's corporate office in Miami, Florida.

This Group Plan is effective on the Group Effective Date shown on the Group Plan Information Page. The first Premium covers the period starting on the Group Effective Date.

Signed for Neighborhood Health Partnership at its corporate office in Miami, Florida, to take effect on the Group Effective Date for delivery in the State of Florida.

Daniel I. Rosenthal

CEO, UnitedHealthcare of Florida

GROUP PLAN INFORMATION PAGE

Small Employer Name

Group Plan Number

Group Identification Number

Group Effective Date

Group Plan Anniversary Date

Eligibility Exceptions

Waiting Period

Group Premium Classes

Single

Employee plus Spouse

Employee plus Child

Employee, Spouse and Child(ren)

RESPONSIBILITIES OF THE SMALL EMPLOYER

The Small Employer is eligible for the health care coverage provided under this Group Plan by virtue of being a Small Employer, as defined in the Florida Statutes, at the time this Group Plan is issued. The Small Employer shall offer to all employees the opportunity to become a Covered Employee under this Group Plan. Such offer shall be made in such a fashion that employees are made aware, and understand, that this Group Plan contains a benefit structure that requires the use of a Primary Care Physician and/or Participating Providers.

The Small Employer may require an employee to pay some portion of the Premium. However, the Small Employer must contribute the same percentage toward the cost of all health benefit plans established and maintained by the Small Employer.

RESPONSIBILITIES OF NHP

In consideration of the payment of Premium by the Small Employer, NHP shall provide coverage for Covered Employees and their Covered Dependents. In doing so, NHP may enter into agreements with providers of health care, one or more other Group Policies or insurers and such other individuals and entities as may be necessary to enable NHP to fulfill its obligations under this Group Plan.

NHP agrees to provide coverage without discrimination because of race, color, sex, religion, national origin or any other basis prohibited by law.

EMPLOYEE ELIGIBILITY

Subject to any Eligibility Exceptions noted on the Group Plan Information Page, an individual becomes eligible for coverage on the date he or she completes any waiting period established by the Small Employer, as shown on the Group Plan Information Page. The waiting period is the length of time an employee must wait before becoming eligible for coverage. The waiting period designated by the Small Employer is shown on the Group Plan Information Page.

If an eligible person is covered under any other Group Plan issued to the Small Employer by NHP, or any other health benefit plan established and maintained by the Small Employer, they will not be considered eligible for coverage under this Group Plan.

COMMENCEMENT OF COVERAGE

On the Group Plan Effective Date as shown on the Group Plan Information Page, NHP agrees to provide the coverage stipulated in this Group Plan to all Covered Employees and their Covered Dependents, if any. Such coverage begins on the Covered Person's effective date, which will be the first of the month after the receipt and approval of the application by NHP, unless this Group Plan specifies a date other than the first of the month (See Special Enrollees, Late Enrollees and Dependent Effective Date provisions). NHP accepts no liability for benefits related to expenses incurred prior to the Covered Person's effective date or after the Covered Person's termination date, which will be on the last day of the coverage month, except as described in the Extension of Benefits provision or as specified in the Terms of Renewal and Termination provisions.

MINIMUM PARTICIPATION REQUIREMENTS

If the Small Employer pays the entire Premium:

A. For employee coverage, requiring no contribution for such coverage by employees, all eligible employees must be covered under this Group Plan or another group plan established and maintained by the Small Employer.

B. For dependent coverage, requiring no contribution for such coverage by employees, all eligible dependents must be covered under this Group Plan or another group plan established and maintained by the Small Employer.

If the Small Employer requires employees to contribute a portion of the Premium:

A. For employee coverage, at least 75% of eligible employees must be covered under this Group Plan or another group plan established and maintained by the Small Employer.

B. For dependent coverage, at least 50% of eligible dependents must be covered under this Group Plan or another group plan established and maintained by the Small Employer.

When applying minimum participation requirements, NHP does not have to consider as an eligible employee, employees or dependents who have qualifying existing coverage in an employer-based insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met.

If these participation requirements are not satisfied, NHP reserves the right to terminate this Group Plan after giving the Small Employer forty-five (45) days written notice prior to the Group's anniversary date.

NHP reserves the right to requests evidence of employee and dependent coverage under other plans to verify compliance with this provision.

TERMINATION OF THIS GROUP PLAN BY THE SMALL EMPLOYER

The Small Employer may terminate this Group Plan as of any Premium due date and should give NHP at least forty-five (45) days prior written notice. In such event, no benefits will be provided on or after such termination date, except as specifically set forth in this Group Plan.

TERMINATION OF THIS GROUP PLAN BY NHP

NHP may terminate this Group Plan as of any Premium due date if the Small Employer has not paid the required Premium by the end of the grace period, as defined in the Grace Period provision. However, if the Small Employer has given NHP prior written notice in advance of an earlier date of termination, this Group Plan will terminate as of that earlier date. The Small Employer is liable to NHP for any unpaid Premium for the time the Group Plan was in force, or for any amounts otherwise due NHP.

If the Group's coverage is terminated for any reason set forth in this Group Plan, NHP will mail the Employer a written notification that this Group Plan has terminated. This notification will tell you the date of termination and the reason(s) for termination. It is the Employer's obligation to immediately notify each Covered Person of any such termination.

TERMS OF RENEWAL

This Group Plan is a guaranteed renewable Plan. This means the Plan renews each year on the Group Plan Anniversary Date shown on the Group Plan Information Page. NHP guarantees the Small Employer the right to renew the Group Plan each year, at the Small Employer's option. With the exception of non-payment of Premium or loss of eligibility, NHP will give the Group at least forty-five (45) days advance written notice of our intent to non-renew this Group Plan, if one of the following circumstances has occurred:

A. The Small Employer fails to timely pay Premium or contributions in accordance with the terms of this Group Plan;

B. The Small Employer fails to comply with material provisions of this Group Plan which relates to rules for contribution or participation;

C. The Small Employer and enrollees no longer work or reside in the service area of NHP or in the area in which NHP is authorized to do business;

D. The Small Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Group Plan;

E. If applicable, the Small Employer no longer belongs to a bona fide association under which this Group Plan was obtained.

The Group must meet group eligibility guidelines as specified in this Group Plan at each policy renewal period. Prior to the Group's Plan anniversary date, NHP will request written documentation to verify eligibility, contribution and participation requirements. Failure to timely return the appropriate documentation will result in the termination of this Group Plan on the Group's anniversary date.

Bona fide association is defined as an association that has been actively in existence for at least five years, has been formed and maintained for purposes other than obtaining insurance, does not condition Membership on any health-status-related factor, makes health insurance coverage available to all Members regardless of any health-status-related factor and does not make health insurance coverage available other than in connection with a Membership in the association.

DISCONTINUANCE OF THE GROUP PLAN

NHP may discontinue offering this particular Group Plan form if:

A. We provide at least ninety (90) days notice to each policyholder and to participants and beneficiaries covered under the Plan prior to renewal; and

B. We off each policyholder the option to purchase all other coverage currently being offered by Us.

DISCONTINUANCE OF ALL COVERAGE IN THE SMALL GROUP MARKET

NHP may discontinue offering all coverage in Florida if:

A. We provide notice to the Office of Insurance Regulation (hereinafter called Office) and each Small Employer and enrollee 180 days prior to renewal; and

B. All health coverage issued or delivered for issuance in Florida is discontinued and coverage under such health coverage is not renewed;

PREMIUM PROVISIONS

PAYMENT OF PREMIUM

The first Premium payment is due on the Group Effective Date shown on the Group Plan Information Page. Each following Premium payment is due the first day of each month unless the Small Employer and NHP agree on some other method and/or frequency of payment. Premium payments should be sent to NHP's home office or the billing address provided by NHP.

PREMIUM DUE DATE

After the Group Effective Date shown on the Group Plan Information Page, the Premium due date will be the first day of each month.

THE GRACE PERIOD

This Group Plan has a 10-day grace period. A grace period means that if any required Premium is not paid on or before the date it is due, it may be paid during the grace period immediately following that Premium due date. During the grace period, the Group Plan will stay in force. The grace period does not apply to the Premium due on the Group Effective Date, if the Small Employer has given NHP written notice that the Group Plan is to be terminated prior to the Premium due date. If the Premium are not paid by the end of the grace period, Group Plan coverage will terminate back to the last day of the month for which the Premium were paid. Any late payment penalties are subject to Office approval.

MONTHLY PREMIUM STATEMENT

NHP will prepare a monthly statement of the Premium due on or before the Premium due date. This monthly statement will also reflect any pro rata Premium charges and credits resulting from changes in the number of Covered Persons and changes in the amounts of coverage that took place in the previous month. If a Covered Person becomes ineligible for coverage under this Group Plan for any reason, the Small Employer shall, if possible, provide NHP with prior written notice of such ineligibility. However, in any event, written notice of such ineligibility shall be provided by the Small Employer to NHP no later than thirty (30) days after such ineligibility. In the event that notice of termination of a Covered Person, or a decrease in coverage, is received by NHP more than one month after the termination or decrease, retroactive credit will be limited to premium paid after date of termination or decrease in coverage.

SIMPLIFIED ACCOUNTING

To simplify the accounting process, Premium adjustments will be made on the monthly Premium statement date that is the same as or next follows the date:

A. A person becomes covered;

B. The amount of coverage on a Covered Person changes, but not due to a revision of the coverage plan; or

C. A person ceases to be covered.

MONTHLY SUBSCRIPTION RATES

The monthly Premium rate for each Covered Employee is shown on the Group Plan Information Page.

CHANGES IN PREMIUM

No change in Premium will be made for the first twelve (12) months that this Group Plan is in effect. A change in Premium will not be made more often than once in a twelve (12) month period. NHP will give the Small Employer written notice of any changes in premium at least thirty (30) days prior to the Group's renewal date.

INCORRECT PREMIUM PAYMENT

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

GENERAL GROUP PLAN PROVISIONS

ENTIRE GROUP PLAN

The entire agreement is made up of this Group Plan, the Small Employer's application, and the applications of all Covered Employees. All statements made by the Small Employer or by a Covered Employee are considered to be representations, not warranties. This means that the statements are considered to have been made in good faith. No such statement will void this Group Plan, reduce the benefits it provides, or be used in defense to a claim for coverage unless it is contained in a written application and a copy is furnished to the person making such statement.

TIME LIMIT FOR CERTAIN DEFENSES

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

THE SMALL EMPLOYER AS NHP'S AGENT FOR LIMITED PURPOSES

The Small Employer is considered to be an agent of NHP only for the following purposes:

A. Collecting employee enrollment information;

B. Collecting any required employee contribution; and

C. Giving out Certificates of Coverage or other coverage information to the Covered Employees.

ADMINISTRATION

The Small Employer must provide NHP with the information it needs to administer this Group Plan and to compute the Premium due. Failure of the Small Employer to provide this information will not void or discontinue a Covered Person's coverage. NHP has the right to examine the Small Employer's records on any issues necessary for the proper administration of this Group Plan at any reasonable time while this Group Plan is in force.

FINANCIAL RESPONSIBILITIES OF THE SMALL EMPLOYER

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

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

CERTIFICATES OF COVERAGE

NHP will issue Certificates of Coverage for each Covered Employee. The certificate will describe the benefits provided and the limitations of this Group Plan. Nothing in the certificate will change or void the terms of this Group Plan.

The Employer agrees that, if requested by NHP, the Employer will distribute to Covered Persons, the Certificate of Coverage and any amendments or endorsements to it, other coverage materials and notices applicable to all or any Covered Persons.

CHANGES TO THIS GROUP PLAN

NHP may change this Group Plan from time to time as required by applicable state and federal laws and subject to Office approval. No change to this Group Plan will be effective unless made by an amendment or rider that has been signed by an officer of NHP. No agent may change this Group Plan or waive any of its provisions.

If We increase the Co-payment for any benefit or delete, amend or limit any of the benefits to which a Covered Person is entitled to under this plan, We will give the Group forty-five (45) days written notice prior to renewal. The Group will not be notified if benefits are increased or if the Group requests any changes, deletions or limitations.

WORKERS' COMPENSATION

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

ASSIGNMENT

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

CERTIFICATE PROVISIONS MADE A PART OF THE GROUP PLAN

The remainder of the Group Plan consists of the provisions shown in the certificate issued to Covered Employees under this Group Plan. These provisions are made a part of the Group Plan. Amendments, if any, changing the provisions of the certificate are also made a part of the Group Plan.

SERVICE AREA

The Service Area shall consist of Miami-Dade, Broward, and Palm Beach Counties, Florida.

7600 Corporate Center Drive, Miami, Florida 33126

Please call 305-715-2500 or toll free at 1-800-354-0222 for assistance regarding claims and information about coverage

CERTIFICATE OF HMO COVERAGE
Basic HMO Co-payment Plan

Small Employer Name:

Certificate Holder: **Certificate Holder Coverage Effective Date:**

Group Plan Number: **Group Identification Number:**

Customer Service Number:

In accordance with the terms of the Group Plan issued to the Small Employer, Neighborhood Health Partnership (hereinafter called NHP), certifies that it will cover all eligible persons for the services described in this certificate. This certificate replaces any and all certificates and riders previously issued.

NHP will provide the services described in this certificate to Covered Employees and their dependents, if any, on a direct-service basis. This means that NHP arranges or contracts with physicians, hospitals, or other providers of medical care and employs administrative personnel to directly provide, organize, and arrange for such service. NHP agrees to use its best efforts to assure that its providers render quality health care services in conformity with accepted community medical standards. The physicians, hospitals and providers of medical care are not our agents or employees, nor is NHP their agent or employee.

This certificate describes the administrative details, services, provisions, and limitations of the group plan. The services outlined in this certificate are effective only if a person is eligible for coverage, becomes covered, and remains covered in accordance with the terms of this plan.

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

Joseph R. Papa

President and Chief Executive Officer

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The provisions of this certificate are divided into two sections. The Administrative Provisions sections explains who is eligible, when coverage becomes effective, when coverage ends, what options are available when coverage ends, and other details on how the plan works. The Coverage Provision sections explain how benefits should be obtained, what is covered and what is not covered and definitions of common terms used in this Group Plan.

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This section provides important information on the administration of this Group Plan, explaining:

A. Who is eligible for benefits under this Group Plan, when coverage becomes effective, when coverage terminates and what the Covered Person can do to continue coverage or convert to other coverage;

B. How this Group Plan will relate to other plans under which Covered Persons have coverage or other situations where payment is made for the services covered under this Group Plan; and

C. How the Covered Person can appeal to NHP on coverage decisions.

ELIGIBILITY AND EFFECTIVE DATES

Because this coverage is group coverage, eligibility for coverage is tied to the individual's relationship with the Employer that establishes this Group Plan. The following sections explain eligibility and effective dates of this coverage.

ELIGIBILITY UNDER THIS GROUP PLAN

To be eligible for coverage under this Group Plan, an individual must be either:

A. An Eligible Employee of the Employer. An **Eligible Employee** means an individual who works for the Employer on a full time basis, with a normal work week of twenty-five (25) hours or more. Part-time, temporary, or substitute employees are not eligible. A husband and wife and dependent children employed by the same Small Employer will be considered a single employee if either spouse has a normal work week of less than twenty-five (25) hours.

B. An Eligible Dependent of an Eligible Employee. An **Eligible Dependent** means the employee’s lawful spouse, and/or the employee’s child until the end of the Calendar Year in which the child reached age 25, if the child meets all of the following requirements:

   1. The child is dependent on the Covered Employee for support; and

   2. The child is living in the household of the Covered Employee, or the child is a full-time or part-time student.

The term **child** includes the employee's natural born child, stepchild, or a foster or legally adopted child of the employee upon placement in the employee's residence, or at the birth of a newborn adopted child, where a written agreement to adopt such child had been entered into prior to the birth of the child, whether or not that agreement is enforceable. If the foster or adopted child is ultimately not placed in the residence of the employee, no benefit will apply.

The term also includes any child for whom the employee is the legal guardian, a child who is dependent on the employee for health care coverage pursuant to a valid court order, or any child who lives with the employee in a normal parent-child relationship, if the child qualifies at all times for the dependent exemption, as defined in the Internal Revenue Code and the Federal Tax Regulations. NHP has the right to request proof of the child's dependency status at any time.

C. If the Employer indicates that they are to be covered, coverage can be provided to a partner of a partnership, or an independent contractor; or

D. To be eligible for coverage under the group plan, the employee, dependents, or other individuals satisfying the requirements of A., B., and C. above must work or live in the Group Plan Service Area.

ENROLLMENT PERIODS

There are three types of time periods for coverage enrollment under this Group Plan:

A. The **Initial Enrollment Period** is the period of time during which an employee or dependent is first eligible to enroll. It starts on employee's or dependent's initial date of eligibility and ends thirty (30) days later.

B. The **Annual Open Enrollment Period** is an annual thirty (30) day period, beginning thirty (30) days prior to the anniversary date of the employer's program, during which:

   1. If the Employer has established and maintained more than one health coverage plan for his or her Eligible Employees, an employee who had elected another plan, and maintained coverage under that plan up to the beginning of the Annual Open Enrollment Period, can change to this Group Plan.

   2. Employees who decided not to enroll themselves and/or their Eligible Dependents for coverage under this Group Plan during the Initial Enrollment Period can enroll, subject to the delayed coverage rules explained in the Late Enrollee provision.

C. A **Special Enrollment Period** that is provided for the special circumstances described in the Special Enrollment provision.

EMPLOYEE ENROLLMENT

Eligible Employees and eligible dependents who become covered under this Group Plan will be referred to as "Covered Persons". To become a Covered Person, the employee must:

A. Complete and submit, through his or her employer, a written request for coverage, using enrollment forms approved by NHP;

B. Provide any additional information needed to determine eligibility, if requested by NHP; and

C. Agree to pay his or her portion of the required Premium, if required by the Employer.

An employee who is a newly Eligible Employee must enroll within the Initial Enrollment Period. An employee who has been covered under another health benefit plan established and maintained by the Employer, and who now wants to change to this Group Plan, must enroll for such coverage change during the Special Enrollment Period if he or she qualifies.

If an employee does not enroll for coverage under this Group Plan during his or her Initial Enrollment Period or as a Special Enrollee, he or she will be considered a Late Enrollee. See the Late Enrollee provision below.

EMPLOYEE EFFECTIVE DATE

The effective date of an employee's coverage as a Covered Person under this Group Plan, excluding Late Enrollees, depends upon when the employee enrolls:

A. If the employee is eligible for coverage on the Group Plan effective date, coverage will be effective on the Group Plan effective date, if the employee enrolls for coverage during the Initial Enrollment Period.

B. If the employee becomes eligible after the Group Plan effective date and enrolls during the Initial Enrollment Period, coverage will be effective on the date the employee becomes eligible. This includes those new employees required to fulfill an employer waiting period (See Service Waiting Period in the Glossary).

C. If an Eligible Employee of the Employer or an Eligible Employee newly hired by the Employer declines coverage at the Initial Enrollment Period but enrolls as a Late Enrollee or, if eligible, as a Special Enrollee, coverage will be effective on the date the employee becomes eligible.

The term Effective Date means to the entire Group Plan, and the Covered Persons properly enrolled when the Group Plan first becomes effective, 12:01 a.m. on the date specified on the Certificate Cover Page of this Group Plan; and with respect to a Covered Person who is subsequently enrolled, 12:01 a.m. on the date on which coverage will commence for that Covered Person as specified in Employee Effective Date and Dependent Effective Date Sections of this Group Plan.

Services or supplies that are payable as benefits under this Group Plan are covered commencing on the employee's effective date. However, services or supplies for a condition that is covered under an extension of group health benefits from a previous employer-related health plan, health insurance plan or other benefit arrangement will not be covered under this Group Plan until the extension for the condition under the prior plan ends.

DEPENDENT ENROLLMENT

The term "Covered Dependent" means an Eligible Dependent of a Covered Employee who becomes covered under this Group Plan. For an Eligible Dependent to become an Covered Person, the employee must:

A. Complete and submit through his or her employer a written request for such dependent's coverage, using enrollment forms approved by NHP;

B. Provide any information needed to determine the dependent's eligibility, if requested by NHP; and

C. Agree to pay his or her portion of the appropriate dependent Premium, as required by the Employer, for the dependent's coverage.

To add dependents on the Covered Employee's effective date, the Covered Employee must enroll his or her Eligible Dependents at the same time he or she initially enrolls during the Initial Enrollment Period.

To add a newborn, an adopted newborn, or an adopted child as a dependent after the Employee's effective date, the Covered Employee must enroll the dependent within the time frames specified in the Newborn and Adopted Children provisions.

To add any other dependent including foster children or court ordered coverage for a spouse or a minor child after the Covered Employee's effective date, the Covered Employee must enroll the dependent within thirty days after eligibility as a dependent begins or thirty days after the court order is issued.

If enrollment is not completed as specified above, the dependent will be considered a Late Enrollee and subject to the delayed coverage rules specified in the Late Enrollee provision.

DEPENDENT EFFECTIVE DATE

The effective date of a dependent's coverage under this Group Plan depends on when the dependent is enrolled:

A. If the dependent is eligible for coverage on the Group Plan effective date, coverage for the dependent will become effective on the Group Plan effective date if the employee enrolls the dependent for coverage at the same time he or she enrolls during the Initial Enrollment Period.

B. If the employee through whom the dependent is eligible first becomes eligible after the Group Plan effective date and the employee enrolls himself or herself and his or her dependents during the Initial Enrollment Period, coverage for the dependents will be effective on the same date that the employee's coverage becomes effective.

C. If the Eligible Employee of the Employer or an Eligible Employee newly hired by the Employer declined coverage at the Initial Enrollment Period but enrolls as a Late Enrollee or, if eligible, as a Special Enrollee, the employee's dependent coverage will be effective on the date the employee becomes eligible.

D. If the dependent is a newly Eligible Dependent who first becomes eligible after the Covered Employee's effective date, and the Covered Employee enrolls the dependent within thirty (30) days after eligibility as a dependent begins, that dependent's coverage will become effective on the date the enrollment form is received by NHP.

E. If the dependent is a newborn or adopted child who first becomes eligible after the Covered Employee's effective date, and the Covered Employee enrolls the dependent within the time frames specified in the Newborn or the Adopted Children provisions, that dependent's coverage will become effective on the date of birth for a newborn or adopted newborn and date of placement for an adopted child.

If, on the date dependent coverage becomes effective, the dependent is covered for a condition under an extension of group health benefits from a previous employer-related health plan, health insurance plan or other coverage arrangement, coverage under this Group Plan for extension related services or supplies for that condition will not begin until the extension under the prior plan ends.

COVERAGE FOR NEWBORN CHILDREN

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

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

Newborn coverage shall take effect at the moment of birth and will continue for thirty (30) days if NHP is notified by the Covered Person to enroll the child. If timely notice is given, no Premium will be charged for the first thirty (30) days. If the Covered Person fails to enroll the child within thirty (30) days of birth, but enrolls the child within sixty (60) days of birth, the Covered Person will be required to pay an additional Premium from the date of birth. If notice is given within sixty (60) days, NHP will not deny coverage due to the failure of the Covered Employee to timely notify Us of the birth. If notice of the birth is not given within sixty (60) days of birth, the newborn child will be considered a Late Enrollee and will not be eligible to enroll for coverage until the next Annual Open Enrollment Period (See Late Enrollee provision). A newborn child of a covered dependent child is covered for a period of eighteen (18) months if the child is enrolled as specified herein.

COVERAGE FOR ADOPTED CHILDREN

All health coverage applicable for children under this Group Plan will be provided for the adopted child of the Covered Employee if the Covered Employee has dependent coverage. Coverage is provided to a child the Covered Employee proposes to adopt who is placed in the Covered Employee's residence in compliance with chapter 63, from the moment of placement. A newborn infant who is adopted by the Covered Employee is covered from the moment of birth if a written agreement to adopt such child has been entered into prior to the birth of the child, whether or not such agreement is enforceable. However, coverage will not be provided in the event the child is not ultimately placed in Your residence in compliance with chapter 63.

The Covered Employee's adopted child is covered from the moment of placement in the residence, or if a newborn, from the moment of birth, if the child is enrolled as specified herein. If the Covered Employee notifies NHP to enroll the child within thirty (30) days from the moment of birth or placement, a Premium will not be charged for the first thirty (30) days. If the Covered Employee fails to enroll the child within thirty (30) days of

the event, but enrolls the child within sixty (60) days of the event, the Covered Employee will be required to pay an additional Premium from the date of birth or placement. If notice is given within sixty 60) days of the event, NHP will not deny coverage due to the failure of the Covered Employee to timely notify Us of the adoption. Notice of the birth or placement after sixty (60) days will be considered a Late Enrollment and subject to the delayed coverage rules specified in the Late Enrollee provision.

COVERAGE FOR FOSTER CHILDREN

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

DEPENDENT AS EMPLOYEE

A Covered Dependent may become eligible as a Covered Employee as long as he or she meets the eligibility requirements for an Covered Employee. However, the Covered Dependent may no longer be covered as a dependent child if eligible for benefits as an employee. Also, a person may not be covered under this Group Plan as a dependent of more than one employee.

TERMINATION OF GROUP COVERAGE

Because this plan provides group coverage, the continuation of the coverage depends on the decisions of the Employer and on the Covered Employee's continued employment relationship to the Employer. The following sections explain when coverage will end, and the options available to the Covered Person to continue or convert coverage.

TERMINATION OF EMPLOYEE COVERAGE

A Covered Employee’s coverage under this Group Plan will end automatically at 12:01 a.m., local standard time, on the date:

A. The contract between the Small Employer and NHP ends.

B. The Small Employer fails to pay the Premium due, or the Covered Employee otherwise fails to continue to meet each of the eligibility requirements under this Group Plan.

C. The Covered Employee becomes covered under another health benefit plan which is established and maintained through or in connection with the Small Employer as an alternative to this Group Plan.

D. The Covered Employee’s coverage is terminated for cause (See the *Termination of Individual Coverage* provision below).

TERMINATION OF A DEPENDENT’S COVERAGE

A Covered Dependent’s coverage under this Group Plan will end automatically at 12:01 a.m., local standard time, on the date:

A. The contract between the Small Employer and NHP ends.

B. The Covered Employee's coverage terminates for any reason.

C. The Covered Dependent otherwise fails to continue to meet each of the eligibility requirements under this Group Plan.

D. The Covered Dependent becomes covered under another health benefit plan which is offered through or

in connection with the Small Employer as an alternative to this Group Plan.

E. The Covered Dependent's coverage is terminated for cause (see the *Termination of Individual Coverage* provision below)

TERMINATION OF AN INDIVIDUAL'S COVERAGE

A. Unless otherwise prohibited by law, if in NHP's opinion any of the following events occur, NHP may terminate a Covered Person's coverage as specified below:

   1. The date specified by NHP due to the Covered Person's disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Covered Person's continued Membership in the Group Plan, impairs Our ability to provide coverage and/or benefits or to arrange for the delivery of health care services to such Covered Person or to other Covered Persons. Prior to disenrolling a Covered Person for any of the above reasons, NHP will:

      a. make a reasonable effort to resolve the problem presented by the Covered Person, including the use or attempted use of NHP's Grievance Procedure; and

      b. to the extent possible, ascertain that the Covered Person's behavior is not related to the use of medical services or mental illness; and

      c. document the problems encountered, efforts made to resolve the problems, and any of the Covered Person's medical conditions involved.

   2. The date specified by NHP that all coverage will terminate due to: (a) fraud or material misrepresentation in applying for or presenting any claim for benefits under this Group Plan; or (b) permitting the use of his or her Covered Membership Card by any other person or (c) furnishing of false or incomplete information on the enrollment forms, or other forms completed for NHP, by or on behalf of the Covered Person for the purpose of fraudulently obtaining coverage. False, material information includes, but is not limited to information relating to residence and/or employment, information relating to another person's eligibility for coverage or status as a Dependent. NHP has the right to rescind coverage back to the effective date, in accordance with s. 641.31(23), Florida Statutes, *Time Limit on Certain Defenses.*

   3. The date specified by NHP if the Covered Person leaves NHP's Service Area with the intention to relocate or establish a new residence.

   4. The date specified by NHP if a Covered Dependent reaches the limiting age as specified in the Eligibility Section of this Group Plan or if a court order, including a qualified medical child support order, covering a dependent child is no longer in effect.

B. Any termination made under these provisions is subject to review in accordance with the Grievance Procedure described herein.

NOTE: "Time Limit on Certain Defenses", Relative to a misstatement in the application, after two (2) years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the two (2) year period.

HANDICAPPED CHILDREN

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

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

B. Chiefly dependent on the Covered Employee for support and maintenance.

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

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

CERTIFICATE OF CREDITABLE COVERAGE

Within thirty (30) days of a Covered Person’s last date of coverage with NHP, a Certificate of Creditable Coverage will be mailed to the Covered Person’s home. This Certificate will indicate the period of time the Covered Person was enrolled with NHP and provides evidence of a Covered Person’s coverage with NHP that may be needed when applying for health coverage in the future.

RIGHTS TO EXTENSION, CONVERSION AND CONTINUATION

If coverage for a Covered Employee or an Covered Dependent ends, that Covered Person may, depending on his or her situation, have the right to have coverage extended under the Extension of Benefits provision. In addition, coverage may be continued under the Federal Continuation of Coverage (COBRA) provision or Florida Continuation of Coverage provision. Finally, the Covered Person may be eligible for an alternative coverage plan under the Conversion Privilege provision.

EXTENSION OF BENEFITS

In the event this Group Plan is terminated for any reason and a Covered Person is totally disabled, the benefits described in the Covered Services section will be payable, subject to the regular benefit limits described in the Covered Services section, for expenses incurred due to the sickness or injury which caused such continuous total disability. This extension of benefits will cease on the earliest of:

A. The date on which the continuous total disability ceases;

B. The end of the twelve (12) month period immediately following the termination date of the Group Plan.

C. For pregnancy, maternity benefits will continue until the date of delivery, provided the pregnancy began after the Covered Person's effective date and prior to the termination of the Group Plan. This extension will not be based on total disability; or

D. For up to 90 days for covered dental expenses incurred for treatment of an injury or sickness covered by this Group Plan.

For the purposes of this section, "continuous total disability" and "totally disabled" mean:

A. For the Covered Employee, the inability to perform any work or occupation for which the Covered Employee is reasonably qualified or trained.

B. For any other Covered Person, the inability to engage in most normal activities of a person of like age and sex in good health.

A Covered Person is not entitled to extension of benefits if coverage is terminated for any of the following reasons:

A. For cause, due to disruptive, unruly, abusive, or uncooperative behavior to the extent that such Covered Person's continued Membership in the Group Plan impairs Our ability to administer this Plan or to arrange for the delivery of health care services to such Covered Persons;

B. Fraud or intentional misrepresentation or omission in applying for any benefits under this Group Plan; or

C. The Covered Person has left NHP's Service Area with the intent to relocate or establish a new residence.

FEDERAL CONTINUATION PROVISIONS (For employers with 20 or more employees)

There is a federal law which permits Covered Persons to continue coverage under an employer established health benefit plan under certain circumstances. This law is referred to as **COBRA**, which stands for "the Consolidated Omnibus Budget Reconciliation Act of 1986" and any amendments thereto. This continuation provision applies only to an employer of 20 or more employees. Covered Persons should check with the Employer regarding the availability of this option.

It is the Employer's responsibility to make employees aware of any COBRA rights they may have, if the employer is subject to COBRA. Information on employee COBRA rights may also be obtained from the United States Department of Labor.

STATE OF FLORIDA CONTINUATION OF COVERAGE

If the Group is not subject to COBRA, continuation as required by the State of Florida ("State Continuation") may be available as described below.

If you are an employee of an employer with fewer than 20 employees and covered by its group health plan, you have a right to choose this continuation coverage if:

A. You lose your group health coverage because of a reduction in your hours of employment; or

B. The termination of your employment (for reasons other than gross misconduct on your part).

If you are the covered spouse of an employee, you have the right to choose continuation coverage for yourself if you lose group health coverage for any of the following four reasons:

Types of Qualifying Events

A. The death of the employee;

B. The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;

C. Divorce or legal separation from the employee; or

D. The employee becomes entitled to Medicare.

In the case of a covered dependent child of an employee, or covered spouse, he or she has the right to continuation coverage if group health coverage is lost for any of the following six reasons:

A. The death of the employee;

B. The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;

C. Parent's divorce or legal separation;

D. Employee becomes entitled to Medicare; or,

E. the dependent ceases to be a "dependent child" under the terms of the group health plan;

F. You also have a right to elect continuation coverage if you are covered under the plan as a retiree of spouse or child of a retiree and lose coverage within one year before or after the commencement of proceedings under Title XI (bankruptcy), United States Code by the employer from whose employment the Covered Employee retired.

Under the law, a qualified beneficiary has the responsibility to inform NHP of a qualifying event. This notification must be made within thirty (30) days of the date of the qualifying event which would cause a loss of coverage.

The notice must be in writing, and include:

A. The name of the qualified beneficiary;

B. The date of the qualifying event;

C. One of the types of qualifying events listed above;

D. The name of the employer;

E. The group health plan number;

F. The name and address of all qualified beneficiaries.

When NHP is notified that one of these events has happened, it will in turn notify you within 14 days that you have the right to choose continuation coverage. Under the law, you have thirty (30) days from the date of receipt of the Election and Premium Notice form, to elect continuation coverage. If and when you make this election, return the Election and Premium Notice form with applicable Premium to NHP. Coverage will become effective of the day after coverage would otherwise be terminated.

If you do not elect coverage and pay the Premium, your group health insurance coverage will terminate in accordance with provisions outlined in your benefits handbook or other applicable plan documents.

If you choose continuation coverage, your coverage will be identical to the coverage provided under the plan to similarly situated employees or family Covered Persons. The law requires that you be afforded the opportunity to maintain continuation coverage for 18 months. However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

A. The employer/former employer no longer provides group health coverage to any of its employees;

B. The Premium for your continuation coverage is not paid by the expiration of the grace period, which is thirty (30) days;

C. You first become, after electing continuation coverage, covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition;

D. You are approved, after electing continuation coverage, for Medicare.

*Note: A qualified beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event, may be eligible to continue coverage for an additional 11 months (29 months total) of the qualified beneficiary provides the written determination of disability from the Social Security Administration to the insurance carrier within 60 days of the date of determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The insurance carrier can charge up to 150 percent of the group rate during the 11-month disability extension. The qualified beneficiary must notify the insurance carrier within thirty (30) days upon the determination that the qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act.

You do not have to show that you are insurable to choose continuation coverage. However, you may have to pay up to 115% of the applicable premium for continuation coverage. The law also requires that, at the end of the 18-months or 29-months, continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the current group health plan.

If you have any questions about this, please contact the person or office shown below. Also if you have changed marital status, or you, your spouse, or any eligible covered dependent have changed address, please notify us in writing, the person of office shown below:

Premium Services
Neighborhood Health Partnership, Inc.
7600 Corporate Center Drive
Miami, Florida 33126
305-715-2400

If any covered child is at a different address, please notify NHP in writing, so that a separate notice may be sent by NHP to the separate household.

THE CONVERSION PRIVILEGE

A Covered Employee who has been continuously covered for at least three months under this Group Plan and/or under another group plan providing similar benefits, in effect, immediately prior to this Group Plan, has the right to apply for a conversion plan if coverage terminates due to the Covered Employee's:

A. Termination of employment;

B. Termination of Covered Employee's Covered Membership in an eligible class;

C. Loss of coverage due to the termination of this Group Plan, if it is not replaced by another health care plan within 31 days of termination.

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

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

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

B. If the Covered Employee dies, the covered spouse may convert.

C. If the Covered Employee and the covered spouse die simultaneously or upon the death of the last surviving parent, the covered children may convert if they are of contracting age.

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

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

At the time of application, You will be offered a choice of at least two plans; the Standard Conversion Plan and another plan in which benefits are substantially similar to the level of benefits in this Group Plan. The new coverage will be issued at rates, not to exceed 200% of the Standard Risk Rate as determined and published by the Office.

REQUESTING CONVERSION

A Covered Person who is eligible for conversion may obtain conversion coverage without having to submit evidence of health qualification. However, the Covered Person must apply in writing and pay the first Premium for the conversion plan within 63 days after his or her coverage under this Group Plan terminates. The application form to be used, and information about conversion benefits may be obtained from NHP.

If the Employer qualifies for federal continuation benefits described in the Federal Continuation section, or qualifies for State Continuation as described above, conversion may take place at the end of the federal or state continuation period, if written application is made and the first Premium payment is made within 63 days of the date coverage under the continuation period ends.

Unless otherwise prohibited by law, conversion is not available if:

A. The Covered Person has not been continuously covered for at least three months under this Group Plan and/or under another group plan providing similar benefits, in effect, immediately prior to the termination of this Group Plan. However, dependents who are Covered Persons on the date coverage ends may convert as dependents of the Covered Employee if the Covered Employee converts coverage under this Group Plan; or

B. Coverage under this Group Plan ends due to failure to pay any required Premium; or

C. This Group Plan is replaced by similar group coverage within 31 days of the termination date of this Group Plan; or

D. The Covered Person has left NHP's geographic area with the intent to relocate or establish a new residence

E. The Covered Person is eligible for the following coverage and those benefits together with the benefits provided by the conversion plan would result in excessive duplication of benefits:

   1. Any arrangements of coverage for individuals in a group whether on an insured or uninsured basis;

   2. Similar benefits under any state or federal program;

   3. Similar benefits by another group hospital, surgical, medical or major medical expense insurance Contract or group hospital and medical service plan or group medical practice or any other prepayment plan or program.

THIS GROUP PLAN AND OTHER PAYMENT ARRANGEMENTS

COORDINATION OF BENEFITS

When a Covered Person is covered under this Group Plan and another health coverage plan, NHP reserves the right to coordinate the benefits of this Group Plan with the benefits of that other plan. This provision explains how that coordination will take place.

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

PLANS AFFECTED

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION

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

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

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

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

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

   2. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a program which cover that child as a dependent of the parent with custody shall be determined before the benefits of a plan which cover that child as a dependent of the step-parent; and the benefits of a plan which cover that child as a dependent of a step-parent will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

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

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

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

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

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

Sometimes, the situations that cause a Covered Person to need the benefits and supplies provided under this Group Plan also result in actions by the Covered Person to recover damages related to that situation. Such actions may often result in duplicate payments for the services and supplies that NHP has already provided to the Covered Person. To protect NHP from this type of duplicate payment, NHP reserves the right to get involved in that recovery process. NHP's right to get involved is called "subrogation".

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

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

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

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

RIGHT TO RECEIVE AND RELEASE INFORMATION

NHP has the right to receive and release necessary information. By accepting coverage under this Group Plan, the Covered Employee gives permission for NHP to obtain from or release to any insurance NHP or other organization or person any information necessary to determine whether this provision or any similar provision in other plans applies to a claim and to implement such provisions. NHP may obtain or release this information without consent from or notice to anyone. Any person who claims benefits under this Group Plan agrees to furnish to NHP, information that may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payment which should have been made by NHP is made to any other person, plan, or organization, NHP shall have the right to pay to that other person, plan or organization any amounts NHP determines to be necessary under this provision. Amounts paid to another plan in this manner will be considered benefits paid under this Group Plan. NHP is discharged from liability under this Group Plan to the extent of any amounts so paid.

RIGHT OF RECOVERY

If NHP makes larger payments than are required under this Group Plan, then NHP has the right to recover any excess benefit payment from any person to to whom such payments were made.

NON-DUPLICATION OF GOVERNMENT PROGRAMS

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

NON-DUPLICATION OF OTHER COVERAGE

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

COOPERATION OF COVERED PERSONS

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

MEDICARE ELIGIBLES

The Effect of Medicare Coverage/Medicare Secondary Payer

When a Covered Person becomes covered under Medicare and continues to be eligible and covered under the Group Plan, the benefits of the Group Plan shall be primary and the Medicare benefits shall be secondary as set forth below, but only to the extent required by law. In all other instances, the benefits under this Group Plan shall be secondary to any Medicare benefits. To the extent NHP is primary payer, claims for Covered Services should be filed with NHP first.

In order to ensure compliance with the Medicare Statute, the Small Employer should advise NHP of any Covered Person who is covered under Medicare prior to or immediately following the date such Covered Person becomes so covered (e.g., prior to the Covered Person's 65th birthday). Additionally, the Small Employer should advise the Health Plan of any Medicare beneficiary who applies for coverage, prior to such individual's Effective Date.

In any circumstances under which the Medicare statute requires that the Benefits under the Group Plan be primary for any Covered Person, the Small Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such Covered Person. Also, the Small Employer may not induce such Covered Person to decline or terminate his or her group health coverage and elect Medicare as primary payer.

Working Elderly

If the Small Employer employs 20 or more persons for 20 or more weeks of the current or preceding Calendar Year, or is a Covered Person of a multi-employer group health plan that includes at least one employer with 20 or more employees, the Group Plan provides primary coverage for employees and/or their spouses, age 65 or older, who are covered under this Group Plan, pursuant to the following terms:

A. The Small Employer provides NHP the names of employees, age 65 or older:

  1. Who are covered under this Group Plan;

  2. Who are employed (not retired);

  3. Who have not elected Medicare as primary payer of their health insurance claims; and

  4. Who are not eligible for Medicare due to end stage renal disease (ESRD).

B. The Small Employer provides NHP the names of spouses, age 65 or older, of current employees of any age:

  1. Who are covered under the Group Plan;

  2. Who have not elected Medicare as primary payer of their health insurance claims; and

  3. Who are not eligible for Medicare due to ESRD.

These names, along with any other identifying information requested by NHP should be provided to NHP on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls under the Group Plan.

A. For an enrolled individual who meets one of the descriptions set out in Paragraph A or B above, NHP will provide group health coverage, as set forth in the Group Plan, on a primary basis beginning with the first day of the month in which the individual attains age 65 or the date of enrollment, if the individual is 65 or over at the time of enrollment.

B. Individual entitlement to primary coverage under this Section will terminate automatically:

  1. For a current employee, age 65 or older, when he or she elects Medicare as the primary payer or when he or she becomes eligible for Medicare due to ESRD;

  2. For the spouse, age 65 or older, of a current employee of any age, when the spouse elects Medicare as the primary payer or when the spouse becomes eligible for Medicare due to ESRD.

The Small Employer notifies NHP the names of any current employees or spouses of such employees, age 65 or older, who choose Medicare as primary payer of their health insurance claims or who become eligible for Medicare due to ESRD.

Under the Medicare statute, the Small Employer may not offer, subsidize, procure, or provide a Medicare supplement insurance policy to such individual. Also, the Small Employer may not induce such individual to decline or terminate his or her group health coverage and elect Medicare as primary payer.

A. Entitlement of the employee and/or spouse to primary coverage under this Section will terminate automatically when:

    1. The employee retire; or

    2. The employee no longer meets the employer eligibility requirements.

B. The primary coverage described in this Section will not be provided in the case of a Covered Person of a multi-employer group health plan where that Small Employer has fewer than 20 employees and the plan has elected treatment of that Covered Person's employees under the exception for small employers described in 42 U.S.C. 1395y(b)(1)(A)(iii).

NOTE: Changes in the number of employees to fewer than 20 employees or from fewer than 20 employees to 20 or more employees, including pertinent changes in multi-employer group health plans, must be immediately reported by the Small Employer to NHP.

Individuals with End Stage Renal Disease

Primary coverage is provided for the Small Employer's current and former employees and/or their dependents who are covered under the Group Plan and who are entitled to Medicare coverage because of ESRD, pursuant to the following terms:

A. The Small Employer provides NHP with the names of any individuals covered under the Group Plan who are or will be undergoing a regular course of renal dialysis or who will receive or already have received a kidney transplant, the beginning date of such dialysis or the date of such transplant, and any other identifying information requested.

B. For an enrolled individual who is entitled to Medicare coverage because of ESRD, NHP will provide group health insurance coverage, as set forth in this Group Plan, on a primary basis for 30 months beginning with the earlier of:

    1. The month in which the individual becomes entitled to Medicare Part A ESRD benefits; or

    2. The first month in which the individual would have become entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the gage of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD on or after March 1, 1996, NHP will provide group health coverage, as set forth in the Group Plan, on a primary basis for 18 months.

Under the Medicare statute, the Small Employer may not offer, subsidize, procure or provide a Medicare supplement policy to such individuals. Also, the Small Employer may not induce such individuals to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

Employers with Less Than 20 Employees

When an Employer employs less than twenty (20) employees, benefits under this Group Plan will be payable for a Covered Person who is age 65 or older and eligible for Medicare as follows:

A. If expenses are incurred for which benefits are payable by both this Group Plan and Medicare Part A, benefits are payable by this Group Plan only for those expenses which exceed the amount payable by Medicare Part A..

B. If expenses are incurred for which benefits are payable by both this Group Plan and Medicare Part B, NHP will reduce the benefits payable by this Group Plan by the amount of benefits payable for those expenses by Medicare Part B..

For a Covered Person who is under age 65 and eligible for Medicare, the benefits payable by this Group Plan will be reduced so that not more than 100% of the expenses incurred are paid jointly by this Group Plan and Medicare.

Conformance with Federal Law

This Medicare Secondary Payer Section shall be subject to, modified if necessary to conform to or comply with, and interpreted with reference to those requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Group Plan.

NOTE: The federal laws described in this Section are directed at the Small Employer. Individuals with questions regarding their rights under those laws should direct their questions to the Small Employer.

CLAIM PROVISIONS

REIMBURSEMENT FOR PARTICIPATING AND NON-PARTICIPATING PROVIDER SERVICES

NHP will provide or arrange for services to be received from Participating Providers on a direct service basis. If a Covered Person receives services from a Participating Provider, NHP will pay the Health Care Provider directly for all care received. The Covered Person will not have to submit a claim for payment, and will be responsible only for any applicable Co-payments.

In the event the Covered Person has an Emergency Medical Condition that requires services from a Non-Participating Provider while inside or outside the Service Area; or, if NHP refers the Covered Person to a Non-Participating Provider, the Covered Person will be reimbursed for the cost of the service at the Participating Provider level.

The following provisions apply in the event the Covered Person needs to file a claim for Non-Participating Provider services:

NOTICE OF CLAIMS

When a Non-Participating Provider renders services, notice of a claim for benefits must be given to NHP. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by NHP within 20 days after the date of the injury or the first treatment date for the sickness on which the claim is based. If this required notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 20 day period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

CLAIM FORMS

After NHP receives written notice of a claim for Non-Participating Provider services, it will provide claim forms to the Covered Person. This form should be furnished within 15 days after NHP receives the written notice. If forms are not given to the claimant within 15 days of the date NHP receives notice of claim, the claimant will meet the proof of claim requirements by giving NHP written statement of the nature and extent of the claim within the time limit stated in the Proof Of Claims provision.

PROOF OF LOSS

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

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

TIME PAYMENT OF CLAIMS

After receiving written proof of claims, NHP will reimburse all claims or any portion of any claim from a Covered Person or a Covered Person's assignees, for payment under this group plan within forty (40) days after receipt of the claim by NHP. If a claim or portion of a claim is contested by NHP, the Covered Person or the Covered Person's assignees will be notified, in writing, that the claim is contested, within forty (40) days after the receipt of the claim by NHP. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim.

NHP, upon receipt of additional information requested from a Covered Person or the Covered Person's assignees, will pay or deny the contested claim or portion of the contested claim within 60 days.

NHP will pay or deny any claim no later than 120 days after receiving the claim.

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

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

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

RIGHT TO REQUIRE MEDICAL EXAMS

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

PAYMENT OF CLAIMS

For services rendered by Non-Participating Providers, benefits are payable to the Covered Employee. However, with NHP's written consent, a Covered Employee may direct NHP to pay all or any part of the

medical benefits to the medical care provider on whose charge the claim is based. NHP is under no obligation to honor such assignments from Non-Participating Providers.

In the event that payment to the Covered Employee is not possible, and the Covered Person to whom benefits would otherwise be payable is a minor or, in the opinion of NHP, is not able to give a valid receipt for any payment due him or her, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, NHP may, at its option, make payment to the person or institution appearing to have assumed his or her custody and support.

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

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

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

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

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

LEGAL ACTIONS AND LIMITATIONS

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

UNUSUAL CIRCUMSTANCES

If the rendering of services or benefits under this plan is delayed or impractical due to: (a) complete or partial destruction of facilities; (b) war; (c) riot; (d) civil insurrection; (e) major disaster; (f) disability of a significant part of Participating hospital and practitioner network; (g) epidemic; (h) labor dispute not involving NHP, Participating hospitals and other Participating Providers, Participating Providers will use their best efforts to provide services and benefits within the limitations of available facilities and personnel. However, neither NHP, nor any Participating Providers shall have any liability or obligation because of a delay or failure to provide such services or benefits. If the rendering of services or benefits under this plan is delayed due to a labor dispute involving NHP or Participating Providers, non-emergency care may be deferred until after the resolution of the labor dispute.

GRIEVANCE PROCEDURE

There are situations when Members have questions about their coverage or are dissatisfied with Plan services. Such questions and Complaints will be handled by the Plan in a timely manner.

Questions relating to this Contract should be addressed by Members to the Customer Service Department of the Plan.

Grievances shall be addressed to the Grievance Coordinator who is the person responsible for the maintenance of records and for the supervision of the Grievance process for the Plan. A specific set of records will be maintained to document Grievances filed. Records will include the reason for Grievance, date filed, consequent actions and final disposition. They will be centrally maintained by the Grievance Coordinator.

A. **Complaint Procedures**

The Plan encourages Members to resolve individual inquiries and problems without the initiation of a formal Grievance. Any Member who has an inquiry or Complaint regarding a matter arising

under the Contract should contact the Customer Service Department of the Plan for verbal resolution. A Customer Service Representative will respond to the Member's inquiry or complaint promptly. All complaints are documented through the phone log system. Complaints are informal and not considered part of the formal grievance process.

B. **Formal Grievance Procedure**

In the event the Member's problem has not been settled at the informal level and the Member is still dissatisfied, he/she will be advised to file a formal written grievance. This is called a Level I Grievance. Someone other than the member can submit a grievance on the member's behalf if they have been appointed by the member as their Legal Representative. Proof of appointment must be submitted with the Grievance, i.e. Power of Attorney, Health Care Surrogate, Appointment of Representation form, etc.

Grievances must be submitted within one year of occurrence (i.e., the date when the issue which is the subject of the Grievance is known to the Member). Grievance forms are available from the Plan by writing to the address below. Additional information or assistance in preparing the written Grievance may be obtained by contacting the Customer Service Department of the Plan.

The Grievance must contain the following information:

1. The Member's name, address and identification number;

2. A summary of the Grievance(s), any previous contact made with the Plan, and a description of relief sought;

3. The Member's signature; and

4. The date the Grievance is signed.

The written Grievance must be mailed to the following address:

NEIGHBORHOOD HEALTH PARTNERSHIP
P.O. Box 526646
Miami, Florida 33152
Attn: Grievance Coordinator

The Grievance Coordinator will acknowledge receipt of the Grievance by the Plan, and will investigate the Grievance. In the case of a medical or quality-of-care Grievance, the investigation will include a review by a Physician or Physicians, including a Physician other than the Primary Care Physician. The Member will receive a decision, in writing, regarding the Level I Grievance. The decision will be provided within 15 days for service denials or 30 days for all other grievances (Claims denials, reimbursement requests, etc.) from the date the written Grievance is received by the Plan, unless the Plan can not make a decision within 30 days due to circumstances beyond its control. In such event, the Plan shall have an additional 15 working days to respond to the Level I Grievance.

In the case of an Adverse Determination, the Member may request within 30 days of the date of the Adverse Determination a hearing and review by the Plan's Grievance Committee. This is called a Level II Grievance. The Grievance Committee will investigate the case and conduct a hearing. The Member and/or an authorized designee may be present at the hearing. If the Member cannot appear in person at the hearing, he/she will be provided the opportunity to communicate with the committee by conference call or other appropriate technology. The decision of the Grievance Committee will be mailed to the Member within five (5) working days of the date of the disposition of the Level II Grievance. The decision of the Grievance Committee will be final.

The Plan will process all Level II Grievances within 15 days for service denials or 30 days for all other grievances from the date of receipt. Level I and Level II cannot exceed a combined total of 30 days for service denials or 60 days for all other grievances.

The review process may be accelerated for an Urgent Grievance and will occur within three (3) calendar days or more expeditiously as required by the medical condition. The Member or the provider acting on behalf of the Member may submit a request for an expedited review orally or in writing. All requests for expedited review must meet the criteria of an Urgent Grievance as set forth in the definition of Urgent Grievance. The Plan Medical Director or designee shall exercise professional discretion in determining cases eligible for accelerated review. The Plan shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of such decision, if the initial notification was not in writing.

If the Member is still not satisfied after completion of the Level I and Level II Grievance process, he/she has the right to appeal to the Agency for Health Care Administration Statewide Provider and Subscriber Assistance Program. The Member may contact the Agency for Health Care Administration Statewide Provider and Subscriber Assistance Program at:

Statewide Provider and Subscriber Assistance Program
2727 Mahan Drive, Mail Stop 26
Tallahassee, FL 32308
(850) 921-5458

Additionally, the Member has the right to contact the Agency for Health Care Administration Hot Line at (888) 419-3456 or the Statewide Provider and Subscriber Assistance Program at any time to inform it of an unresolved Grievance.

COVERAGE PROVISIONS

This section provides important information about the coverage provided under this Small Group Plan, explaining:

A. What rules the Covered Person must follow in accessing care;

B. What services and supplies are covered; and

C. What services and supplies are not covered.

COVERAGE ACCESS RULES

It is important that Covered Persons become familiar with the rules for accessing health care services through NHP. The following sections explain the role of NHP and the Primary Care Physician, how to access primary and specialty care through NHP, and the Primary Care Physician, and what to do if Emergency Services and Care is needed.

CHOOSING A PRIMARY CARE PHYSICIAN

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

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

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

C. Except for Emergency Medical Conditions and direct access to Participating chiropractors, podiatrists, OB/GYNs and dermatologists, all services must be received from the Covered Person's Primary Care Physician, from Participating Providers on referral from the Primary Care Physician, or through another Health Care Provider designated by NHP.

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

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

   2. Instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with the Covered Person. In such circumstances, the Primary Care Physician may request that the Covered Person be directed to select another Primary Care Physician.

E. If for any reason the Primary Care Physician or other contracting Health Care Provider fails to or is unable to provide the Covered Person with services they have agreed to provide, NHP agrees to provide, arrange or pay for services equivalent to those described in the Covered Services section up to the date for which payment has been made by the Covered Person. If Non-Participating Providers are used, they will be reimbursed at the Allowed Charge amount, as defined in the Reimbursement For Participating and Non-Participating Provider Services provision..

F. If the Primary Care Physician selected by the Covered Person terminates his or her agreement with NHP, We will assist the Covered Person in selecting another Primary Care Physician whose practice is open to new Covered Persons.

ADDITIONAL HEALTH CARE PROVIDER INFORMATION

A. If a Participating Provider terminates his or her contract with NHP or is terminated by Us for any reason other than for cause, a Covered Person receiving active treatment may continue coverage and care with that Provider when Medically Necessary and through completion of treatment of a condition for which the Covered Person was receiving care at the time of the termination until:

1. the Covered Person selects another treating provider, or during the next open enrollment period, whichever is longer, but not longer than six (6) months after termination of the provider's contract.

2. the Covered Person, who is pregnant and who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, completes postpartum care.

A provider may refuse to continue to provide care to a Covered Person who is abusive, non-compliant, or in arrears in payment for services provided.

B. When payment is provided for surgical first assisting benefits or services, payment will also be provided for the services of a registered nurse first assistant or employers of a physician assistant or nurse first assistant who performs such services that are within the scope of their professional license and only when their services are used as a substitute. If such services are provided by a registered nurse first assistant, NHP will only pay the reimbursement for such provider and will not also pay for the supervising physician.

SPECIALTY CARE

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

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

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

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

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

EMERGENCY SERVICES AND CARE

The procedure the Covered Person should follow for Emergency Services and Care for an Emergency Medical Condition as defined in this Group Plan, depends on whether the treatment is rendered inside or outside the Service Area. In either instance, if the use of a Participating or Non-Participating Hospital Emergency Room is not due to an Emergency Medical Condition for a Condition covered by this Group Plan, the only payment made will be for the determination of whether an Emergency Medical Condition existed. If an Emergency Medical Condition did not exist, no further benefits will be paid.

Within The Service Area

If Emergency Services and Care are required within the Service Area, the Covered Person must notify his/her Primary Care Physician. The Covered Person should, in the instance of an Emergency Medical Condition, seek Emergency Services and Care and then contact his/her Primary Care Physician, not later than 48 hours after services are received, if the Covered Person is lucid and able to communicate. If not, the Covered Person or a member of the Covered Person's family should notify the Covered Person’s Primary Care Physician as soon as reasonably possible.

Outside The Service Area

Emergency Services and Care for an Emergency Medical Condition provided outside the Service Area will be covered if the Covered Person sustains an accidental injury or becomes ill while temporarily away from the Service Area.

If the Covered Person requires treatment for an Emergency Medical Condition while outside the Service Area, Emergency Services and Care may be sought. Only initial treatment is covered without the Primary Care Physician's approval. The Covered Person should notify his/her Primary Care Physician as soon thereafter as is practical, so that the Primary Care Physician may initiate necessary follow-up care.

If the Covered Person is admitted to a Hospital for an Emergency Medical Condition, by a Physician other than the Covered Person's Primary Care Physician, the Covered Person or a member of the Covered Person's family should notify the Covered Person’s Primary Care Physician at the earliest time reasonably possible to allow the Primary Care Physician to coordinate any necessary follow-up care.

CO-PAYMENTS

For some services, the Covered Person is responsible for paying a portion of the cost of Covered Services. Usually, this portion is a flat dollar amount referred to as a Co-payment. A Co-payments is due at the time of service. The Co-payment requirements for this Group Plan are set forth in the Schedule of Benefits.

The total Co-payments a Covered Person is responsible for in any single Calendar Year will be limited to an Out-of-Pocket Maximum Limit as set forth in the Schedule of Benefits. Prescription Drug Co-payments do not count towards the Out-of-Pocket Maximum Limit.

It is the Covered Person’s responsibility to notify NHP when the Out-of-Pocket Maximum Limit has been reached. The Covered Person will be required to verify that they have reached their Out-of-Pocket Maximum Limit by submitting receipts for Co-payments actually paid. Thereafter, the Covered Person will be reimbursed for any additional Co-payments made during the Calendar Year in which the Out-of-Pocket Maximum Limit has been met. The Covered Person must submit receipts to NHP within sixty (60) days from the end of the Calendar Year in which the Out-of-Pocket Maximum Limit has been met. The Covered Person may call NHP’s Customer Service Department for information on Co-payment limits.

INDIVIDUAL OUT-OF-POCKET MAXIMUM EXPENSE LIMIT

The Individual Out-of-Pocket Maximum Expense Limit is the maximum amount of Co-payment expenses that must be paid in a Calendar Year by each Covered Person before this Group Plan pays Covered Services at 100% of the Allowance determination for the remainder of that Calendar Year, up to the Lifetime Benefit Maximum set forth in the Schedule of Benefits. Only Out-of Pocket expenses related to Co-payments will count toward satisfying the Individual Out-of-Pocket Maximum Expense Limit.

Out-of-pocket expenses related to charges for services not covered by this Group Plan, Prescription Co-payments, any charges in excess of the Allowance determination, or expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits will **not** count toward satisfying the Individual Out-of-Pocket Maximum Expense Limit.

The application of any specific service limits or specific benefit maximums noted in the Covered Services section or in the Schedule of Benefits is not affected by the action of the out-of-pocket maximum. These specific service provisions will still apply after the out-of-pocket maximums are satisfied.

FAMILY OUT-OF-POCKET MAXIMUM EXPENSE LIMIT

If more than one person is covered under this Group Health Plan, there is also a Family Out-of-Pocket Maximum Expense Limit. After the Family Out-of-Pocket Maximum Expense Limit has been satisfied in a Calendar Year, expenses for additional Covered Services become payable at 100% of the Allowance determination for the remainder of that Calendar Year for all Covered Persons in that family. Only Out-of Pocket expenses related to Co-payments will count toward satisfying the Family Out-of-Pocket Maximum Expense Limit.

Out-of-pocket expenses related to charges for services not covered by this Group Plan, Prescription Co-payments, any charges in excess of the Allowance determination or expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits will **not** count toward satisfying the Family Out-of-Pocket Maximum Expense Limit.

The application of any specific service limits or specific benefit maximums noted in the Covered Services section or in the Schedule of Benefits is not affected by the satisfaction of the out-of-pocket maximum. These specific service provisions will still apply after the out-of-pocket maximums are satisfied.

LIFETIME BENEFIT MAXIMUM

While this Group Plan remains in force, the total amount of all Covered Benefit expenses payable under this Group Plan for each Covered Person shall not exceed the Lifetime Benefit Maximum shown in the Schedule of Benefits. The Lifetime Benefit Maximum applies regardless of the fact that some expenses for Covered Services may have separate annual or lifetime benefit maximums.

DISCRETIONARY AUTHORITY

NHP has the discretionary authority to determine eligibility, to construe terms of this Group Plan, and to make decisions concerning claims for benefits under the terms of this Group Plan.

BASIC PLAN COVERED SERVICES

This section describes the services that are covered under this Plan and those that are not covered. It is important that this whole section be reviewed to be sure both Covered Service details and the limitations and exclusions are understood. Also, important information is contained in the Schedule of Benefits. **ALL OF THESE PROVISIONS SHOULD BE READ CAREFULLY TO UNDERSTAND THE BENEFITS PROVIDED UNDER THIS GROUP PLAN.**

Covered Services

The services and supplies listed below will be considered Covered Services under this Group Plan if the service is:

A. Set forth Within the Covered Services categories in this section;

B. Received from or provided under the orders, direction or authorized approval of the Covered Person's Primary Care Physician except for Emergency Services and Care for an Emergency Medical Condition. Authorization for all covered health care services is provided twenty-four (24) hours a day, seven (7) days a week.

C. Actually rendered while coverage under this Group Plan is in force

D. Medically Necessary, as defined in this Group Plan; and

E. Not specifically limited or excluded under this Group Plan.

The Co-payment amounts for which the Covered Person is responsible for each category of Covered Services listed below are set forth in the Schedule of Benefits. The payment of expenses for Covered Services received from Non-Participating Providers is subject to NHP's Allowance guidelines.

Hospital Services

The services and supplies listed below shall be considered Covered Services when furnished to a Covered Person at a Hospital on an inpatient or outpatient basis, if the service or supply is ordered or authorized by NHP and the Covered Person's Primary Care Physician. Covered Services are subject to the Co-payments noted on the Schedule of Benefits:

A. Room and board for semi-private accommodations, unless the patient must be isolated from others for documented clinical reasons;

B. Confinement in an intensive care unit including cardiac, progressive, and neonatal care;

C. Miscellaneous hospital services;

D. Services provided by a birthing center licensed pursuant to Florida Statutes, chapter 383.30-383.335;

E. Routine nursery care for a newborn child;

F. Drugs and medicines administered by the Hospital;

G. Respiratory, pulmonary, or inhalation therapy (e.g., oxygen);

H. Rehabilitative services, when hospitalization is not primarily for rehabilitation;

I. Use of operating room and recovery rooms;

J. Use of emergency rooms;

K. Intravenous solutions;

L. Dressings, including ordinary casts, splints and trusses;

M. Anesthetics and their administration;

N. Transfusion supplies and equipment;

O. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG));

P. Chemotherapy treatment for proven malignant disease; and

Q. Other Medically Necessary services and supplies.

Ambulatory Surgical Center Services and Other Outpatient Medical Treatment Facilities

The services and supplies listed below will be considered Covered Services when furnished to a Covered Person at a Participating Provider ambulatory surgical center or other outpatient medical treatment facility, if authorized by NHP and the Covered Person’s Primary Care Physician. Covered Services are subject to the Co-payments noted on the Schedule of Benefits:

A. Use of operating room and recovery rooms;

B. Respiratory or inhalation therapy (e.g., oxygen);

C. Drugs and medicines administered at the Ambulatory Surgical Center or other Outpatient Medical Treatment Facility;

D. Intravenous solutions;

E. Dressings, including ordinary casts, splints or trusses;

F. Anesthetics and their administration;

G. Transfusion supplies and equipment;

H. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG));

I. Chemotherapy treatment for proven malignant disease; and

J. Other Medically Necessary services and supplies.

Medical Services

The medical services and supplies listed below will be considered Covered Services if authorized by NHP and provided or authorized by the Covered Person's Primary Care Physician. Covered Services are subject to the Co-payments noted on the Schedule of Benefits:

Allergy treatment, including allergy testing, desensitization therapy and allergy immunotherapy, including hyposensitization serum.

Ambulance services, provided by a ground vehicle may be covered provided it is necessary to transport you from:

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

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

C. The place an Emergency Medical Condition occurs to the nearest Hospital that can provide proper care.

Ambulance services by boat, airplane, or helicopter will be reimbursed at the Allowed Charge level for a ground vehicle unless:

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

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

C. The travel distance involved in getting the Covered Person to the nearest Hospital that can provide proper care is too far for medical safety, as determined by NHP and the Covered Person's Primary Care Physician.

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

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

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

Coverage for mastectomies includes:

A. all stages of reconstruction of the breast on which the mastectomy has been performed;

B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C. prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining a pre-existing condition unless evidence of breast cancer is found during or as a result of the follow-up care.

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

Coverage will not be excluded for any drug prescribed for the treatment of cancer on the grounds that the drug is not approved by the FDA for a particular indication, if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature. Coverage also includes Medically Necessary services associated with the administration of the drug.

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

Child health supervision services including periodic Physician-delivered or Physician-supervised services from the moment of birth up to the 16th birthday are covered as follows:

A. A newborn's first examination in the Hospital. The examination must be provided and billed by a Physician other than the delivering obstetrician or anesthesiologist;

B. Periodic examinations, which include a history, a physical examination, developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;

C. Oral and/or injectable immunizations; and

D. Laboratory tests normally performed for a well child.

These services must conform to prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Benefits may be limited to one visit payable to one provider for all of the services provided at each visit.

Cleft Palate and Cleft Lip treatment is provided for a dependent under age eighteen (18). Coverage includes medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the Primary Care Physician or treating referral physician. Coverage is subject to benefit and benefit limitations listed in the Covered Services and Exclusions and Limitations sections of this Group Plan.

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

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

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

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

Dental Treatment in a Hospital or Ambulatory Surgical Center. Coverage is provided for general anesthesia and hospitalization services in connection with necessary dental treatment or surgery for:

A. A dependent child under age eight (8) whose treating physician, in consultation with the dentist, determines necessary dental treatment is required 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 proved to be ineffective; or

B. A Covered Person who has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any medically necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia and hospital services must be authorized by the Covered Person's Primary Care Physician and NHP prior to the treatment. Coverage does not include diagnosis or treatment of dental disease, or the services of the dentist or oral surgeon.

Dermatologic Services. A Covered Person does not need to obtain a referral or prior authorization for dermatologic office visits or minor procedures and testing performed by a Participating dermatologist. A Covered Person is limited to five (5) visits every twelve (12) months. Visits exceeding the maximum of five visits in a twelve-month period, or services or testing not considered minor or routine in nature require a referral or prior authorization.

Diabetes Outpatient Self-Management Services, including diabetes outpatient self-management training and education Services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes, if the Covered Person's Primary Care Physician, or the physician to whom the Covered Person has been referred who specializes in treating diabetes, certifies that the equipment, supplies, or services are Medically Necessary. In order to be covered, diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board certified Physician specializing in endocrinology. Additionally, in order to be covered, a licensed dietitian must provide nutrition counseling. Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Diagnostic Services, procedures, lab tests or x-ray exams, including their interpretation, for the treatment of a Condition when ordered by a Physician**.**

Diagnostic and surgical procedures involving bones or joints of the jaw and facial region are covered, if under acceptable medical standards, such procedures or surgery is Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury. This coverage does not include coverage for care or treatment of the teeth or gums, for intraoral prosthetic devices or for surgical procedures for cosmetic purposes.

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

The only equipment that is covered is as follows: Canes/crutches, walkers, hospital beds, commode chairs, bedpans/urinals, decubitus care equipment, ostomy and urinary products, LSO and TLSO braces, traction equipment and standard wheelchairs.

Eye care, limited to the following:

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

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

C. Physician Services to treat an injury to or disease of the eyes**.**

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

Immunizations, when Medically Necessary, including flu shots.

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

Mammograms performed for breast cancer screening, the plan shall provide coverage for at least the following:

A. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.

B. A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations.

C. A mammogram every year for any woman who is 50 years of age or older.

D. One or more mammograms a year based upon a physician's recommendation for any woman who is at risk of breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

Mammograms performed pursuant to the above are covered in full and not subject to a Co-payment.

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

Newborn hearing screening at birth, and any Medically Necessary follow-up reevaluations leading to diagnosis is covered through age 12 months. Treatment and services covered under this Group Plan and delivered or authorized by the child's Primary Care Physician will be provided to any Covered Dependent child diagnosed as having a permanent hearing impairment.

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

Obstetrical/Gynecologist Annual Exam. A female Covered Person is allowed to visit a Participating obstetrician/gynecologist for one annual exam without authorization or referral from the Covered Person's Primary Care Physician. Any Medically Necessary follow-up care detected at that visit must be coordinated with the Covered Person's Primary Care Physician.

Osteoporosis Screening, Diagnosis, and Treatment

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals is covered, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;

2. individuals who have vertebral abnormalities;

3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or

4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

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

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

Pathologist services on an inpatient or outpatient basis.

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

Radiologist services on an inpatient or outpatient basis.

Surgical procedures that are Medically Necessary and performed by a Physician on an inpatient or outpatient basis.

Special Services

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

Alcohol and Substance Abuse Treatment, services and supplies provided by, or under the supervision of, or prescribed by a licensed Physician or licensed Psychologist. Services and supplies must be authorized by NHP and the Covered Person's Primary Care Physician. The program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the State of Florida for the treatment of alcohol or drug dependency. The services covered are as follows and benefits are limited as specified in the Schedule of Benefits:

A. Inpatient care treatment provided in a general specialty or rehabilitative Hospital; and,

B. Outpatient care services provided or prescribed by, or under the supervision of a licensed Physician or licensed Psychologist. Detoxification services and supplies are not Covered Services when provided on an outpatient basis.

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

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

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

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

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

Home health services include:

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

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

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

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

Hospice Services, when hospice services are the most appropriate and cost effective treatment, as determined by NHP. Covered Persons who are diagnosed as having a terminal illness with a life expectancy of one year or less may elect hospice care for such illness instead of the traditional services covered under this Group Plan.

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

A. Home hospice care, comprised of:

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

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

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

The hospice treatment program must:

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

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

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

D. Be directed by a Physician in consultation with the Covered Person's Primary Care Physician and coordinated by a registered nurse, with a treatment plan that provides an organized system of hospice facility care; uses a hospice team; and has around-the-clock care available.

Mental and Nervous Disorders Treatment. Expenses for the services and supplies listed below for the treatment of Mental and Nervous Disorders will be considered Covered Services if provided to the Covered Person by a Physician, Psychologist, or Mental Health Professional:

A. Inpatient confinement or Partial Hospitalization in a Hospital or a Psychiatric Facility for the treatment of a Mental and Nervous Disorder if authorized by NHP and the Covered Person's Primary Care Physician. If Partial Hospitalization services or a combination of inpatient and partial Hospitalization services are rendered, the total benefits paid for all such services combined will not exceed the benefit limits shown in the Schedule of Benefits. Partial Hospitalization services must be provided under the direction of a licensed Physician to be covered.

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

Pre-admission tests when ordered or authorized by NHP and the Covered Person's Primary Care Physician. However, the following conditions must be met:

A. The admission to the Hospital or the scheduled outpatient surgery must be confirmed in writing by NHP before the testing occurs.

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

C. The tests must be ordered or authorized by NHP and the Covered Person's Primary Care Physician.

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

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

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

Prescription drugs, including covered syringes and needles are covered when prescribed by a Physician or other Health Care Provider authorized to prescribe drugs within the scope of his or her license, and is received by the Covered Person. The Co-payments paid by Covered Persons for Covered Prescription Drugs and/or covered syringes and needles will **not** be applied to the Out-of-Pocket Maximum Expense Limit set forth in the Schedule of Benefits.

Prescription drugs purchased from a Participating or Non-Participating Pharmacy are subject to the following provisions. Unless otherwise specified, in order to be covered, Prescription Drugs and/or syringes and needles must be:

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license;
2. dispensed by a Pharmacist;
3. be Medically Necessary; and
4. not otherwise limited or excluded.

Pharmacy Alternatives and Payment Rules:

The prescription drug Co-payment is set forth in the Schedule of Benefits and is printed on the Covered Person's ID Card. The Covered Person's ID Card must be presented to a Participating Pharmacy each time a prescription is filled or refilled. The applicable prescription drug Co-payment must be paid by the Covered Person each time a prescription is filled or refilled at a Participating Pharmacy.

When prescription drugs are purchased from a Non-Participating Pharmacy due to an Emergency Medical Condition or at the direction of the Covered Person's Primary Care Physician, the Covered Person is required to pay the full cost of the prescription and then obtain an itemized paid receipt and submit a claim to NHP. NHP will reimburse the Covered Person for the Allowable amount for such prescription drug less the applicable Co-payment. If the Covered Person does not have an Emergency Medical Condition or does not have authorization from the Covered Person's Primary Care Physician, prescriptions filled or refilled at a Non-Participating Pharmacy are not covered.

The amount which must be paid by the Covered Person for Covered Prescription Drugs and/or covered syringes and needles may vary depending on:

1. the participation status of the Pharmacy selected (i.e., Participating pharmacy versus Non-Participating Pharmacy);

2. whether the Prescription Drug is a Brand Name Prescription Drug or a Generic Prescription Drug; and,

3. whether the Prescription Drug is on the Preferred Medication List.

Prescription drugs may be either Preferred Generic Prescription Drugs or Preferred Brand Prescription Drugs each having a separate Co-payment amount as outlined on the Schedule of Benefits. Prescription drugs not identified as a Preferred Generic or Preferred Band Prescription drug on the Preferred Medication List of covered prescription drugs are also covered, unless specifically excluded by this Group Plan. Non-Preferred drugs are subject to the same requirements specified herein for Preferred drugs and subject to the Non-Preferred Prescription Drug Co-payment specified in the Schedule of Benefits.

Mail-order Pharmacy. A Mail-Order program is available for a 90-day supply or such lesser amount as the NHP determines to be Medically Necessary. The Co-payment amount for covered prescription drugs dispensed by the Mail-order Pharmacy is the applicable amount listed on the Schedule of Benefits.

Covered prescription drugs:

A. Include any drug, medicine or medication or oral contraceptive that, under Federal or state law, may be dispensed only by prescription from a Physician, or any compounded prescription containing such drug, medicine or medication;

B. Includes covered syringes and needles dispensed only by prescription from a Physician.

C. Includes insulin, hypodermic needles and syringes with insulin on prescription;

D. Must be prescribed by a Physician or Health Care Provider for the treatment of a Condition;

E. Must be dispensed by a Pharmacist;

F. Are limited to the lesser of a 30 day supply or such lesser amount NHP determines is Medically Necessary per prescription per month if purchased from a Pharmacy other than a Mail-order Pharmacy in which case the Covered Prescription Drugs are limited to a 90-day supply or such lesser amount NHP determines to be Medically Necessary per prescription;

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

H. Injectable drugs and biologicals only if:

1. They are furnished incidental to a Health Care Provider's covered professional services;

2. They are reasonable and necessary for the diagnosis or treatment of the Covered Illness or Injury for which they are administered according to accepted standards of NHP;

3. They have not been determined by the FDA to be "less-than-effective";

4. The injection is considered the indicated effective method of administration according to the accepted standards of medical practice for the Covered Condition;

5. The frequency, amount, and duration of the course of injectable drug or biological meets accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections;

6. They are a cost-effective alternative for an otherwise Covered Service as determined by NHP.

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

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

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

1. Injection is considered the indicated effective method of administration for which the drug or biological is prescribed according to accepted standards of NHP for the covered condition;

2. The drug or biological can be safely self-administered based upon accepted standards of medical practice;

3. They are not immunizing agents;

4. They are reasonable and necessary for the specific or effective treatment for the covered condition according to accepted standards of medical practice for the covered condition;

5. They have not been determined by the FDA to be "less than effective";

6. The frequency, amount and duration of the prescribed course of injectable drug or biologicals meets accepted standards of medical practice as an appropriate level of care for a specific condition, unless there are extenuating circumstances which justify the need for additional injections;

7. They are cost-effective alternative for an otherwise Covered Service as determined by NHP.

No coverage is provided for:

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

B. Any portion of a prescription or refill that exceeds a 30day supply or an amount NHP determines is Medically Necessary, whichever is less if purchased from a Pharmacy other than a Mail-order Pharmacy, in which case the Covered Prescription Drugs that exceed a 90-day supply per prescription or an amount NHP determines is Medically Necessary, whichever is less;

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

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

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

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

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

H. Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use." Prescription Drugs which have not been approved by the FDA, as required by federal law, for distribution and delivery into interstate commerce;

I. Immunizing agents, biological serums or allergy serums;

J. Any drug or medicine that is lawfully obtainable without a prescription, with the exception of insulin;

K. Any appetite suppressant and/or other Prescription Drug indicated, or used, for purposes of weight reduction or control;

L. Prescription Drugs used for cosmetic purposes including but not limited to Minoxidil, Rogaine, and Renova. (Retin-A is excluded after age 26);

M. Drugs listed in the Homeopathic Pharmacopoeia;

N. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;

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

Preventive medical and reproductive care services, limited to the services listed below. Coverage is subject to the Calendar Year Preventive Medical and Reproductive Care Services Maximum set forth in the Schedule of Benefits. Expenses for these services are subject to the Co-payment requirements or Allowance, whichever is less, and the Calendar Year Maximum set forth in the Schedule of Benefits.

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

A. A health history;

B. A physical examination;

C. Laboratory tests which include urinalysis for blood, sugar, and acetone, and hemoglobin and hematocrit tests;

D. A stool for occult blood;

E. A tuberculin skin test;

F. Tests for sexually transmitted diseases;

G. Vision screening; and

H. Hearing screening.

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

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

Rehabilitative Outpatient Therapy Services. Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such services. NHP and the Covered Person's Primary Care Physician must specifically approve a written plan of treatment submitted by the Covered Person's Physician. The outpatient therapies listed in this category are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

A. Cardiac Therapy – Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.

B. Occupational Therapy – Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Covered Condition are covered.

C. Speech Therapy – Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Covered Condition are covered.

D. Physical Therapy – Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.

Rehabilitative Therapy Services are limited to four (4) modalities per day not to exceed the benefit maximum set forth in the Schedule of Benefits.

Second Medical Opinion. Each Member may request a second medical opinion whenever the Member disagrees with his or her Participating Physician's opinion regarding the reasonableness or necessity for surgery, or treatment for a serious Injury or Illness. If requested, the second opinion will be provided by a Physician chosen by the Member. The Member may select: 1) a Participating Physician; or 2) a Non-Participating Physician located in the NHP Service Area. Any tests that may be required by a Non-Participating Physician in connection with a second medical opinion must be Medically Necessary and performed at a NHP facility. A second opinion may be requested by contacting the Primary Care Physician or NHP before the second opinion consultation.

The Member is responsible for payment of any applicable Co-payment for second opinions provided by a Participating Physicians. Reimbursement for a second opinion by a Non-Participating Physician is limited to 60% of charges that the NHP determines are Usual, Customary and Reasonable in the Service Area. The Member shall be responsible for the difference. A Physician who renders a second opinion may not treat the condition for which the second opinion was sought, without NHP's prior authorization. The Participating Physician's professional judgment concerning the treatment of a Member derived after review of a second opinion shall be controlling as to the treatment obligations of NHP. The Member is financially responsible for treatments that are not Prior Authorized by the NHP. Any such treatments are not Covered Services under this Contract.

NHP may require a member to obtain a Second Medical Opinion when, in NHP's judgment, it determines that a Participating Physician's opinion should be reviewed by a Second Medical Opinion.

NHP may deny a Member access to Second Medical Opinions if NHP determines that the Member has unreasonably over-utilized the second opinion privilege. A Member denied coverage under this section shall have recourse through the Grievance procedures described herein.

Skilled nursing facility services expenses are covered only if NHP and the Covered Person's Primary Care Physician approves a written plan of treatment submitted by a Physician and only if NHP and the Covered Person's Primary Care Physician agree that such skilled level services are being provided in lieu of hospitalization or continued hospitalization. If provided in the Skilled Nursing Facility, covered expenses include room and board; respiratory therapy (e.g., oxygen); drugs and medicines administered while an inpatient; intravenous solutions; dressings, including ordinary casts; anesthetics and their administration; transfusion supplies and equipment; diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG)); chemotherapy treatment for proven malignant disease; and other Medically Necessary services and supplies. Services must be skilled level services, and must be ordered by and provided under the direction of a Physician.

Spine and Back Disorder Treatment, consisting of services by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray. The Schedule of Benefits sets forth the maximum amount that NHP will pay for treatment.

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

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

A. Cornea;

B. Heart;

C. Heart-lung combination;

D. Liver;

E. Kidney;

F. Lung-whole single or whole bilateral transplant;

G. Pancreas;

H. Pancreas transplant performed simultaneously with a kidney transplant; or

I. Bone Marrow Transplant, as defined in the Glossary section, which is specifically listed in Rule 59B-127.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare as described in the

most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. NHP will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for the Covered Person and will be subject to the same limitations and exclusions as would be applicable to the Covered Person. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified though the National Bone Marrow Donor Program.

For a transplant procedure to be considered approved for this transplant benefit, prior approval from NHP's Utilization Management Department is required in advance of the procedure. The Covered Person or the Covered Person's Physician must notify NHP in advance of the Covered Person's initial evaluation for the procedure in order for NHP to determine if the transplant services will be covered. For approval of the transplant itself, NHP's Utilization Management Department must be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval will be based on written criteria and procedures established by NHP's Utilization Management Department. If approval is not given, benefits will not be provided for the transplant procedure.

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

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

B. NHP's Utilization Management Department is not contacted for authorization prior to referral for transplant evaluation of the procedure.

C. NHP's Utilization Management Department does not approve coverage for the procedure.

D. The transplant procedure is performed in a facility that has not been designated by NHP's Utilization Management Department as an approved transplant facility.

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

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

G. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by NHP, except
as specifically covered herein for bone marrow transplants only.

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

I. Any bone Marrow Transplant, as defined herein, which is not specifically listed in Rule 59B-127.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;

J. Any Service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;

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

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

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

C. Transplant expenses that exceed the Lifetime Benefit Maximum noted on the Schedule of Benefits.

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

For approved transplant procedures, and all related complications, NHP will pay benefits only for the following covered expenses:

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

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

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

D. Organ acquisition and donor costs, except as specifically covered herein for bone marrow transplants only. However, donor costs are not payable under this Group Plan if they are payable in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

EXCLUSIONS AND LIMITATIONS PROVISIONS

FOLLOWING ACCESS RULES

If a Covered Person does not follow the Access Rules described in this section, the Covered Person risks having services and supplies received not covered by this Group Plan. In such a circumstance, the Covered Person would be responsible for reimbursing the plan for the reasonable cost of the services rendered.

Covered Persons must remember that services that are provided or received without having been prescribed, directed or authorized in advance by NHP's Medical Director or his or her designee. by the Covered Person's Primary Care Physician, or if the service is beyond the scope of practice authorized for that Health Care Provider under state law, except in the case of Emergency Services and Care for an Emergency Medical Condition as defined in this Group Plan, are not covered unless such services otherwise have been expressly authorized under the terms of this Group Plan. Except for Emergency Services and Care for an Emergency Medical Condition, and direct access to podiatrists, chiropractors, OB/GYNs and dermatologists, all services must be received from Participating Providers on referral from NHP or the Primary Care Physician.

Also, Covered Persons must understand that services that, in NHP's opinion, are not Medically Necessary will not be covered. The ordering of a service by a Physician, whether Participating or Non-Participating, other than the Covered Person's Primary Care Physician or when expressly authorized by the Covered Person's Primary Care Physician, does not in itself make such service Medically Necessary or a Covered Service.

PRE-EXISTING CONDITIONS EXCLUSION PERIOD

A Pre-existing Condition, for a Small Employer who has two or more employees or for a Small Employer who has fewer than two employees which have been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date, is any Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six month period immediately preceding the earlier of:

1. the first day the Covered Person's Waiting Period, typically the date full-time employment begins, for individuals enrolling during their Initial Enrollment Period; or

2. the Effective Date of the Covered Person's coverage for individuals enrolling during a Special Enrollment or Annual Enrollment Period.

A Pre-existing Condition does not include:

1. pregnancy;

2. genetic information in the absence of a diagnosis of the Condition;

3. routine follow-up care of breast cancer after the person was determined to be free of breast cancer; or

4. conditions arising from domestic violence.

A Pre-existing Condition, for a Small Employer who has fewer than two employees and which have not been continually covered by Creditable Coverage within 63 days before the Covered Person's Effective Date, is any Condition that during the 24-month period immediately preceding the Covered Person's Effective Date of coverage, has manifested itself in a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received for that Condition.

Pregnancy is a Pre-existing Condition when inception of the pregnancy preceded the Effective Date of the pregnant Covered Person's coverage regardless of whether the pregnant Covered Person knew she was pregnant prior to the Effective Date.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family Covered Person. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes.

Creditable Coverage is any of the following health care coverage under which an individual may have been previously covered:

1. A group health plan;

2. Health insurance coverage;

3. Part A and Part B of Title XVII! of the Social Security Act (Medicare);

4. Title XIX of the Social Security Act (Medicaid, other than coverage consisting solely of benefits under Section 1928 of the program for distribution of pediatric vaccines);

5. Chapter 55 of Title 10, United States Code (medical and dental care for Covered Persons and certain former Covered Persons of the uniformed services and their dependents);

6. A medical care program of the Indian Heath Services or of a tribal organization;

7. A State health benefits risk pool (FCHA);

8. A health plan offered under chapter 89 of Title 5, United States Code;

9. A public health plan; and

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504 EI).

Pre-existing Conditions Exclusion Period for a Small Employer who has two or more employees or for a Small Employer who has fewer than two employees which have been continually covered by Creditable Coverage within 63 days before the Covered Person's Enrollment Date:

There is no coverage for Health Care Services to treat a Pre-existing Condition or Conditions arising from a Pre-existing Condition until 12 months has lapsed from the Enrollment Date. This Preexisting Condition exclusionary period begins on the first day of the Waiting Period for Initial Enrollees or the Covered Person's Effective Date of coverage for Special and Annual Enrollments. This limitation also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

Pre-existing Conditions Exclusion Period for a Small Employer who has fewer than two employees, who has no prior Creditable Coverage applicable at the time of enrollment:

There is no coverage for Health Care Services to treat a Pre-existing Condition or Conditions arising from a Pre-existing Condition until the Covered Person has been continuously covered for a 24-month period. This 24 month Pre-existing Condition exclusionary period begins on the Covered Person's Effective Date. This limitation also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

General Pre-existing Conditions Exclusion Period Limitations:

All employees and dependents enrolled subsequent to the Effective Date will be subject to the Preexisting Conditions exclusionary period, except newborn or adopted dependents who are properly enrolled. However, credit will be given for the time an eligible Covered Person or dependent was covered under previous Creditable Coverage if there was previous Creditable Coverage with no more than 63 consecutive day break in coverage prior to the earlier of the Covered Person's:

1. first day of the Waiting Period (i.e., first day of employment) for individuals applying for coverage during his or her Initial Enrollment Period; or

2. the Effective Date of coverage for individuals applying for coverage during a Special or Annual Enrollment Period.

If there was a break in coverage of 63 consecutive days or more, no credit will be given for prior Creditable Coverage.

Credit will be given for the time an Eligible Employer or dependent was covered under previous Creditable Coverage if there was previous Creditable Coverage with no more than a 63 consecutive day break in coverage prior to the earlier of the Covered Person's:

1. date of hire for initial enrollees; or

2. effective date of coverage for special or annual enrollees.

Prior health insurance and/or group health plans are required to provide a certification of Creditable Coverage to the Covered Person upon termination of their coverage.

SPECIAL ENROLLMENT PERIOD

An Eligible Employee or Dependent may request to enroll in this Group Plan outside of the Initial enrollment and Annual Open Enrollment Periods if that Individual, within the immediately preceding 31 days, was covered under another employer health benefit plan as an employee or Dependent at the time he or she was initially eligible to enroll for coverage under this Health Plan, and:

A. Demonstrates that he/she or his/her Dependent has lost coverage due to a loss of eligibility under the prior plan as a result of: legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or termination of coverage due to the termination of employer contributions toward such coverage;

B. Requests enrollment within 31 days after the termination of coverage under another employer health benefit plan; and

C. Provides proof of continuous coverage under the other employer health benefit plan.

Also, in the event of acquiring a dependent through marriage, birth, adoption, or placement for adoption, a Special Enrollment period will also be provided for an employee and a spouse who are otherwise eligible for coverage even when other coverage is not lost.

When coverage is requested, as shown above, enrollment will be allowed outside of the Initial and Annual Open Enrollment Periods, with coverage becoming effective on the date the enrollment request is received by NHP.

If enrollment is not completed, as shown above, that individual will be considered a Late Enrollee and subject to the Pre-Existing Conditions Exclusion Period provisions in this Section.

LATE ENROLLEES

An Eligible Employee or Eligible Dependent who does not enroll under this Group Plan during his or her Initial Enrollment Period will be considered a **Late Enrollee**, unless he or she qualifies and enrolls under the Special Enrollment Period.

Unless otherwise prohibited by law, Late Enrollees who want to enroll for coverage under this Group Plan must wait until the Annual Open Enrollment Period that next follows the date of the Late Enrollee's Initial Enrollment Period. The Late Enrollee will then be covered for all conditions except pre-existing conditions as defined in the Pre-existing Conditions Exclusion Period provisions in this Section.

NHP reserves the right to collect from the Covered Person the cost of any service or supply paid as benefits to the Covered Person in error for a pre-existing condition.

EXCLUSIONS AND LIMITATIONS

In addition to Access Rule Conditions and the Pre-existing Condition limitations noted above, the following services and/or supplies are excluded from coverage, and are not Covered Services under this Group Plan:

Abortion, including any service or supply related to an elective abortion. However, spontaneous abortions are not excluded nor are abortions performed for reasons when Medically Necessary..

Alcoholism or substance abuse treatment, services and supplies except as specifically provided for in the Covered Services Section and the Schedule of Benefits.

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

Arch supports, orthopedic shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

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

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

Blood, (if replaced) including whole blood, blood plasma, blood components, and blood derivatives which are not classified as drugs in NHP's formulary.

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

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

Cosmetic surgery (plastic and reconstructive surgery) and other services and supplies to improve the Covered Person's appearance or self-perception (except as covered under the Breast Reconstructive Surgery category), including without limitation: procedures or supplies to correct baldness or the appearance of skin (wrinkling). The restoration of bodily function, or the correction of a deformity resulting from disease, injury or congenital or developmental abnormalities, is covered.

Costs incurred by the Covered Person related to the following:

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

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

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

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

under the Accidental Dental Injury provision or the Congenital or Developmental Abnormality provision. Dental treatment in a hospital or ambulatory surgical center; or dental treatment for children under age 18 due to cleft palate or cleft lip are covered only as specified in the Covered Services section.

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

Dietary regimens or treatments for reducing or controlling weight.

Durable Medical Equipment other than the equipment specifically listed in the Covered Services section. This exclusion includes, but is not limited to items that are primarily for convenience and/or comfort; wheelchair lifts or ramps, modifications to motor vehicles and or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, swimming pools, whirlpools or hot tubs; exercise and massage equipment, electric scooters, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used.

Experimental and Investigational treatment as defined in this Group Plan.

Eye care, including:

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

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

C. Training or orthoptics, including eye exercises unless otherwise covered by a rider or endorsement attached to this coverage document.

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

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

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

Home health care services, except as specifically set forth in the Covered Services section.

Home infusion therapy, except for prescription drugs.

Hospice services, except as specifically set forth in the Covered Services section.

Hypnotism or hypnotic anesthesia.

Immunizations and physical examinations , when required for travel, or when needed for school, employment, insurance, or governmental licensing, except insofar as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

Infertility treatment, services and supplies, including infertility testing, treatment of infertility, diagnostic procedures and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

Injectables, injectable medication, except as specifically provided for in the Covered Services section.

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

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

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

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

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

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

Private duty nursing care, except as related to and set forth in the covered home health care services provision.

Rehabilitative therapy services, including cardiac, speech, occupational and physical therapy, except as set forth in the Covered Services section. This exclusion includes any service or supply:

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

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

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

Services or supplies that are:

A. Determined to be not Medically Necessary;

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

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

D. For the treatment of a Condition resulting from:

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

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

3. Engaging in an illegal occupation;

4. Services in the armed forces;

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

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

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

F. Provided by a Physician or other Health Care Provider related to the Covered Person by blood or marriage.

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

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

I. Supplied at no charge when health coverage is not present, and if applicable, any charges associated with the Co-payment requirements which are waived by a Health Care Provider.

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

Skilled nursing facility services except for those services set forth in the Covered Services Section**.**

Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

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

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

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

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

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

D. Any service or supply in connection with identification of a donor from a local, state or national listing, except as specifically set forth for bone marrow donors in the Covered Services section.

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

Volunteer services or services which would normally be provided free of charge and any charges associated with a Co-payment requirement which are waived by a health care provider.

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

Weight control Services, including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise program; equipment; whether or not it is part of a treatment plan for a Covered Condition.

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

Work related condition services to the extent the Covered Service is paid by Workers' Compensation.

GLOSSARY OF COVERAGE TERMS

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

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

ADVERSE DETERMINATION means a coverage determination by NHP that an admission, availability of care, continued stay, or other health care service or health care supply has been reviewed and, based upon the information provided, does not meet NHP's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.

AGENCY means the Agency for Health Care Administration

ALLOWANCE OR ALLOWED CHARGE means for Participating Providers, NHP will pay providers based om contracted rates. For Non-Participating Providers, NHP will pay charges for Covered Services which, as determined solely by NHP, are representative and reasonable charges for the geographic area in which the Covered Service was rendered. NHP may consult the Medicare fee schedule, Health Insurance Association of America data, the Florida Relative Value Study, and other available sources to make usual, customary and reasonable fee determinations. For reimbursement purposes, in no event will a provider be reimbursed UCR when provider's actual charges are less than the UCR established by NHP.

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

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation, the administration of chemotherapy and the chemotherapy drugs. The term "bone marrow transplant" also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all hospital, physician or other health care provider services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).

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

COMPLAINT means any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provisions of services, which relate to the quality of care provided by a provider pursuant to this Contract. Members may submit a Complaint to NHP or to a State Agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a Grievance as defined below.

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

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

A. Due to a Covered Condition; and

B. Authorized by a licensed medical health care provider with admission privileges.

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

CO-PAYMENT means those amounts payable by the Covered Person at the time of service as a supplement to the monthly Premium payments, as specifically set forth in the Schedule of Benefits and any rider or endorsement attached to this Group Plan. The Co-payment is normally expressed as a dollar amount.

COVERED OR COVERAGE means inclusion of an individual for payment of expenses related to Covered Service under this Group Plan.

Covered Employee means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Plan.

COVERED PERSON means the Eligible Employee or any Eligible Dependent included for coverage under this Group Plan. Eligibility requirements for employees and dependents are specified in the Eligibility section of this Group Plan.

Covered PrescriPtion Drug(s) means a Drug which, under federal or state law, requires a Prescription and which is covered in the Covered Services section of this Group Plan.

COVERED SERVICES means those Medically Necessary services and supplies described in the Covered Services section of this Group Plan certificate, and any rider or endorsement attached to it.

DRUG means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound.

DURABLE MEDICAL EQUIPMENT means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3.) not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

EFFECTIVE DATE with respect to the Small Employer and to Covered Persons properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the Group Master Plan Information Page; and with respect to Covered Persons who are subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Eligibility and Enrollment Sections of this Group Plan.

ELIGIBLE DEPENDENT means a Covered Employee's:

A. Legal spouse; or

B. Natural, newborn, adopted, Foster, or step child(ren); or

C. A child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian;

Who meets and continues to meet all of the eligibility requirements described in the Eligibility Section of this Group Plan.

Eligible Dependent also includes a newborn child of a Covered Dependent child if properly enrolled. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

ELIGIBLE EMPLOYEE means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility section of this Group Plan and is eligible to enroll as a Covered Employee. Any individual

who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee by NHP.

EMERGENCY MEDICAL CONDITION means:

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

    1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.

    2. Serious impairment to bodily functions.

    3. Serious dysfunction of any bodily organ or part.

B. With respect to a pregnant woman:

    1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

    2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

    3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

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

ENROLLMENT DATE means the date of enrollment of an individual in this Group Plan or coverage or, if earlier, the first day of the Service Waiting Period of such enrollment.

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

A. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health, and approval for marketing has not, in fact, been given at the time such is furnished to the Covered Person;

B. Reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I, or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question.

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

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

Reliable evidence means (as determined by NHP):

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

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

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

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

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

GENERIC PRESCRIPTION DRUG refers to a drug which is chemically the same (has the same active ingredients) as the brand-name drug. These drugs are usually referred to by their common chemical names. Generic drugs can be produced and sold after the patent has expired on a brand-name drug. Generic drugs must meet the same FDA standards as their brand-name counterparts.

GRIEVANCE means a written Complaint submitted by or on behalf of a Member to NHP regarding:

1. availability, coverage for the delivery, or quality of health care services, including a Complaint regarding an Adverse Determination made pursuant to utilization review;

2. claims payment, handling, or reimbursement for health care services; or

3. matters pertaining to the contractual relationship between a Member and NHP.

Only those providers who have been directly involved in the treatment or diagnosis of the Member relating to the Grievance may submit a Grievance on behalf of a Member.

Group Plan means the written document which is the agreement between the Employer and NHP whereby coverage and benefits specified herein will be provided to Covered Persons. The Group Plan includes the Certificate of Coverage, all applications, rate letters, face sheets, riders, amendments, addenda exhibits, and Schedule of Benefits which are or may be incorporated in this Plan from time to time.

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

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

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

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

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

INJURY means an accidental bodily injury that:

A. Is caused by a sudden, unintentional, and unexpected event or force;

B. Is sustained while the Covered Person's coverage is in force; and

C. Results in loss directly and independently of all other causes.

LIFETIME BENEFIT MAXIMUM means the total amount of Covered Services payable to a Covered Person by NHP under the Group Plan and any renewals thereof. The Lifetime Benefit Maximum is set forth in the Schedule of Benefits.

MAIL-ORDER CO-PAYMENT means the amount payable to the Mail-order Pharmacy for each Covered Prescription Drug and/or Covered Supply as set forth in the Schedule of Benefits.

Mail-order Pharmacy means the mail-order pharmacy designated by NHP..

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

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

MEMBER means an Eligible Employee or Eligible Dependent covered under this Group Plan.

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

NON-PARTICIPATING HOSPITAL means a Hospital which has not made an agreement with NHP to provide services to Covered Persons.

NON-PARTICIPATING PHARMACY means a Pharmacy that has not made an agreement with NHP to provide services to Covered Persons.

NON-PARTICIPATING PHYSICIAN means a Physician who has not made an agreement with NHP to provide services to Covered Persons.

NON-PARTICIPATING PROVIDER means a Non-Participating Hospital, a Non-Participating Physician, or a Non-Participating Health Care Provider who has not made an agreement with NHP to provide services to Covered Persons.

NON-PREFERRED PRESCRIPTION DRUG refers to a drug manufactured and marketed under a trademark or name by a specific drug manufacturer but is **not** identified on NHP's Preferred Medication List as a preferred drug.

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

A. Acting within the scope of that person's license; or

B. Authorized by a Physician; and

C. Not a Covered Person of the Covered Person's immediate family.

OFFICE means the Office of Insurance Regulation.

OUT-OF-POCKET MAXIMUM LIMIT means the maximum amount of Covered expenses each Covered Person pays every Calendar Year before benefits are payable at one hundred percent (100%) of the Allowance under this Plan.

PARTICIPATING HOSPITAL means a Hospital which has made an agreement with NHP. to provide service to Covered Persons.

PARTICIPATING PHARMACY means a Pharmacy which has made an agreement with NHP to provide service to Covered Persons. The Mail-order Pharmacy is also a Participating Pharmacy.

PARTICIPATING PHYSICIAN means a Physician who has made an agreement with NHP to provide service to Covered Persons.

PARTICIPATING PROVIDER means a Participating Hospital, a Participating Physician, or a Participating Health Care Provider who has made an agreement with NHP to provide services to Covered 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 is a person properly licensed to practice medicine pursuant to Florida law, or another state's applicable laws, including:

A. Doctors of Medicine (MD) or Doctors of Osteopathy (D.O.);

B. Doctors of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.);

C. Doctors of Chiropractic (D.C.);

D. Doctors of Optometry (O.D.);

E. Doctors of Podiatry (D.P.M.).

PREFERRED BRAND-NAME PRESCRIPTION DRUG refers to a drug manufactured and marketed under a trademark or name by a specific drug manufacturer and identified on the drug Preferred Medication List as a preferred drug.

PREFERRED MEDICATION LIST means a list of drug products, including their strengths and appropriate dosages, that are available for use by Covered Persons.

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

PRIMARY CARE PHYSICIAN means a Participating Physician who has been chosen by the Covered Person to be responsible for providing, prescribing, directing, and authorizing all care and treatment for the Covered Person.

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

SERVICE AREA means the geographic area shown in the Service Area provision of this Group Plan, in which NHP is authorized to provide health services as approved by the Agency for Health Care Administration.

SERVICE WAITING PERIOD means a period of time after full-time employment begins before an employee is first eligible to enroll under this Group Plan. The service waiting period is determined by the Employer. In no case will coverage begin later than ninety (90) days after the date full time employment began.

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

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

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

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

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

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

SMALL EMPLOYER OR EMPLOYER means the employer who has signed a Contract with NHP, allowing this group health insurance coverage to be provided. To be eligible for coverage, a Small Employer means in connection with a health benefit plan with respect to a Calendar Year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business. The Small Employer must have it's principal place of business in this state, employed an average of at least one (1) but not more than fifty (50) eligible employees on business days during the preceding Calendar Year, and employs at least one (1) employee on the first day of the plan year.

SUBSCRIBER means the Eligible Employee covered under this Group Plan.

URGENT CARE means medical screening, examination, and evaluation received in an Urgent Care Center or rendered in your Primary Care Physician's office after-hours and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

URGENT GRIEVANCE means a Grievance regarding an Adverse Determination when the standard time frame of the Grievance procedure would seriously jeopardize the life or health of a Member or would jeopardize the Member's ability to regain maximum function.

WAITING PERIOD shall mean the period, if any, that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of this Group Plan.

WE, US, OUR means Neighborhood Health Partnership.

YOU, YOURS means the Eligible Employee or Eligible Dependent who is a Covered Person under this Group Plan.

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