

AMENDMENT TO GROUP STOP-LOSS POLICY

ISSUED BY HUMANA INSURANCE COMPANY

AMENDMENT NO. 1

ATTACHED TO GROUP STOP-LOSS
POLICY NO. 707218

EFFECTIVE DATE OF
THIS AMENDMENT
January 1, 2014

The following provisions are made a part of the Group Stop-Loss Policy to which this Amendment is attached; however, nothing contained herein shall vary, alter or extend any provision of the Group Stop-Loss Policy to which this Amendment is attached except as stated herein:

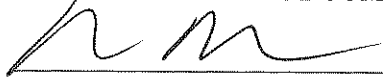
A NEW SCHEDULE OF COVERAGE IS ADDED TO THE GROUP STOP-LOSS POLICY COVERING THE COVERED PERSONS OF LEXINGTON FAYETTE URBAN COUNTY GOVERNMENT. THIS NEW SCHEDULE OF COVERAGE SHALL SUPERSEDE AND BE SUBSTITUTED FOR ANY PREVIOUSLY EXISTING SCHEDULE TO THE POLICY OF THE SAME OR SIMILAR DESIGNATION.

IN WITNESS WHEREOF, Humana Insurance Company has caused this Amendment to be executed at its Home Office in the City of Green Bay, Wisconsin to take effect at 12:01 A.M., Standard Time, on the Effective Date shown herein.

Accepted for the POLICYHOLDER by

HUMANA INSURANCE COMPANY

AUTHORIZED REPRESENTATIVE - TITLE



BRUCE BROUSSARD
PRESIDENT

STOP-LOSS SCHEDULE OF COVERAGE

HUMANA HEALTH PLAN

1100 Employers Blvd.
Green Bay, WI 54344

This Schedule of Coverage forms a part of the Policy issued to the Policyholder and shall be effective as of January 1, 2014 and continue in effect until December 31, 2014 unless sooner amended or revised.

Name of Policyholder's Plan: Lexington Fayette Urban County Government

Plan Administrator: Lexington Fayette Urban County Government
(Humana is *not* the Plan Administrator as defined by ERISA)

Plan Administrator address: 200 E. Main Street, Lexington, KY 40507

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1. Covered entities other than Policyholder (affiliates/subsidiaries or other related entities):

Name	Location	Relationship	Business	Number of Employees
Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

2. Classes of employees excluded from coverage: Not Applicable

3. Covered Benefits:

Specific Stop-loss
<input checked="" type="checkbox"/> Medical
<input checked="" type="checkbox"/> Prescription Drug
<input checked="" type="checkbox"/> Mental Health
<input type="checkbox"/> _____

Does Aggregate coverage mirror Specific coverage above? Yes No
If no, please indicate which claim types are covered under the Aggregate coverage:
No Aggregate Coverage.

4. Coverage Options:

Stop-loss Contract	Explanation
<input checked="" type="checkbox"/> 24/12	Claims Incurred during the period: 01/01/2013 – 12/31/2014 and Paid during the 12 months immediately following the Policy Effective Date
<input type="checkbox"/> 12/12	Claims Incurred and Paid during the 12 months immediately following the Policy Effective Date
<input type="checkbox"/> 12/___	Claims Incurred during the 12 months following the Policy Effective Date and Paid during the period: ___/___/___ - ___/___/___
<input type="checkbox"/> ___/___	Claims Incurred during the period: ___/___/___ – ___/___/___ and Paid during the period: ___/___/___ – ___/___/___

Does Aggregate coverage mirror Specific coverage above? Yes No

5. Run In. Yes No

Aggregate Stop-loss	Specific Stop-loss
<input type="checkbox"/> 3 Months	<input type="checkbox"/> 3 Months
<input type="checkbox"/> 6 Months	<input type="checkbox"/> 6 Months
<input type="checkbox"/> _____	<input type="checkbox"/> _____
Limit:	Limit:

6. Monthly Aggregate Advance Option Yes No

7. Aggregating Specific Option Yes No

Amount – Not Applicable

8. Stop-loss Coinsurance:

Note: Select only one of the options below.

A. Standard Stop-loss Reimbursement (100%) Yes No

This option provides reimbursement for all covered Stop-loss claims at 100%.

B. Stop-Loss Coinsurance Yes No _____%

Under this option, Stop-loss claims will be reimbursed using this designated Stop-loss coinsurance.

C. Domestic Coinsurance (Healthcare providers only) Yes No _____%

Non-Domestic Claims will be reimbursed at 100%

Proposed Policyholders who are healthcare providers or an affiliation of providers that render health care services to individuals covered under the Policyholder's self-funded plan shall provide a list or file of affiliated providers including name, address, and identification number, and inform the Company of updates to this listing as they occur. These stop loss claims for those "Domestic" providers will be reimbursed using this designated stop-loss coinsurance. All other providers will be reimbursed at 100%.

9. Annual Aggregate Maximum Benefit: Not Applicable

10. Annual Specific Deductible: \$250,000

11. Annual Specific Maximum: Unlimited

12. Specific Lifetime Maximum: Unlimited

13. Minimum Annual Aggregate Deductible: Not Applicable

14. Covered Persons with unique Specific Stop-loss deductible amounts and maximums:

Name	Unique Annual Specific Stop-loss Deductible Amount	Unique Specific Maximum Benefit
Not Applicable	<input type="checkbox"/> Lifetime <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unlimited	<input type="checkbox"/> Lifetime <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unlimited

15. Monthly Rates:

	Aggregate Stop-loss Premium	Specific Stop-loss Premium
Employee Only	Not Applicable	\$23.36
Employee + Spouse	Not Applicable	\$42.04
Employee + Child	Not Applicable	\$40.41
Employee + 1	Not Applicable	Not Applicable
Family	Not Applicable	\$49.05
Other	Not Applicable	Not Applicable

Aggregate Stop-loss Monthly Deductible Factors						
Plan Type	EE Only	EE + SP	EE + Child	EE + One	Family	Other
Not Applicable	N/A	N/A	N/A	N/A	N/A	N/A

16. Organ Transplant Step Down Deductible Option Yes No

Note: This option is only available if the Policyholder's Plan incorporates Transplant benefits consistent with Humana's standard, as approved by Humana.

Step-Down Amount – \$10,000, less than the Specific or Unique Specific deductible.